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Brief Admission: manual for training and implementation developed from the Brief Admission Skåne Randomized Controlled Trial (BASRCT).

Liljedahl, Sophie; Helleman, Marjolein; Daukantaité, Daiva; Westling, Sofie

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PO Box 117
221 00 Lund
+46 46-222 00 00

Brief Admission

Manual for training and implementation developed from the Brief Admission Skåne Randomized Controlled Trial (BASRCT)

Sophie I. Liljedahl, Ph. D., Marjolein Helleman, Ph. D., Daiva Daukantaitė, Ph. D. & Sofie Westling, M.D., Ph. D.

REGION SKANE

LUND UNIVERSITY

Clinical Psychiatric Research Center

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Sophie I. Liljedahl, Ph. D., Marjolein Helleman, Ph. D., Daiva Daukantaitė, Ph. D. & Sofie Westling, M.D., Ph. D.

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Daiva Daukantaitė & Sofie Westling
Clinical Psychiatric Research Center, Region Skåne
Psychiatry, Department of Clinical Sciences, Lund, Lund University

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Dedication

Suicide.

It is to be expected that people with recurrent self-harm and complex mental illness including borderline personality disorder will be suicidal. They will be suicidal throughout the Brief Admission. In three days we cannot change that.

It may take years until stress no longer triggers suicidality.

What we can help with over the course of the Brief Admission is the stress.

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List of abbreviations

Brief Admission Skåne (BAS) refers to the current randomized controlled trial evaluating the effectiveness of a standardized version of brief admission (BA) for individuals with recurrent self-harm, escalating suicidality, and BPD.

BA	Brief Admission
BASFM	Brief Admission Skåne Fidelity Measure
BAS	Brief Admission Skåne
BPD	Borderline personality disorder
CES	Clinician Experience Scale (BAS measure)
DBT	Dialectical Behavior Therapy
IES	Individual Experience Scale (BAS measure)
MBT	Mentalization-Based Therapy
RCT	Randomized controlled trial

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Training Requirements

Minimal training requirements

Mental health professional.

Ideal training requirements

Clinicians implementing Brief Admission (BA) in their settings will ideally have at least one year of experience working closely with individuals with recurrent and severe self-harm and suicidal behaviour, including experience working with individuals with Borderline Personality Disorder (BPD). Registration as a licensed mental health professional (nurse, psychologist, psychiatrist) is also preferred.

Important considerations for clinicians implementing BA

It is our collective professional experience that issues related to fitness to practice will become apparent to clinicians working with this population perhaps more quickly than while working with other, less acutely ill individuals. An essential quality for clinicians administering BA is good mental health and the flexibility that emerges from the experience of being mindful of the ratio between one's emotional burdens and resources.

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Steps in BA certification

Clinician competency

The authors provide 1-day BA training. Certification provided upon successful completion.

Trainer competency

After the 1-day BA training, clinicians who would like to become trainers in BA must participate in a workshop that teaches the pedagogical aspects of delivering BA training for clinicians. These mental health professionals should have some familiarity with adherence measures for evidence-based treatments as part of their professional training. They should also have had five of their BA videotaped negotiation discussions reviewed by the two expert raters affiliated with the Brief Admission Skåne Randomized Controlled Trial (BASRCT).

Clinicians who become trainers in BA will also complete an intensive "Train the Trainers" workshop offered by the authors on request. This training initiative also provides certification upon successful completion.

Hospital administrators/Psychiatrist competency

Those with ultimate clinical and legal responsibility for individuals receiving the BA must attend a 1,5 hour presentation to inform them of the practicalities that must be in place on the ward prior to adopting the BA initiative on the ward.

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Agenda: BA training for Clinicians

Time	Activity
8:30	Welcome!
8:45 – 9:30	Overview of the BA intervention Preparations The Contract
9:30 – 09:45	Coffee break
9:45 – 12:00	The Negotiation - *Theory, video and exercise* Approach during BA Ward routines Intake conversation - *Theory, video and exercise* The Admisson

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12:00 – 13:00	Lunch break
13:00 – 14:30	Ward routines Clinician's conversation during the BA *- Theory, video and exercise* The discharge The care stucture Evaluation - IES and CES *- Theory, video and exercise*
14:30 - 15:00	Coffee break
15:00 - 15:30	Practical considerations for the ward Clinical experience with BA
15:30 – 16:00	Summative evaluation "place mat" Exercise
16:00 - 16:30	Review of exercise, concluding remarks, formal evaluation

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Learning Objectives

1. A full understanding of the rationale for BA.

2. The understanding that the goal of the BA is to prevent escalating crisis, self-harm, and suicide attempts.

3. Understanding of the purpose of a “respectfully interested,” supportive and structured approach during the intake conversation, and the other key conversations with the individual during BA.

4. Understanding of the importance of delivering the core elements of BA in a manner that can be objectively evaluated using the Brief Admission Skåne Fidelity Measure (BASFM).

5. Understanding of the documentation associated with this initiative, including rationale for having individuals complete the Individual's Experience Scale (IES), and in completing the Clinician's Experience Scale (CES) themselves.

6. The understanding that BA is not an acute admission, but rather a crisis management strategy intended to increase the individuals’ autonomy at key points of high vulnerability and distress.

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Self-harm, suicide, and BPD

Characteristics and lived experience

Most research and knowledge on the clinical treatment of repeated and severe self-harm arises from the research conducted with individuals diagnosed with Borderline personality disorder (BPD). BPD is the most common personality disorder seen in clinical settings, and it is present in many cultures throughout the world (American Psychiatric Association [APA] Practice Guidelines, 2001). Borderline personality disorder (BPD) is characterized by interpersonal sensitivity, a fearful preoccupation with expected abandonment, and intense but unstable interpersonal relationships (Gunderson, 2011). Other characteristics are affective instability–including intense anger, poor impulse control, and self-harming behaviour at times (DSM-5; APA, 2013), as well as difficulties in relation to identity and self-direction (Bender & Skodol, 2007).

Individuals with BPD are known to experience lifelong struggles as a consequence of the negative effects associated with the disorder. They describe their experience of having a BPD diagnosis as living with a label which can result in limited access to care due in part to self-destructive behaviour, which may be inaccurately perceived by others as manipulation (Nehls, 1994), and due in part also to stigma against BPD within the mental health system.

Individuals with BPD have reportedly greater impairment at work, in social relationships, and in leisure activities when compared to individuals with a major depressive disorder (Gunderson et al., 2011). Unremitting suicidality is a characteristic of BPD. Accordingly, individuals with PBD consume a high volume of health care, social services, and–in particular–psychiatric services and emergency hospital services (Chiesa, Fonagy, Holmes, Drahorad, & Harrison-Hall, 2002).

The onset of BPD is principally during adolescence or early adulthood (APA, 2013), with prevalence estimates ranging from 1-6% of

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the general adult population (APA, 2000; Grant et al., 2008). Many individuals with BPD also have other diagnosable disorders that are severe enough to impair their functioning, largely within the mood, anxiety, neuropsychiatric and personality disorder spectra (Grant et al., 2008; Philipsen et al., 2008). It is estimated that 10% of individuals with BPD complete suicide, which is 50 times higher than estimated mortality from suicide found in the general population (Lieb et al., 2004). As Lieb and colleagues observe, "These individuals can be distinguished from other groups by the overall degree of their multifaceted emotional pain" (p. 453).

Individuals with BPD typically receive psychotherapy as outpatients, but they may also require pharmacotherapy, psychosocial support, and/or crisis intervention for suicidality or severe self-harm. Treatment for individuals with BPD is provided in different settings, including community mental health care (outpatient treatment), day treatment, Brief Admission (BA: in the Netherlands where BA is a treatment option), acute hospitalization, and residential treatment centres. Although BA has a long tradition of being utilized within public healthcare in the Netherlands, there is a notable absence of crisis management protocols in hospitals and outpatient mental health settings internationally. Unfortunately this has led to individuals in crises being poorly served by mental health services historically, due to space limitations and differences in treatment approaches, some of which emphasize keeping borderline individuals out of the hospital.

Recommended Reading

Liljedahl, S. I. (2012). Clinical guidelines for deliberate self-harm, non-suicidal self-injury and borderline personality disorder. Retrieved from the Swedish National Self-Injury Project website: http://nationellasjalvskadeprojektet.se/wp-content/uploads/2016/06/4LiljedahlClinicalguidelines.pdf

Åkerman, S. (2009). För att överleva – om självskadebeteende. Stockholm: Natur och Kultur.

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Effective clinical responses to BPD

Mentalization-Based Therapy (MBT)

Mentalization is the capacity to understand one's own state of mind, one's impact on someone else's state of mind as well as the ability to be curious and try and understand the state of mind of the other. It is the ability to understand actions in terms of thoughts and feelings. The capacity to mentalize is sensitive to emotional arousal. Under conditions of heightened emotional arousal, the capacity to mentalize can diminish. Individuals with BPD in particular are prone to lapses in their ability to mentalize in the face of even mild interpersonal stress. During these moments they experience a sense that people are not behaving predictably or coherently. They misunderstand the motives of others and can perceive neutral behaviour as judging, attacking or humiliating. This can lead to out-of-control behaviour when the individual with BPD is highly emotionally dysregulated. Strengthening the capacity to mentalize in individuals with BPD, particularly at times of high distress, leads to an improved sense of agency and self-control, and protects against affective and behavioural dysregulation (Fonagy, 1998).

The focus of the therapeutic work in MBT is in the "here-and-now." Detailed attention is paid to the affective state of the individual. In the face of insufficient mentalization, the therapist will try and rewind to what happened before the negative event, and then try to establish the affect as well as the interpersonal context in which the negative event occurred. Clarifying the details of the interpersonal event allows the assumptions that triggered the affective storm to become clearer. Once clearer they can be understood, challenged or questioned (Bateman & Fonagy, 2004; 2006).

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Dialectical Behaviour Therapy (DBT)

Dialectical Behaviour Therapy (DBT) is the Cognitive Behaviour Therapy of Borderline Personality Disorder (Linehan, 1993, 2015). The phenomenology of BPD such as pervasive emotion dysregulation and repetitive self-harming and suicidal behaviours are understood within BPD's etiological model, the Biosocial Theory (Linehan, 1993). The Biosocial Theory of BPD describes the disorder as arising from and being maintained by reciprocal interplay between the individual with a sensitive temperament (that is, more quickly and easily stimulated affectively and with a slower return to baseline compared to less sensitive peers) and an invalidating environment. The invalidating environment is one that communicates to the individual either directly or indirectly that their responses, cognitions, and emotions are not only wrong, but that the individual is also to blame for situations that bring them distress. This interaction and transaction between the invalidating environment and the individual with a sensitive temperament produces and maintains heightened emotional arousal and dysregulation of emotion and related systems (Lieb et al., 2004), that, over time, shapes personality functioning towards Borderline symptom presentation (Linehan, 1993). Understandably, the circumstances of an invalidating environment and subsequent out-of-control behaviour are not conducive to skill acquisition required to function well in relationships, at work, or more generally in the context of a meaningful life. DBT is a multi-component intervention for individuals with BPD that, amongst other things, teaches skills that essentially facilitate building of "a life experienced as worth living" (Linehan, 2015).

In order for DBT to be effective, the individual must be alive and participating in therapy. Accordingly, there are a number of stages and targets in DBT that emphasize the preservation of life, and the continuation of therapy as the top-ranking targeted priorities. In order to offset the likelihood of therapist burnout, which is a risk in DBT as it is in MBT, "therapy interfering behaviour" on behalf of the individual and the therapist is discussed and monitored weekly (Linehan, 1993). Therapists providing DBT are part of consultation teams that review the progress of individuals receiving DBT weekly.

Consultation teams ensure that therapist burnout is regularly evaluated, discussed, and protected against within the team (Linehan, 1993). DBT is a multi-component evidence-based treatment for BPD that has been extensively evaluated through randomized controlled trials and meta-analysis.

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Clinical management of crises in the Netherlands

The Dutch Multidisciplinary Guideline for Personality Disorders (2008) recommends Brief Admissions (BA) as a treatment and crisis management approach for BPD. They mention the development of autonomy and promotion of individual choice as key elements defining BA. Individuals should be actively involved in finding solutions for their difficulties even when they are in crisis. Problem-solving even when distressed allows people to gain experience with the handling of crises. It enhances autonomy with regard to the decisions to be made at such times. Also recommended is the development of a crisis plan that outlines those self-management strategies that are likely to be effective during future crises, and planning in advance how to access treatment services when self-management strategies are insufficient.

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What is a Brief Admission?

Brief Admission (BA) is a crisis management intervention that was standardized and is being tested in Skåne within the context of a randomized controlled trial – the Brief Admission Skåne Randomized Controlled Trial (BASRCT). The target group for the intervention are individuals with recurrent self-harming and/or suicidal behaviour, with at least three symptoms of BPD and a history of at least 7 days of admission to a psychiatric ward, or presenting to a psychiatric emergency department at least three times, during the last 6 months. Standardized BA has a duration of three nights maximum, a clear treatment plan, and a maximum of three BAs per month. The treatment plan is arranged by the individual and clinician when the individual is not in crisis. Helleman et al. (2014) performed a review and identified five primary aspects of BA used primarily with individuals diagnosed with BPD:

1. Discussion of the goal of the BA with the individual in advance of a crisis.

2. Notation of the BA procedure in a written contract.

3. Clear understanding of the admission procedure and duration of the BA.

4. Description of the interventions used during the BA.

5. Specification of the conditions for premature discharge, which are partially determined on a case-by-case basis.

BA promotes autonomy and empowerment of the individual in the sense that the individual chooses a BA to prevent a crisis and a general psychiatric admission, which is typically of an unknown duration. The

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BA can be used alongside many other therapeutic interventions, such as DBT or MBT. While admitted to a BA, the individual is still free to attend their pre-existing treatment in outpatient settings as previously planned.

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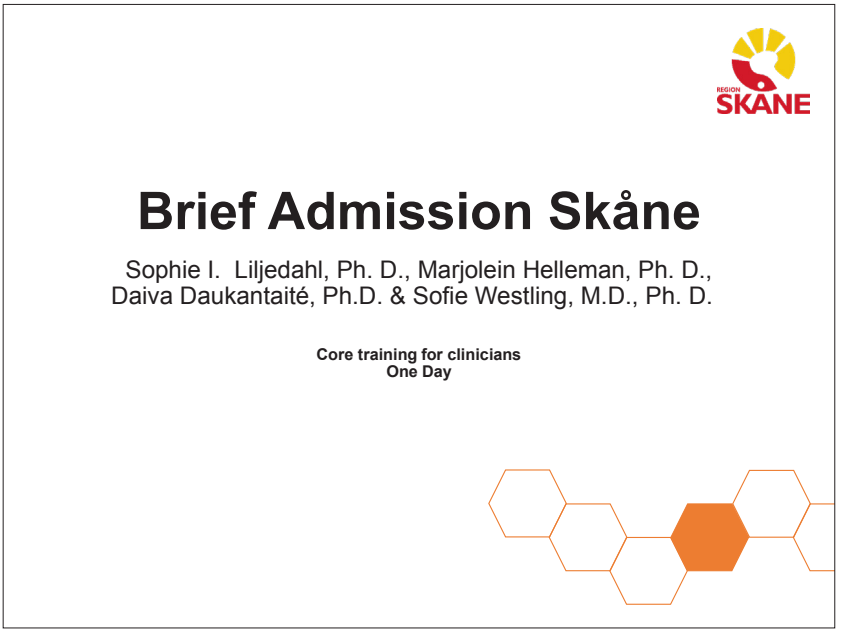
Slides from BA training presentation



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Welcome!

Dedication

Suicide

It is to be expected that people with recurrent self-harm and complex mental illness including borderline personality disorder will be suicidal. They will be suicidal throughout the Brief Admission. In three days we cannot change that.

It may take years until stress no longer triggers suicidality.

What we can help with over the course of the Brief Admission is the stress.

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Learning objectives (1)

1. A full understanding of the rationale for Brief Admission (BA)
2. An understanding of the overarching goal of the BA:
   - **To prevent escalating crisis, self-harm, and suicide attempts**
3. Understanding of the purpose of a "respectfully interested," supportive and structured approach during the BA
4. Understanding of the importance of delivering the core elements of BA in a manner that can be objectively measured and evaluated

Learning objectives (2)

5. Understanding of the documentation associated with this initiative:
   - Individual's Experience Scale (IES)
   - Clinician's Experience Scale (CES)

6. The understanding that the BA is *not* a clinical or acute admission, but rather a crisis management strategy

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Definitions

- **Individual:** Refers to the person seeking mental health services
- **Clinician**: Refers to every person who works with these individuals at the clinic or in the community health care
- **Self-harm:** This signifies behaviours ranging from self destructive behaviour with no suicidal intent through to suicide attempt

(Hawton & James, 2005)

Program BAS training: Morning

Time	Activity
8.30	**Welcome!**
8:45 – 9:30	**Overview of the BA intervention** **Preparations** • The Contract
9:30 – 09:45	**Coffee break**
9.45-12:00	• The Negotiation - *Theory, video and exercise* **Approach during BA** **Ward routines** • Initiating a BA - *Theory, video and exercise* • The Admisson - *Theory, video and exercise*
12:00 – 13:00	**Lunch break**

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Program BAS training: Afternoon

13:00 – 14:30	**Ward routines (continued)** • The The discharge • Premature discharge **The care structure** **Evaluation - IES and CES** *- Theory, video and exercise*
14:30 - 15:00	**Coffee break**
15:00 - 15:30	**Practical considerations for the ward**
15:30 – 16:00	**Summative evaluation** "Place Mat" - Exercise
16.00 - 16:30	**Review of exercise, concluding remarks, formal evaluation**

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OVERVIEW OF BA

Theory

Overview of BA (1)

- Brief admission (BA) is a crisis management intervention with:
  - Maximum three nights duration
  - A clear treatment plan, formulated in a BA-contract
  - A maximum number of BAs per month
- The BA contract is arranged by the individual and the clinician before-hand, when the individual is <u>not</u> in crisis
- Brief Admission Skåne (BAS) refers to the randomized controlled trial used to test the efficacy of this intervention (BA)

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Overview of BA (2)

- Brief admission (BA) addresses individuals:
  - With current episodes of self-harm and/or recurrent suicidality
  - Fulfilling at least three criteria for a diagnosis of BPD
  - Admitted to psychiatric hospital for acute care for at least 7 days or presenting to the psychiatric emergency department at least three times during the last 6 months
  - Age 18-60 years
- Exclusion criteria:
  - No regular contact with outpatient psychiatric services
  - Unstable housing
  - Somatic disorder or need for medication management that significantly contributes to inclusion criteria

Overview of BA (3)

What is BA?

Helleman et al. (2014) performed a review and identified five primary aspects of BA used with patients with Borderline Personality Disorder:

i. Discussion of the goal of the brief admission with the patient in advance

ii. Notation of the brief admission procedure in a written treatment or crisis plan

iii. Clear understanding of the admission procedure and duration of the brief admission

iv. Description of the interventions used during the brief admission

v. Specification of the conditions for premature discharge, which are determined on a case-by-case basis

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Overview of BA (4)

Brief Admission Skåne Fidelity Measure (BASFM):

A. The contract
B. The negotiation process
C. The approach/ “bemötande”

Allows us to evaluate the method objectively
by video taping and rating fidelity

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PREPARATIONS BEFORE BA

A. The contract
B. The negotiation

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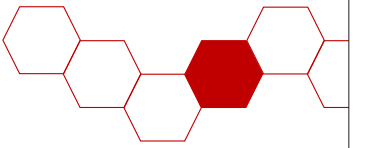
A. The contract

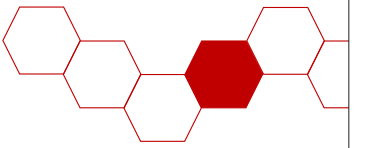
Theory



A. The Contract (1)

Overarching purpose

- To clarify the goal/goals to be achieved through BA
- To enable the individual to determine their own health care
- To explain to the individual how BA works
- To clarify to the individual how they can influence their health care
- To clarify to the individual how BA can be integrated in their daily life



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A. The Contract (2)

- The contract is a document that is completed in a meeting attended by:
  - The individual
  - An intake staff member at the location where BA will be held
  - The individual's primary clinician (outpatient or community-based)
- The contract is a standardized form that you will find in the Brief Admission Training Manual, Appendix 3, Section D
- The contract should be completed with the individual **before they are in a crisis**, at a time when the individual expresses interest in Brief Admission, or when it is suggested by someone within the individual's circle of care

A. The Contract (3)

The purpose of BA:

- To reduce risk of self-harm and suicidal behaviour
- To take control over health care
- To increase sense of personal control over one's situation more generally

Personal goals:

- The individual formulates their own goals with using the BA
- The individual is informed that they will work with a clinician to determine a specific goal for each BA

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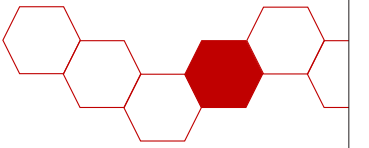
A. The Contract (4)

When and how to apply for a BA?

- The individual's description of their own "early signs" for needing BA
- The BA ward telephone number and address
- The BA hours of operation when one can request a bed
- What to do if the BA-beds are full

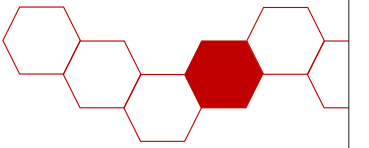
E.g., *try again the next day and plan for support in the meantime*



A. The Contract (5)

How does it work at the ward?

- Maximum 3 days at at time at a maximal frequency of three times/month
- Ward staff are responsible for intake and discharge
- What will be offered on the ward?
  - Up to two 15-20 minute conversations with ward staff daily
  - Participating in activities organized on the wards (give examples)
- What will not be offered on the ward during the BA:
  - Medication (bring your own in a box and store in a locker)
  - Consultation with a physician/psychiatrist
  - Changes in medication or psychotherapy



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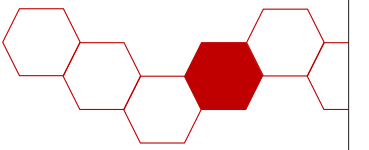
A. The Contract (6)

Health care besides BA:

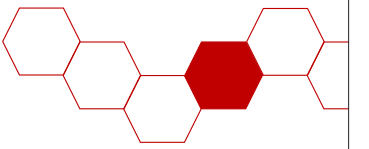
- Also during BA I am responsible for my health care to continue at the out-patient clinic in the form of already planned visits
- Apart from the possibility of having BA, I have access to the same healthcare as if I had not signed this contract



A. The Contract (7)

What do I need to reach my goals during BA?

- Activities to reduce emotional arousal / relax / feel better / distract at the ward
- I prefer this approach from the staff (for example, to be left resting, for me to be the one to initiate contact, etc)
- Other specific support I have at home which may be needed at the ward, with an ongoing focus on the autonomy of the individual



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A. The Contract (8)

My responsibilities that need arrangement when I'm unavailable for three days (children, pets, and so on) including phone numbers to persons that can help with arrangements.

A. The Contract (9)

How is adherence to the contract evaluated?

- The contract is evaluated every six months by those signing
- Every BA will be evaluated at discharge and by using an evaluation form, the Individual Experience Scale (IES)

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A. The Contract (10)

Commitments during BAS:

- To seek and accept help
- To not self-harm or use other destructive behaviours including attempting suicide
- To bring own medication at appropriate doses for the duration of the BA, and not share medication with others
- To follow the rules of the ward
- To not bring any items that might impair safety on the ward (review rules of local ward)
- To not put other people at the ward at risk
- To not become violent or intoxicated over the course of BA
- Other commitments that are specific to me:

Any questions…

…regarding *The Contract*?

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B. The Negotiation

Theory

B. The negotiation (1)

CONDUCTED PRIOR TO THE BA
with the purpose to create a BA CONTRACT.

Regarding the goals of the brief admission

"Discuss with the (individual) what the expectations of the brief admission are. . . . Put this on paper, individually. What to expect from the clinic. Let this be clear."

Individual with experience of BA

(Helleman, Goossens, Kaasenbrood, & van Achterberg, p. 446 (2014)

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B. The negotiation(2)

- The setting is private, quiet, and appropriate for discussion
- Electronic devices are turned off for every person in the room
- The clinician:
  - Shows warmth and engagement
  - Is mindful of the individual
  - Information is not just read to the individual without ensuring that they understand the information being shared
  - Both the individual and the BA clinician remain engaged in the process

B. The negotiation (3)

- The clinician provides a rationale for the parameters of the BA
- During the negotiation process the clinician reflects that the individual's preferences are important
- The clinician does not oppose the individual's point of view. If requests are not possible to grant, the reason is shared
- The clinician is as collaborative as possible asking for suggestions or thoughts during the negotiation

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B. The negotiation (4)

- The clinician plans creatively with the individual to minimize intrusiveness of the BA to the individual's life and priorities
  - Jobs, family members, pets, and other commitments are queried and valued
  - The individual has the freedom to choose to make their own arrangements or ask for help as needed
- Duration: The negotiation is not shorter than 30 minutes or longer than 60 minutes

Any questions….

…about *The Negotiation*?

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B. The Negotiation

Video and exercise

Negotiation, video

- History of the individual in the video
- We will divide in three groups. Take the perspective of:
  - The individual
  - The clinician from the closed ward
  - The clinician from outpatient care

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Negotiation, exercise

- Follow the contract
- Three to four in each group
- Each one a role
- Change roles after 5 mins

Any questions…

…on the preparations before BA?

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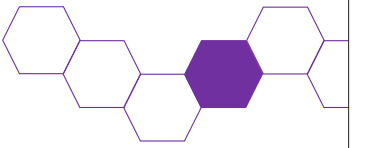
C. The Approach

Theory



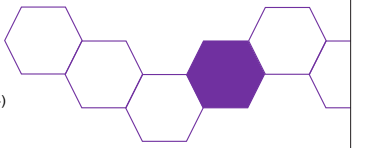
C. The Approach (1)

Overcoming a crisis

- The individuals described conversations with clinicians as most helpful for overcoming a crisis, particularly when they felt the contact involved mutual trust

- The individuals reported that it was hard to start talking about problems and emotions when in the middle of a crisis, and reported feeling emotionally 'locked up', extremely tired, or confused, which made it harder to share their thoughts and emotions

(Helleman, Goossens, Kaasenbrood, & van Achterberg, p.446 (2014)



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C. The Approach (2)

"The nurses think about things which I cannot think about at such moments. What I can do to find distraction, for example (and) how to handle things the next time. You learn what causes the problems, why you react the way you did. I think about these conversations, even after discharge."

Person with lived experience, reflecting on BA

(Helleman, Goossens, Kaasenbrood, & van Achterberg, p.446 (2014)

C. The Approach (3)

1. The clinician greets the individual with warmth and expresses appropriate positive regard for the well-being of the individual

2. The validity of the individual's distress is acknowledged
   - This can be accomplished by carefully listening until there is certainty about why the individual is feeling distressed in their situation. Understanding of the validity of the individual's distress can be in expressed and reflected in a number of ways

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C. The Approach (4)

3. The clinician has a bright demeanor, smiles, and shows enthusiastic interest in individual's efforts as the individual takes the lead in choosing a goal for the brief admission.
   - An energetic and enthusiastic demeanor is maintained unless to do so would clearly invalidate the individual, based on the circumstance surrounding their BA (e.g., death of a spouse or child, or similar)

4. The clinician shares information about the BA process and parameters readily, openly, and transparently. The individual's questions are answered as fully and directly as possible

C. The Approach (5)

5. The clinician is not cold, detached, distant or preoccupied in spoken or body language

6. The individual is not criticized or treated dismissively

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C. The Approach (6)

7. The clinician is both deeply authentic and capable of shifting flexibly between listening and acknowledging the importance of the individual's perspective and requests while also maintaining structure in the meeting.
   - 100% "themselves" [as a person]
   - 100% "themselves" [as a mental health professional]
   - Both qualities are equally present

8. Humor appropriate to the individual and the situation may be used to keep the mood bright.
   - The individual (or anyone in the social or care providing network) is never mocked, made fun of or belittled

Any questions…

…about *The Approach*?

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WARD ROUTINES

Initiating a BA
The admission
Discharge
Premature discharge

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Initiating a BA

Theory

Intitiating a BA (1)

"When I arrive, I have a conversation with the (clinician).
What do you need? What can I do for you?
Who do you want to talk (about)?
So that's all clear to me. "

Individual with experience of BA

(Helleman, Goossens, Kaasenbrood, & van Achterberg, p. 446 (2014)

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Initiating a BA (2)

The individuals described how a conversation at the start of each brief admission helped them:

- overcome their fear of contacting a clinician
- helped to clarify practical matters, such as when to contact a clinician on the ward
- discussing the goal of the brief admission and clarifying issues, such as what the individual was trying to achieve through a brief admission

(Helleman, Goossens, Kaasenbrood, & van Achterberg, p. 446 (2014)

Initiating a BA (3)

The individual calls directly to the ward and asks for BA. The staff who answers the telephone:

a. Starts to look for an available bed. If all BA beds are occupied by BAS, possible alternatives are discussed with the individual and the possibility of calling back next day
b. If a bed is available a time is set for the intake conversation
c. Reviews medical records and BA-contract

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Initiating a BA (4)

If a bed is available the head nurse and the ward psychiatrist are informed.

a. These persons have no further role but need to know which individuals are staying at the ward

Initiating a BA (5)

Upon arrival the clinician:

a. Greets the individual at the earliest possible convenience
b. Shows the individual to their bed in a welcoming and friendly manner
c. Does not check the contents of their bags

The responsibility for the individual's welfare is completely belonging to the individual. This is done deliberately to enhance autonomy. Checking a bag does not support this objective.

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Initiating a BA (6)

Intake conversation during which the clinician:

- Asks what caused the crisis that the individual is trying to prevent
- Validates the feelings of distress of the individual
- Reads the contract together with the individual and talks about the content:
  - What plan is there for relaxation and distraction?
  - Which approach from the staff is preferred?
  - Is medication brought in adequate doses?
  - Review at the safety rules

Initiating a BA (7)

Together with the individual plans the schedule of the admission, including times for conversation.

Together with the individual set a goal for the current BA admission.

Together with the individual sets the date and time for discharge, which is communicated to head nurse (or equivalent) and ward psychiatrist.

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Intake conversation

Video and exercise

Intake conversation - video

At the start of a BA:

- Review the mental health history of the individual
- Two groups - observe as the individual or the clinician
- Exercise in groups, using the checklist

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Intake conversation - exercise

Checklist:

- Welcome the individual in a friendly manner.
- What happened to the individual? Why in crisis?
- What is the goal of the BA?
- Look together to the BA contract.
- How many nights? Discharge date?
- What will work to relax? Look together in the contract. Give some structure to plan these things.
- Did you bring your medication in day boxes?
- Safety on the ward:
  - No knives or other weapons
  - No drugs other than those prescribed, in appropriate doses
  - No…….. (Look at the contract)

Negotiation process / intake conversation

Differences between the negotiation process and the intake conversation

Negotiation process	Intake conversation
Before BA starts	At the admission of BA
In calm period	The individual is aiming to prevent crisis, or is in crisis
With individual, clinic, and outpatient care clinician	With individual and nurse (or equivalent) of the clinic
Goal: make BA contract, (frequency, duration BA, other considerations)	Goal: look at BA contract and discuss practical matters

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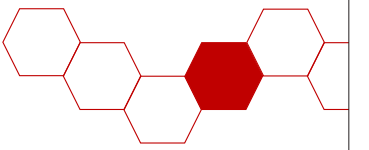
The admission

Theory



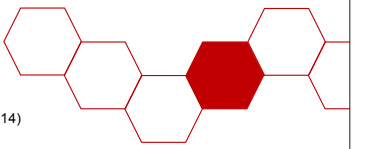
The Admission (1)

Rest and relaxation

- Getting a lot of sleep and rest is perceived as helpful to recovery
- Getting away from the busy responsibilities of daily life
- Having fewer demands

"You feel safe when you're in the clinic. At home, I go on and on, and I run around like a chicken with its head cut off. In the clinic, I surrender, feel my tiredness, and (I) rest."

Individual with experience of BA



(Helleman, Goossens, Kaasenbrood, & van Achterberg, p. 447 (2014)

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The Admission (2)

Distraction

- Pleasant distraction activities help decrease the level of tension.
  - Having a cup of coffee with others or staff
  - Taking a walk
  - Taking a bath/ shower
  - Participating in ward activities

(Helleman, Goossens, Kaasenbrood, & van Achterberg, p. 447 (2014)

The Admission (3)

Structure

"To find the structure again.
Like . . . the sleeping times, the meal times."

- Can help individuals regain a sense of control over their lives.
- Many individuals have overwhelming thoughts and feelings prior to admission due to no structure in the home
- Daily conversations with a clinician to plan the day and achieve a balance between activity and relaxation can provide much-needed structure
- On some wards, individuals can participate in ward activities, such as sports events and group sessions, which was reported to be highly valued

(Helleman, Goossens, Kaasenbrood, & van Achterberg, p. 447 (2014)

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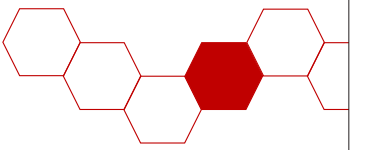
The Admission (4)

Conversations during BA (15-20 mins, one to two times daily):

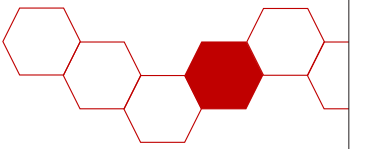
- Focus on here and now
- Topics that are not “here and now” are redirected to the outpatient clinician
- Trying to understand why the individual is upset or in distress when this occurs in relation to the present moment



The Admission (5)

If the individual reports suicidal or self-harming impulses, the BA clinician:

- Asks for triggering events related to the present moment
- Listens carefully to the individual and works hard to understand them and communicate understanding
- If this is not enough, look at the contract to help plan distracting and relaxing activities until the next planned conversation
- At the end of the conversation, the clinician tells the individual when they are back at the ward next time and affirms that they are looking forward to meeting then



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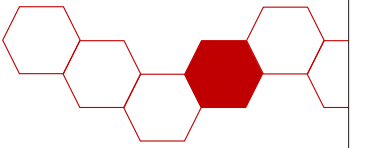
The Admission (6)

Conversation and invitations to activities on the ward are only offered if this is written in the BA contract.

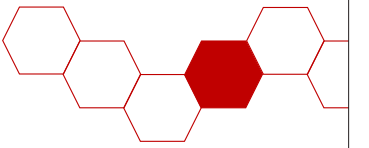
- Requests for rest are respected
- On the other hand, if the client who negotiated a rest wishes to have a conversation, or to join an activity, this is granted



The Admission (7)

To maintain focus on the goal of the BA:

- The clinician may occasionally and respectfully remind the individual of the value of this goal if they become cognitively or emotionally dysregulated or question the validity of the BA and its purpose
- The goal is written in the BA-contract



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The Admission (8)

If the individual wants a therapeutic intervention, they are redirected to speak to their primary clinician outside the BA at their earliest convenience.

- Help to plan the conversation with their primary clinician outside the BA is offered
- In other words, discussing or planning how to ask for the intervention is not taboo

The Admission (9)

- Amount and nature of contact with clinicians has been determined in the BA contract
- This is adhered to as closely as circumstances allow

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The Admission (10)

Specific questions that may arise:

- The contract as documented will remain as it is
  If the individual wants things changed during a BA they can practice putting limited changes into place while on the ward
- The individual cannot have more than one to two conversations with clinicians a day
- If the individual wants less contact than planned, their progress will be evaluated (by themselves and the clinicians at the termination of the BA)
- Feedback will be shared to determine whether the BA still had good results and if the individual still meets the goal of the BA including the changes implemented during BA

Questions...

… on The Admission?

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Clinician's conversation during the BA

Video and Exercise

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Clinician's conversation during the BA

Video

- Mental health history of the individual
- Two groups - observe as the individual or the clinician
- Exercise in groups, using the checklist

Clinician's conversation during the BA

Checklist

- Structure in time and frequency
  (15-20 min conversations with staff, maximum two times/day)
- Stay in the here and now
- Try to understand why the patient is upset or stressed
- Make the individual feel understood and heard
- Validate their feelings
- Redirect other topics to the community mental health clinician

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Discharge

Theory

Discharge (1)

The time for discharge is planned during the intake conversation

The clinician requests feedback regarding the experience of the BA for the individual.

- What went well?
- Were the goals of this BA met?
- What can be done different next time, by both the clinician and the individual?
- Emphasize that the use of the BA is a learning process. This is particularly relevant if there is a premature discharge

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Discharge (2)

The clinician responds to the individual's feedback in an open and non-defensive manner.

- If there are negative observations or comments, collaborative suggestions can be asked for regarding how to plan for BAs going forward so that negative experiences can be minimized or avoided when possible in the future

Enhancing the individual's autonomy is a cornerstone of the BA.

- Being mindful of opportunities to increase autonomy through goals set in future BAs are discussed and documented for future reference

Premature Discharge (1)

Conditions for Premature Discharge:

- Violation of the BA contract, self-harming behaviour, aggressive behaviour, or alcohol/drug use are often described as conditions for premature discharge
- These are discussed with the patient on beforehand.
- It may seem contradictory to discharge a patient with self-harm behaviour for showing symptoms of being in crisis. The rationale is that BA must be a safe place
- The individual is welcome to seek emergency / general psychiatric admission if their needs exceed what can be safely offered during BA

(Helleman, Goossens, Kaasenbrood, & van Achterberg, 2014)

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Premature Discharge (2)

Communication during and about premature discharge must be exquisitely on-point:

- neither minimizing the seriousness of breaking the contract
- nor blaming the individual for engaging in the behaviour for which they are seeking treatment.

Make it clear that nobody has failed here.

Premature Discharge (3)

- Emphasize that all people need time to learn, and so their response may be less than perfect when first getting used to BA
- Validate the loss to the person who is discharged prematurely. It is fine to communicate sadness that it did not work out this time
- Follow quickly up with instructions to initiate another BA as soon as the individual feels it would be helpful

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Premature Discharge (4)

- Remind the individual that this experience can be used to plan more carefully for the next BA
- Be explicitly clear that they are warmly welcome back and that we (staff) will be happy to see them
- Some individuals using BA who must be discharged prematurely may have difficulty expressing emotions accurately. Some might dissociate due to shame or become defensive and angry if they are triggered to recall earlier events that feel like rejections or failures

Any questions…

…regarding Discharge?

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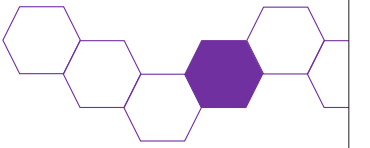
The Care Structure

Theory



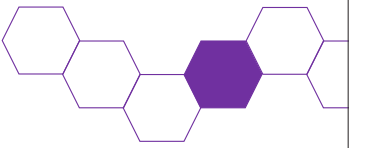
The Care Structure (1)

The mental health professional with ultimate clinical responsibility for the individual has approved BA method in the setting.

- If this is not the case, please do not implement the BA method until there is clinical and administrative support

There has been a review of the individual's chart prior to the BA, or staff are closely familiar with the individual's mental health history and needs during the BA, specifically:

- Current risk of self-harm and suicide
- Current status in relation to alcohol and substance use
- Current status in relation to interpersonal violence
- Current status in relation to risk for aggression towards others on the ward



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The Care Structure (2)

”The goal is, of course, to prevent worsening. . . .
To prevent ending up on a slippery slope.
The brief admission can stop the slippery slope.”

Individual with experience of BA

Helleman, Goossens, Kaasenbrood, & van Achterberg, (2014). p. 446

The Care Structure (3)

One contact person/clinician per hospital shift is available for the individual on the ward during the BA. After shift changes, the individual is informed who their primary clinician is for the that shift.

The individual, the outpatient clinician and a clinician from the ward create a BA contract, which includes a BA goal that is jointly agreed upon by all three.

The goal of the BA is determined in advance, during the negotiation process.

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The Care Structure (4)

A BA contract is signed by:

- The individual
- The clinicians of the clinic
- The outpatient mental health care provider

indicating that they understand and agree with the parameters of the BA

The individual receives no other mental health intervention from the ward other than the contact with the ward staff during the BA and previously scheduled appointments as part of their treatment as usual.

The individual is informed at this juncture (now) that changes in medication can only be initiated by the outpatient clinician, not during the BA.

The Care Structure (5)

The head nurse or equivalent approves the final brief admission contract.

The nurse expresses appreciation / acknowledges the positive decision made by the individual to seek support at a time they felt they were decompensating.

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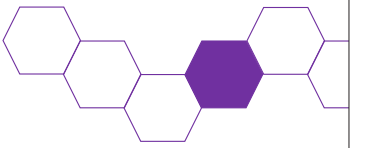
Any questions…

…regarding the Care structure?



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IES and CES scales

Exercise

IES and CES scales

The *Individual's Experience Scale* (IES) is developed in order for the individual to be able to evaluate the BA. The individual completes it themselves.

- (After completion, the last page is filled in and put in the electronic record of the individual)
  - An exception exists, regarding an RCT testing BA, which uses online data collection tools for this purpose

The *Clinician's Experience Scale* (CES) is developed to evaluate the experience of the BA on behalf of the clinician.

- After completion, the last page is filled in and put in the electronic record of the individual
  - The same exception is made with respect to documentation for the RCT

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IES and CES Exercise

Exercise

- Look at the film with the negotiation conversation
- Complete section B in IES or CES
- Discuss the experience with your neighbour

Practical considerations for the ward

Interview on Skype with clinician currently working with BA.

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Summative evaluation

“Placemat exercise”.

Learning objectives

1. A full understanding of the rationale for Brief Admission (BA).
2. The understanding that the goal of the BA is to prevent escalating crisis, self-harm, and suicide attempts.
3. Understanding of the purpose of a “respectfully interested,” supportive and structuring approach during the BA.
4. Understanding of the importance of delivering the core elements of BA in a manner that can be objectively evaluated.

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Learning objectives (2)

5. Understanding of the documentation associated with this initiative:
   - Individual's Experience Scale (IES)
   - Clinician's Experience Scale (CES).

6. The understanding that the BA is *not* a clinical or acute admission, but rather a crisis management strategy.

Concluding remarks

Feedback from summative evaluation

Concluding remarks from the training

Completion of a formal evaluation

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Thank you for your attention!

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APPENDIX 1:
Individual's Experience Scale

Individual's Experiences Scale (IES)

Please respond to the following questions with respect to your experience as an individual receiving the Brief Admission (BA) intervention by circling the number that best expresses your perspective. Please complete these forms for the BA that you just experienced. Fill it in before you are discharged.

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A. Care Structure

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. My BA contract was followed as closely as I needed for the BA to be successful. I was given a copy of relevant paperwork explaining BA and documenting my agreement.	0	1	2	3	
2. Medications and services I receive on an outpatient basis were managed as planned in my BA contract.	0	1	2	3	
3. I had the support I needed from the ward staff and the ward setting itself in order for the BA to be successful.	0	1	2	3	

Comments: .....

.....

.....

.....

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B. The negotiation process: The time in which we planned the BA, its goal, and structure

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. Information was shared with me in a way I could understand in terms of what to expect from the BA (that is, specification of location, number of nights, frequency of BA, how to manage my medications, degree of contact and responsiveness from clinicians, as well as rules for early discharge).	0	1	2	3	
2. During the negotiation process, I truly felt as though we were working towards forming an agreement that was based on acceptance and respect.	0	1	2	3	
3. I felt that the clinician maintained a view of my needs throughout the negotiation process.	0	1	2	3	
4. The tone of the negotiation process felt like we were working together on equal footing throughout. Both I myself and my clinician contributed to what was ultimately decided.	0	1	2	3	
5. I received an explanation for the rationale for why things are structured the way they are in the BA. I was given a reason if a request I made could not be granted.	0	1	2	3	
6. My BA was planned carefully, so that important commitments in my life such as family members, jobs, pets, volunteer placements (and so on) were not intruded upon. If this was unavoidable, I felt supported to plan extra steps to reduce chaos in my life caused by my absence.	0	1	2	3	

Comments: .....

.....

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C. The admission

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. My clinician was able to greet me in a timely manner when I first checked into the ward.	0	1	2	3	
2. My clinician was respectful and sharing in their manner with me when showing me to my bed. My belongings were not checked.	0	1	2	3	
3. My clinician stuck to the BA contract in terms of starting conversations and activities with me.	0	1	2	3	
4. Even if I requested minimal clinician contact during my BA, I was not ignored. On the other hand, I was not pursued or persuaded to engage in unwanted conversations or activities on the ward.	0	1	2	3	
5. If it happened that I wanted some treatment or service (e.g., medication change) not offered during the BA, my clinician helped me to make a plan for how I could get it as soon as possible after I was discharged from the BA.	0	1	2	3	
6. The amount and type of contact between myself and my clinician was followed the way we planned it in the BA contract as much as possible.	0	1	2	3	

Comments: .....

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D. The approach during BA

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. My clinician expressed sincere regard for my well-being as I was welcomed to the BA.	0	1	2	3	
2. I felt that my suffering was acknowledged in the best way possible for me.	0	1	2	3	
3. My clinician enthusiastically applauded my progress over the BA as much as possible.	0	1	2	3	
4. My clinician shared information freely and openly with me.	0	1	2	3	
5. My clinician was focused on my care, and showed me warmth even if our contact was limited based on my request in my BA contract.	0	1	2	3	
6. I felt that my decisions and point of view were valued by the clinician. If my clinician disagreed with me, my clinician expressed their disagreement respectfully and provided a reason for their point of view.	0	1	2	3	
7. I truly felt that my clinician was both sincere and professional in how they worked with me during the BA.	0	1	2	3	
8. My clinician used appropriate humor and lightness, in order to create and maintain an up-beat environment on the ward.	0	1	2	3	

Comments: .....

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E. Discharge

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. My discharge from the BA went as planned in my BA contract.	0	1	2	3	
2. My clinician sought feedback from me regarding how I felt the BA went.	0	1	2	3	
3. If I had negative reflections or feedback, my clinician took time to openly plan how to improve things for me in future BA.	0	1	2	3	
4. My clinician planned with me in a way that shared power and responsibility about how I can increase my independence in future BAs, based on what we learned in this BA.	0	1	2	3	

Comments: .....

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F. Overall BA evaluation

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. I truly felt that the decisions made by me, my clinician and the outpatient/community clinician during the BA negotiation resulted in the best possible outcome for me, given my circumstances.	0	1	2	3	
2. Although acute crises are always stressful, I feel as though the structure in place to manage crises during the BA were sufficient to avoid stress and conflict between me and my mental healthcare providers.	0	1	2	3	
3. I would not hesitate to recommend BA to anyone else in my circumstance.	0	1	2	3	

Any other parts of the BA that you would like to share based on your experience?

Comments: .....

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Thank you for your time and participation!

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Individual's Experience Scale Scoring

Domain		Highest possible score	Achieved score	Observations
A	Care structure	9		
B	The negotiation process	18		
C	The admission	18		
D	The approach during BA	24		
E	Discharge	12		
F	Overall BA evaluation	9		
	Total	90		

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APPENDIX 2:
Clinician's Experience Scale

Clinician's Experience Scale (CES)

Please respond to the following questions with respect to your experience as a clinician delivering the Brief Admission (BA) intervention in your setting by circling the number that best expresses your perspective. Please complete these forms for the BA that you just delivered.

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A. Care Structure

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. There were no barriers in completing all the necessary documentation for the BA.	0	1	2	3	
2. There were no structural barriers in my ability to be present for the individual who received the BA under my care to the extent requested by the individual in their BA contract.	0	1	2	3	
3. There was a good collaboration amongst myself, the individual, and the outpatient clinician regarding the planning of the BA admission.	0	1	2	3	
4. The contract was adhered to without major deviation.	0	1	2	3	
5. Medications were managed as specified in advance in the BA contract and no other therapeutic interventions were given on the ward during the BA without major deviation.	0	1	2	3	
6. I had the support I needed from the head nurse in order to prepare myself for the BA.	0	1	2	3	
7. I had the support I needed from my colleagues on the ward and the setting itself required in order for the BA to be successful.	0	1	2	3	

Comments: .....

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B. The negotiation process (both the initial major and subsequent minor negotiations), prior to BA

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. There were no barriers in sharing an understanding of the BA parameters between myself and the individual (that is, specification of location, number of nights, frequency, medications, degree of contact and responsiveness from me, as well as rules for premature discharge).	0	1	2	3	
2. The negotiation process truly felt as though we were working towards forming an agreement that was based on acceptance and respect.	0	1	2	3	
3. I was able to maintain a view of the individual's needs throughout the negotiation process.	0	1	2	3	
4. The tone of the negotiation process was collaborative throughout. The individual and I both contributed to what was ultimately decided.	0	1	2	3	
5. I was able to explain the rationale for the parameters of the BA, and provide a reason if I was unable to grant a request by the individual that they initially wanted in their BA contract.	0	1	2	3	
6. I made sure to plan the BA carefully with the individual, ensuring that important commitments in their lives such as family members, jobs, pets, volunteer placements (and so on) were not intruded upon. When this was unavoidable, I supported the individual to take extra steps to minimize intrusion.	0	1	2	3	

Comments: .....

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C. The admission

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. I was able to greet the individual in a timely manner when they first checked into the ward.	0	1	2	3	
2. I was able to maintain a respectful and collaborative tone when showing the individual to their bed. Nothing on the individual's person, clothing or belongings were checked.	0	1	2	3	
3. I was able to adhere to the BA contract with respect to initiating conversations and activities without major deviation.	0	1	2	3	
4. I did not ignore individuals who wanted minimal contact during their admission. I also did not pursue them to do more than was written in their BA contract, nor did I try to persuade them to become engaged in conversations or activities.	0	1	2	3	
5. When an individual wanted an intervention not offered during the BA, we made a plan together regarding how the individual could get the desired intervention as soon as possible after completion of the BA.	0	1	2	3	
6. The amount and nature of contact between myself and the individual was followed as specified in the BA contract without major deviation.	0	1	2	3	

Comments: .....

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D. The approach during BA

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. I expressed sincere regard for the individual's well-being as I welcomed them to the BA.	0	1	2	3	
2. I validated the individual's experience of distress in a manner consistent with their request for responsiveness in the BA contract.	0	1	2	3	
3. I maintained a bright stance as much as possible and appropriate to the individual's circumstance.	0	1	2	3	
4. I shared information freely and openly with the individual.	0	1	2	3	
5. I remained engaged, warm, and focused on the individual, even if our contact was limited based on the request of the individual as specified in their BA contract.	0	1	2	3	
6. I affirmed the decisions and perspective of the individual. If I disagreed with the individual, I expressed my disagreement respectfully and provided a rationale.	0	1	2	3	
7. I remained sincere and professional in my demeanor at all times.	0	1	2	3	
8. I used humor and lightness appropriate to the individual and situation, in order to create and maintain a friendly environment on the ward.	0	1	2	3	

Comments: .....

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E. Discharge

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. There were no significant deviations in the discharge process as specified in the BA contract.	0	1	2	3	
2. I sought feedback from the individual regarding their experience of the BA.	0	1	2	3	
3. If the individual had negative reflections or feedback, we took time to openly plan how to improve things for the individual in future BA.	0	1	2	3	
4. We planned collaboratively regarding how the individual's autonomy might be enhanced in future BAs, based on what we learned in this current admission.	0	1	2	3	

Comments: .....

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F. Overall BA evaluation

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Not Applicable
1. I truly felt that clinical decision-making with the individual, myself, and the outpatient clinician during the BA crisis planning resulted in the best possible outcome for the individual, given their circumstances.	0	1	2	3	
2. Although acute crises are always stressful to a certain extent, I feel as though the parameters in place to manage crises during the BA were sufficient to protect my own well-being with respect to conflict and stress.	0	1	2	3	
3. I would not hesitate to recommend working as a clinician administering BA to new graduates, my supervisees, and others I have mentored.	0	1	2	3	

Any other elements of the BA that you feel are important to reflect upon based on your experience as a clinician administering this intervention?

Comments: .....

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Thank you for your time and participation!

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Clinician's Experience Scale Scoring

Domain		Highest possible score	Achieved score	Comments
A	Care structure	21		
B	The negotiation process	18		
C	The Admission	18		
D	The BA approach	24		
E	Discharge	12		
F	Overall BA Evaluation	9		
	Total	102		

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APPENDIX 3:
Brief Admission Skåne Protocol

Section A: Brief Admission Care-Providing Structure (Almelo Model)

Ward Psychiatrist

- Has ultimate clinical responsibility for all individuals

Head Nurse

- Has reviewed mental health history of individual from chart or is familiar with their needs from previous BA

- Is responsible for ensuring needs of individual are well-accommodated during the BA

- Gives final approval of the written BA contract

Nurse clinician

- Administers the brief admission

- Works in close liaison with the head nurse, outpatient clinician, and individual

- Completes documentation related to the admission

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Section B: Template for Local mental health service provision

.....

[Please specify responsible clinician]
- Has ultimate clinical responsibility for all individuals

.....

[Please specify responsible clinician]
- Has reviewed mental health history of individual from chart or is familiar with their needs from previous BA

- Is responsible for ensuring needs of individual are well-accommodated during the BA

- Gives final approval of the written BA contract

.....

[Please specify responsible clinician]
- Administers the brief admission

- Works in close liaison with the aforementioned responsible clinician, ambulatory clinician, and individual

- Completes documentation related to the admission

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Section C: Care Structure Checklist

Care Structure Checklist

1. Ward psychiatrist or other mental health professional with ultimate clinical responsibility for the individual has signed off for the brief admission (or other designation indicating agreement or acceptance of ultimate clinical responsibility). Please specify the structure of ultimate clinical responsibility in your setting:

.....

.....

.....

2. Head nurse has reviewed chart for the individual prior to the brief admission (BA), or is closely familiar with the individual's mental health history and needs during the BA. Please describe preparatory steps (reading file or knowing individual's history from previous contact):

.....

.....

.....

3. Nurse clinician is available to the individual over the course of the BA, and completes all relevant documentation for the admission.

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4. Individual (i), outpatient clinician (ii), and a clinician from the ward (iii) make a BA contract, which includes a BA goal that is jointly agreed upon by all three. The goal of the BA is determined during the negotiation process (see below)

5. A contract is signed by the individual indicating that they understand and agree with the conditions of the BA.

6. The individual receives no individual or group therapy or other mental health intervention from the ward other than the contact with the nurse clinician during the BA and already-scheduled appointments with the ambulatory clinician.

7. The individual is informed at this juncture (now) that changes in medication can only be done by the ambulatory clinician.

8. The head nurse approves the final brief admission contract.

9. The nurse expresses appreciation / acknowledges the positive decision made by the individual to seek support at a time they felt they were decompensating. Time and care is taken here. If the individual is crying or otherwise visibly distressed, the negotiation process waits until the client is less emotionally dysregulated. This is achieved through a gentle conversation in which suffering is acknowledged and support is offered.

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Section D: Sample Brief Admission Contract

Brief Admission Contract

Name: .....

Social security number: .....

Date for contract: .....

The purpose of Brief Admission (BA) is to have the choice of being admitted to the hospital, at times I feel at risk of self-harm and suicide attempts, if my previous attempts to disengage from these behaviours have not diminished my urges, which remain high. Through a BA, I can personally manage my own health care, which will help me to further increase the sense of control I experience over myself and my situation.

My goals:
My goal/goals with Brief Admission (BA) are:
(Write the goal /goals which are important to you!)

* .....

* .....

* .....

I will work with a mental health service provider at intake to determine a specific goal for each BA.

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When and how do I apply for BA?
What are early signs for me needing Brief Admission?
(Write early signs that you can notice!)

* .....

* .....

* .....

How do I apply for admission?
I contact the ward providing BA, ward XX, (phone: XXX-XX XX XX, address: XXXXXXXXX). BA is possible every day between 08:00 AM and 8:00 PM, at the hospital beds provided for this type of care. If none of these beds are free, I am welcome to try again the following day and speak on the telephone with someone on the ward about how to get the support I need in the meantime.

The BA setting
Who will I meet when I arrive?
At the ward, I will meet with a clinician who greets me and completes an intake interview.

How long can I stay at the hospital and how often can I admit myself?
BA may last no more than three consecutive days, at a maximum of three times a month.

What will I be offered on the ward during the BA?
I will be offered conversations with the care providers and my contact person for approximately 15-20 minutes once, or at maximum twice a day. These are not psychotherapy sessions, but rather gentle and easy discussions about my day.

I can participate in the activities organized on the wards.

Brief Admission Skåne (BAS): Training manual
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What will not be offered on the ward during the BA?
Consultation with a physician/psychiatrist, or any changes in medication or psychotherapy.

Medication (you must bring your own, at the appropriate dose needed for the duration of your stay).

Can I seek medical care beyond this?
Alongside BA, I have access to exactly the same care that I had if I had not signed this contract, with the exceptions already listed above.

Even during BA I maintain responsibility for my treatment that will continue in regular outpatient care in the form of already-planned visits (for example attending groups in which I am a participant).

What do I need during BA to achieve my goals?
These are things I can do at the ward to reduce my emotional arousal or tension/ feel better/ distract myself:
(Write your own examples, like rest, take a shower, play a game on my phone or in real time, have a cup of tea, go for a walk, do crafts or paint, talk with the staff, listen to music, watch a movie, call a friend…)

* .....

* .....

* .....

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Please specify the approach you prefer from the clinicians:
(For example would you prefer to be in your room resting, initiate contact with the clinicians or would you prefer for them to check in on you, to help you to become more active.)

* .....

* .....

* .....

At times, when I do not feel well, it is important for me that the clinicians are aware of that:
(Write your own examples, like: "I prefer to rest." "I want them to be transparent in how they communicate to me and about me." "I need to be reminded of what's on my crisis plan.")

* .....

* .....

* .....

Other specific support that you have at home that you would like to access on the ward: (describe only if this applies to you!)

.....

.....

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My responsibilities that need arrangement, when I am not available for three days:

If I have children, I will ask .....
to take care for them when I need a BA.

If I have pets, I will ask .....
to take care of them when I need a BA.

If I work I will call this person to inform them of my absence:

.....

Other persons I need to inform that I am I am unavailable for 3 days (like community-based health care, work, school…):

* .....

* .....

* .....

Will my experience of the BA be evaluated?
My experience and outcomes related to the BA will be evaluated every six months by those signing this contract. Also I will evaluate my experience, using an evaluation form, the Individual's Experience Scale (IES).

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What are my commitments during BA?

- I commit to bringing my own medication, at the appropriate dose for the days I will be in BA. I will not share my medication with anyone else on the ward.
- I commit to seeking and accepting help.
- I commit to not self-harming or using other destructive behaviours including attempting suicide.
- I commit to following the rules of the ward.
- I commit to not bringing any items that might impair safety on the ward (review rules of local ward).
- I commit to not becoming violent or intoxicated over the course of BA.
- Other rules which are specific to me:

* .....

* .....

* .....

I understand that commitments become active as soon as I sign this contract.
A signed contract is necessary in order to access BA.
I have read, understand, and agree with the procedures as described above.

.....

Place, date

.....	.....	.....
Individual receiving BA	*Outpatient clinician*	*Ward nurse*

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Section E: Sample Brief Admission (BA) Ward Routines

The process of initiating a BA

- The individual calls directly to the ward to ask for a BA. The clinician who answers:
    1. Seeks an available bed. If no bed is available, the clinician starts looking with the individual for alternatives for today and discusses the possibility of calling back tomorrow.
    2. Chooses a time for the individual to arrive at the ward.
    3. Starts reading up on individual's medical records and contract

- If a bed is available, the clinician informs the clinically responsible physician and the head nurse at the ward that the individual is coming for a BA. These clinicians have no further role, but need to know which individuals are staying at the ward.

- Upon admission, the BA clinician greets the individual at the earliest possible convenience.

- The individual is shown to their bed in a welcoming and friendly manner. The contents of their bags are not checked.

- The BA clinician has an intake conversation with the individual, during which the clinician:
    1. Asks for the reasons for the upcoming crisis and validates the feelings of distress of the individual.
    2. Reads the contract together with the individual and talks about the content:
    i. What plan is there for relaxation and distraction?
    ii. Which approach from the staff is preferred?
    iii. Is medication brought in adequate doses?

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iv. Review at the safety rules.
   a. Together with the individual plans the schedule of the admission, including times for conversation (15-20 mins, one-to-two times daily)
   b. Together with the individual set a goal for the current BA admission.
   c. Together with the individual sets the date and time for discharge.

- The clinician informs the senior psychiatrist and head nurse/primary clinician on what time the discharge is planned.

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During BA

- Individual conversations during the BA consists of 15-20 min talks, one-to-two times daily, according to what is written in the BA contract. During these conversations, the clinician:
    a. Focuses on here and now
    b. Tries to understand why the individual is upset or in distress.
    c. Checks for suicidal thoughts. If present, the BA clinician:
        i. Asks for triggering events in the current situation.
        ii. Listens deeply to the individual feel heard and works hard to understand them and communicate understanding.
        iii. If this is not enough, looks at the contract to help planning distracting and relaxing activities, until the next planned conversations.
        iv. At the end of the talk, the clinician tells the individual when they are back at the ward next time and affirms that they are looking forward to meet then.
    d. Redirects other topics to the outpatient clinician.

- Conversation and invitations to activities on the ward are only offered if this is written in the brief admission crisis plan. Requests for rest are respected. On the other hand, if the client who negotiated a rest wishes to have a conversation, or to join an activity, this is granted.

- The clinician maintains focus on the goal of the BA throughout the duration of the admission. The clinician may occasionally and respectfully share the value of this goal with the individual if they become cognitively or emotionally dysregulated or question the validity of the BA and its goal.

- If individuals want only to rest during the BA, this request is accommodated. If this is the case, these individuals are still greeted and acknowledged by the nurse and other staff on the ward (they are not ignored), but they are not pursued or persuaded to participate in conversations or activities.

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- If the individual wants a therapeutic intervention, they are redirected to speak to their primary clinician outside the ward at their earliest convenience. Help to plan this conversation with their primary clinician outside the BA is offered (in other words, discussing or planning how to ask for the intervention is not taboo).

- Amount and nature of contact with BA clinicians has been determined in the BA contract. This is adhered to as closely as circumstances allow.

- The BA contract cannot be changed during a BA! If the individual wants changes in the BA contract they have to talk with their outpatient clinician about it.

- The medication cannot be changed during a BA! If the individual wants medication changes they have to talk with their outpatient clinician about it.

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Discharge

- The time for discharge is planned during the intake conversation.

- During the discharge planning the clinician:
  a. Requests feedback regarding the experience of the BA. Possible questions:
     i. What went well?
     ii. Were the goals of this BA met?
     iii. What can be done different next time, by both the clinician and the individual?
  b. Responds to the individual's feedback in an open and non-defensive manner.
  c. Emphasize that the use of the BA is a learning process. This is particularly relevant if there is a premature discharge

- Enhancing the individual's autonomy is a cornerstone of the BA. Opportunities to increase autonomy through goals set in future BA are discussed and documented for future reference.

- The individual and the clinician complete the Individual's Experience Scale (IES) and the Clinician's Experience Scale (CES) respectively.

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Premature discharge

Based on the safety standards that underlie the rules of the hospital ward, certain behaviours engaged in over the course of BA are grounds for early termination or discharge earlier than the 3 days planned in the contract. Most often this has to do with engaging in behaviours intended to be avoided as a goal of the BA. In these circumstances premature discharge is necessary, since the purpose in that specific admission can no longer be fulfilled, and because other users of BA, staff, and the unit might be put at risk if safety procedures are not followed.

- Communication during and about premature discharge must be exquisitely on-point:
  a) neither minimizing the seriousness of breaking the contract
  b) nor blaming the individual for engaging in the behaviour for which they are seeking treatment.
- Make it clear that nobody has failed here.
- Emphasize that all people need time to learn, and so their response to other admissions will surely be different from the first one or the one that resulted in premature discharge.
- Validate the loss to the person who is discharged prematurely. It is fine to communicate sadness that it did not work out this time.
- Follow quickly up with instructions to initiate another BA as soon as the individual feels it would be helpful.
- Remind the individual that this experience can be used to plan more carefully for the next BA.
- Be explicitly clear that they are warmly welcome back and that we will be happy to see them.

Finally, please be mindful that some individuals using BA who must be discharged prematurely may have difficulty expressing emotions accurately, including demonstrating sadness about this loss. Some might dissociate due to shame or become defensive and angry if they are triggered to recall earlier rejections or failures. This is an important part of learning.

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Section F: Brief Admission Skåne Fidelity Measure (BASFM)

BASFM SCORING FORM

Video ID# ..... Date .....

A. The contract

0 = Missing (should be present), **0.5** = partially present, **1** = Present, **NA** = Not applicable

Item #	Item	Rater 1	Rater 2
1	Information regarding the purpose:	/1	/1
1a	To reduce the risk of self-harm and suicide	/1	/1
1b	To take control over one's own health.	/1	/1
1c	To increase sense of personal control.	/1	/1
2	Individual asked to write their goals	/1	/1
2a	Informed that they will determine specific goal at intake	/1	/1
3	Clinician explains how and when to apply for BA	/1	/1
3a	Discusses "early signs" for needing BA	/1	/1
3b	Individual asked to write own early signs	/1	/1
4	Procedures for applying for BA explained including		
4a	How the individual contacts the ward	/1	/1
4b	The hours of BA operation when a bed can be requested	/1	/1
4c	What to do if ward is full (try again next day + support)	/1	/1
5	The BA setting is explained	/1	/1
5a	Clinician explains who they will meet at intake conversation	/1	/1
6	Clinician explains how long the individual can stay and how to admit themselves	/1	/1
7	Clinician explains what is offered on the ward, specifically		
7a	Up to two 15-20 min conversations with clinicians is possible	/1	/1
7b	Participating in activities organized on the wards (give examples)	/1	/1

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A. The contract (cont.)

0 = Missing (should be present), **0.5** = partially present, **1** = Present, **NA** = Not applicable

Item #	Item	Rater 1	Rater 2
8	The clinician explains what will not be offered on the ward, specifically		
8a	Consultation with physician/psychiatrist or changes to ongoing treatment	/1	/1
8b	Medication (must bring own)	/1	/1
9	The clinician explains that the individual is responsible for outpatient care & pre-planned visits	/1	/1
10	The clinician explains that medical care co-occurring with BA is still available	/1	/1
11	Individual asked to write in the contract what they can do to reduce arousal	/1	/1
12	Clinician asks if other specific support is needed that the individual has at home	/1	/1
13	Clinician asks for preferred approach over BA	/1	/1
14	Clinician asks what the individual prefers when the individual is feeling poorly	/1	/1
15	Clinician asks about responsibilities that need delegation during BA	/1	/1
16	Clinician explains about evaluation of contract as well as evaluation of every BA completed.	/1	/1
17	Clinician explains committments, specifically:		
17a	Commitment to bring own medication at correct dose; no sharing	/1	/1
17b	Commitment to ask for and accept help	/1	/1
17c	Commitment to not self-harm or use other destructive behaviours	/1	/1
17d	Commitment to follow rules of ward	/1	/1
17e	Commitment not to bring items that would impair safety	/1	/1
17f	Commitment not to put others at risk	/1	/1
17g	Commitment not to become violent or intoxicated	/1	/1
Total A		**/34**	**/34**

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B. The Negotiation process

0 = Missing (should be present), **0.5** = partially present, **1** = Present, **NA** = Not applicable

Item #	Item	Rater 1	Rater 2
1	Setting: Private, quiet, appropriate	/1	/1
2	Electronic devices turned off	/1	/1
3	Communication with warmth and engagement; sharing	/1	/1
4	Rationale and parameters shared collaboratively	/1	/1
5	Individual's preferences shown to be important	/1	/1
6	Nobody opposes the individual's point of view. Reasons for saying no when necessary are shared.	/1	/1
7	Collaborative tone is maintained. Suggestions and thoughts are elicited from individual	/1	/1
8	Freedom to choose is emphasized when discussing how to delegate the individual's responsibilities	/1	/1
9	Duration: Negotiation not shorter than 30 mins or longer than 60 mins	/1	/1
Total B		**/9**	**/9**

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C. Approach

0 = Missing (should be present), **0.5** = partially present, **1** = Present, **NA** = Not applicable

Item #	Item	Rater 1	Rater 2
1	Clinician greets individual with warmth and positive regard	/1	/1
2	Validity of individual's distress is acknowledged (careful listening; expression of understanding)	/1	/1
3	Clinician has a bright demeanor, smiles, has appearance of being glad to be working with individual	/1	/1
4	Clinician shares information openly and transparently. Questions are answered fully.	/1	/1
5	Clinician is not cold or detached, distant, or preoccupied in spoken or body language	/1	/1
6	Individual not criticized or treated dismissively	/1	/1
7	Clinician deeply authentic, flexible, and "themselves."	/1	/1
8	Humor appropriate to the individual and situation to keep the mood bright. Nobody is belittled.	/1	/1
Total C		**/8**	**/8**

Global SUM	**/51**	**/51**

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Notes

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