Keeping on Track

Functional Recovery in Early Psychosis

Orygen
The National Centre of Excellence in Youth Mental Health

EPPIC
Early Psychosis Prevention and Intervention Centre

Special thanks are extended to the clinicians from Orygen Youth Health (OYH) who made themselves available to contribute to this resource. OYH is the specialist youth mental health service located on the Orygen campus in Melbourne. For more than two decades, OYH has been a pioneer in the field of early intervention for emerging and severe mental illness. In that time it has become a world-leader in the development and provision of best-practice mental health care for young people: care founded on clinical expertise and the latest evidence. The integration of OYH's wealth of skills, experience and knowledge into Orygen's comprehensive range of research, clinical and knowledge transfer services enables Orygen to sustain a comprehensive academic health sciences centre at the forefront of innovation in youth mental health care.

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Introduction

Between the ages of 12 and 25 is a period of significant developmental change. It is when young people are individuating, developing social roles and relationships, completing education and beginning vocational paths. The onset of early psychosis can affect a young person's developmental trajectory and may have long-term, adverse effects on their functioning in these areas. Thus, to a young person recovering from an episode of psychosis, retaining or regaining the ability to successfully and independently function and live a meaningful life is at least as important as remission of symptoms.

Interventions to promote functional recovery are therefore crucial and can have lasting benefits if provided early in the course of psychosis. Functional recovery interventions help young people return to previous roles and meaningful activities or develop new skills, roles and interests. In this way, they can support the young person to function day-to-day and approach the future with a sense of hope and optimism.

About this manual

Keeping on track: functional recovery in early psychosis is aimed at mental health professionals working with young people experiencing early psychosis.

This manual has been developed as part of an overall training program delivered by the EPPIC National Support Program (ENSP), which also includes face-to-face training and online learning modules. It should be read in conjunction with the other manuals in this series. The ENSP is assisting with the implementation of the Early Psychosis Prevention and Intervention Centre (EPPIC) Model in early psychosis services.

The EPPIC Model aims to provide early detection and developmentally appropriate, effective, evidence-based care for young people (aged 12–25 years) at risk of, or experiencing, a first episode of psychosis. It has been developed on the basis of many years' clinical experience within the Orygen Youth Health Clinical Program. It has been further informed by the 2011 Early Psychosis Feasibility Study Report written for, and published by, the National Advisory Council on Mental Health.[1] That report includes consensus views from early psychosis experts around the world. It is based on current evidence and the experience of other early psychosis programs internationally, and is shaped by real world considerations.

There are a number of core values and principles of practice that inform the EPPIC Model of care. Ideally, an early psychosis service should incorporate:[2]

- easily accessible expert care
- a holistic, biopsychosocial approach to clinical interventions
- a comprehensive and integrated service approach
- evidence-based clinical practice that promotes recovery
- the presence of youth-friendly culture throughout the service (reflected in staff behaviour, clinical skills, attitudes and decor)
- a spirit of hope and optimism that is pervasive throughout the service
- a family-friendly ethos reflected in all aspects of the service
- a service culture that facilitates culturally sensitive care to all young people and their families and friends
- a high level of partnerships with local service providers.

A functional recovery program is one of the 16 core components of the EPPIC Model. It is important to note that though each of the core components can be read separately, they are interrelated. Thus, the philosophy and aim of the EPPIC Model can only be fulfilled when all of the components are in place to enable provision of an integrated and comprehensive service.

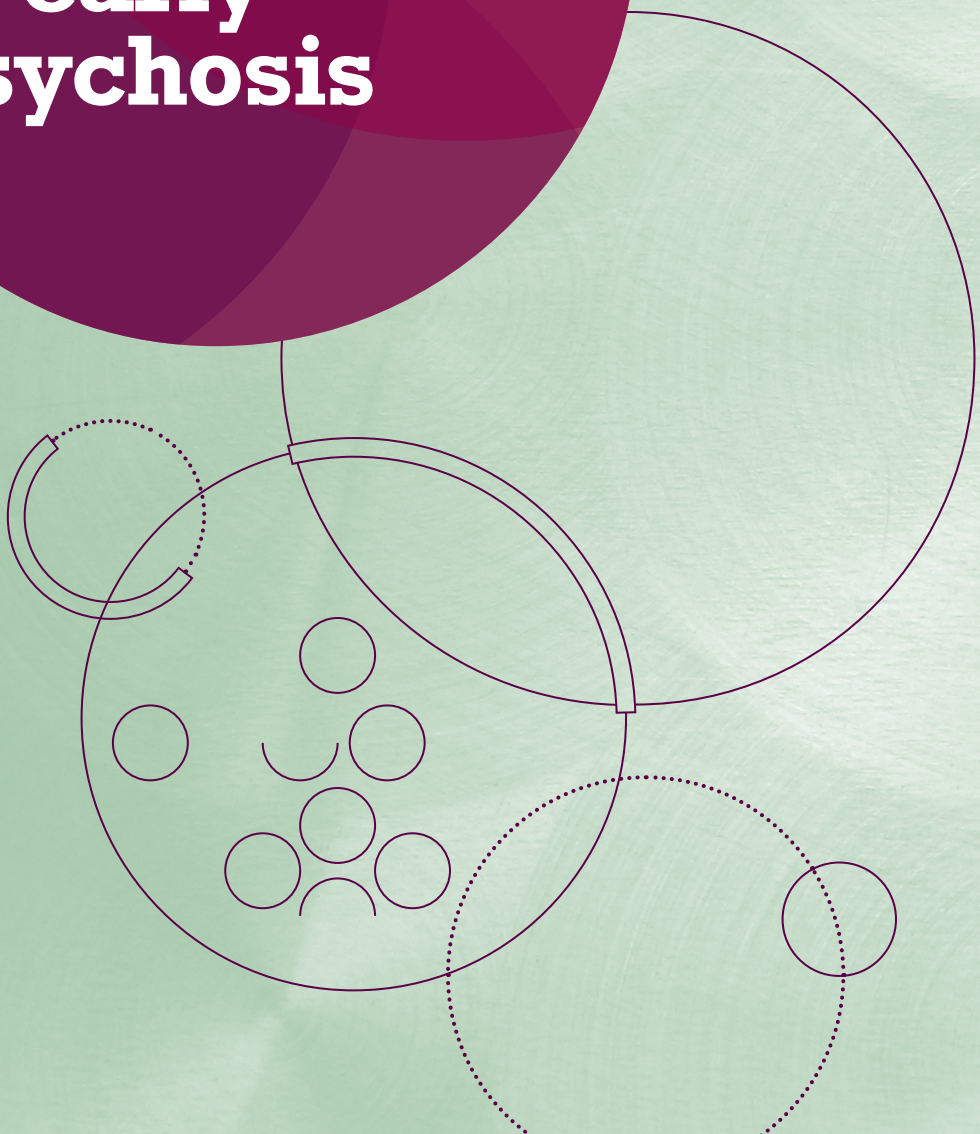
This manual is designed to be a practical guide to incorporating functional recovery interventions in an early psychosis service. It is aimed at all clinicians, including medical practitioners and service leads, who work with young people with early psychosis.

How to use this manual

This manual is divided into three parts. The first, 'Background and rationale', explains what is meant by functional recovery and reviews the evidence for the importance of functional recovery for young people with early psychosis. The second, 'Key considerations for functional recovery', outlines service-level considerations for implementing a functional recovery program in an early psychosis service and describes models and theories that underpin functional recovery, and highlights the core principles of functional recovery in early psychosis. The third part, 'Functional recovery in the real world,' provides an overview of how to assess functioning. The final part, 'Specialised interventions in functional recovery' outlines the interventions used to aid recovery.

Case scenarios and anecdotes from young people who have received care from the EPPIC service at Orygen Youth Health Clinical Program provide real world context throughout.

Functional recovery in early psychosis



Functional recovery in early psychosis

What is functional recovery?

Human function can be understood as a complex dynamic interaction between an individual's behavioural patterns – performed in roles and systems – and the environment in which they are performed. A change in any of these (the individual, their behavioural pattern or activity, or the environment) can both positively and negatively influence functional performance and capacity. For example, if you are right handed, being asked to write with your left hand would probably result in reduced capacity and performance of the task (writing). Over time, and with practice, most individuals would eventually learn to write with their left hand as long as they have the physical, cognitive and emotional components necessary to perform the task.

Early psychosis (including the ultra-high risk [UHR] phase) often involves a decline in the person's functioning – frequently before any psychotic episodes emerge.[3] UHR and first episode psychosis (FEP) often occur in adolescence and early adulthood, when young people are beginning to develop the skills they will need throughout their adult lives. Typically, this involves participating in and completing education and training or looking for work; transitioning out of the family home and developing skills for independent living; exploring sexuality and establishing romantic relationships; and focusing on developing self-sufficiency, financial independence and identity.[4]

Functional recovery can be understood as a reintegration and return to previous roles, habits and meaningful activities. It also includes the development of new skills, roles and interests that are in keeping with the young person's developmental trajectory and that support their goals for the future. Functional recovery should not focus on symptoms. It should focus on what the person is (or isn't) doing, how satisfied they feel with their life and to what degree they are functioning in a meaningful way.[5] Functional recovery should also incorporate the journey of personal recovery, during which the person is able to make sense of their experience and move forward in their life. For young people, this means developing roles, returning to engaging in tasks or activities that are developmentally appropriate, and continuing to develop an interest in new or previously disregarded activities.[6]

Symptomatic remission from the symptoms of mental ill health, though very important, is not an end in itself. Instead it must be seen as part of a process, the ultimate aim of which is to restore the individual's functional capacity. Focusing only on symptom remission is simplistic and falls short of satisfying the expressed needs of young people and families.[7] It is important to realise that functional deterioration is not inevitable for young people with early psychosis. For young people who do experience functional impairment it is not an implicit part but may reflect a range of other factors not related to illness.[7] Not all young people who present with FEP will automatically experience functional deterioration. However, it is important

for clinicians to understand that any mental health problem left untreated has the potential to disrupt normal developmental trajectory.

In keeping with the above description of functional recovery, interventions should broadly focus on a range of domains, including:

- **Personal activities of daily living:** doing the things we need to do every day to survive and look after our own health and wellbeing, and personal hygiene (bathing and grooming, eating, sleep, dressing and taking medication).
- **Instrumental activities of daily living:** more complex tasks such as looking after the household, other people or pets, financial management, communication management, and driving or using public transport. This would also include the ability to negotiate and participate in community activities or attend health-related or other appointments. Such tasks usually require interface with organisations such as banks, public transport, health services or other community agencies and spaces.
- **Educational and vocational functioning:** anything that could be considered as contributing to productivity, such as working, studying, volunteering or engaging in any activities related to training and education.
- **Leisure activities:** it is important to consider how people spend their time when engaged in leisure activities – what they do for recreation or enjoyment, including watching TV or movies or participating in sports, creative pursuits, hobbies and other interests.
- **Social functioning:** family relationships, friendships, intimate relationships, and general social functioning within the broader community including relationships at work, or in educational settings. Social functioning should consider how the person interacts with others across different social settings.

The ability to carry out tasks and activities in all of these domains contributes to an individual's capacity to successfully and independently function and live a meaningful life. Although they are presented as discrete categories, most of these areas are interrelated, so that functioning or activities in one domain will necessarily affect others. For instance, addressing areas of social functioning will probably result in improvements in educational and vocational functioning, and vice versa.

Why is functional recovery important in early psychosis?

FEP has the potential to cause significant disruption across a range of domains.[8,9] Deviations from the normal developmental trajectory have the potential to affect the future lives and everyday functioning of young people. Early functional recovery plays an important role in prevention of longer-term disability.[10] Research shows that deterioration in function begins before threshold onset of psychosis (in the UHR phase); functioning continues to decline after the onset of the first episode.[3,11,12,13]

Early functional recovery is likely to influence long-term outcomes for young people.[14,15] The impact of psychosis needs to be considered both socially and economically. The costs of psychosis are calculated not only in terms of the treatment, but include the loss of productive life. The onset of psychosis at a time of significant vocational development and engagement means that vocational outcomes are significantly worse for people with FEP compared to the general population. Approximately 50% of people are unemployed from the outset of illness and this rate increases to between 75 and 95%.[16]

Similarly, psychosis can significantly impact a young person's educational engagement. Educationally, people with mental illness are disadvantaged compared with their peers in the general community, experiencing higher rates of educational drop-out, which can negatively affect vocational, social and financial outcomes.[2,17] The early phases of a psychotic disorder significantly disrupt social relationships, potentially resulting in social exclusion or isolation. Social exclusion leads to poorer functional outcomes across a range of measures.[18]

People with poorer social, vocational or educational outcomes experience negative economic impacts of this disruption. They are less likely to be able to contribute to society through paid work, and are more likely to be receiving government financial assistance or unemployment benefits and to have poorer physical health outcomes. Recent data suggest that the annual cost associated with individuals with psychosis or their carers being unable to work in Australia is around $2.6 billion every year – more than all health care costs for this group.[19] Although that study included all people living with psychosis in Australia (including those with chronic conditions), it highlights the need to prevent loss of productive life and improve physical health and social functioning outcomes for young people with FEP.

Physical health complications are the single most common cause of mortality among people with psychosis – more common than suicide – and are greater for young people with psychosis than for their peers.[20,21] Generally, people with psychosis (including those with long-term mental illness) have a significantly shorter life expectancy, on average by 15–20 years.[22] This higher physical morbidity may be due to a complex interplay between low physical activity, poor diet, substance misuse, and genetic and illness-related factors such as symptoms and side effects of treatment.[23] Loss of self-esteem, lower quality of life, and added stigma and social exclusion as a consequence of weight gain and poor physical health also need to be considered as potential impacts on young people's lives.

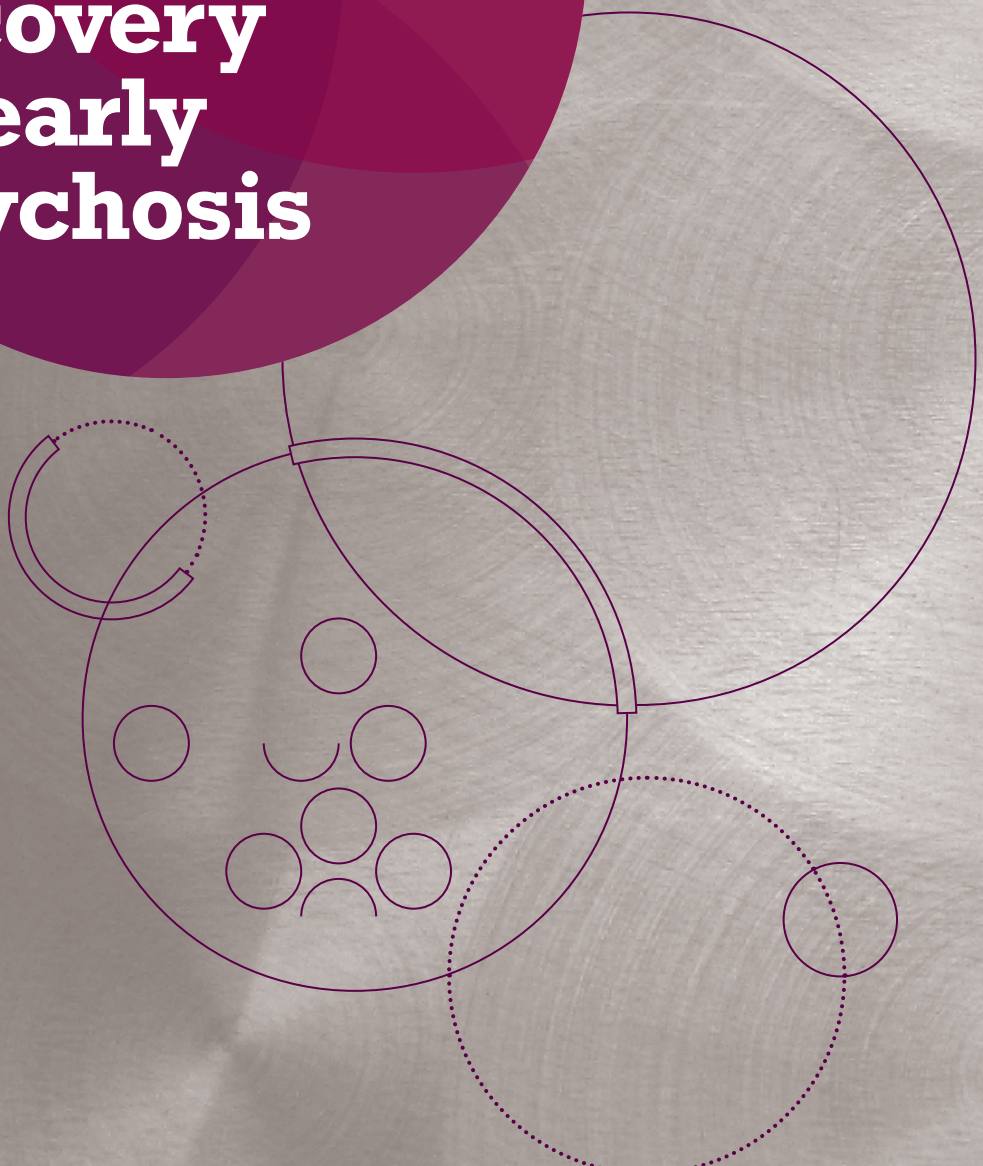
The potential cost to the community through loss of productive life and the economic impact of poor physical health (through increased service use) is difficult to ignore. The national Survey of High Impact Psychosis (SHIP) study reports that health sector costs for people living with psychosis (including mental, physical and pharmaceutical costs) are 3.9 times higher than those of the average Australian.[19]

Early psychosis services have a unique opportunity to prevent loss of functioning and improve interpersonal, psychosocial and vocational functioning for young people receiving care. Early functional and vocational recovery plays a pivotal role in preventing the development of long-term functional deficits and negative symptoms. It emphasises the need for early interventions to specifically address psychosocial recovery.[10] Addressing aspects of functional recovery early on in treatment may also be important for engagement of young people and families in care. Self-esteem and identity, social behaviour and substance misuse by young people who experienced psychosis were the most important concerns for their families.[24] Ramsay and colleagues also examined treatment goals among young people with FEP. Employment, education, relationships, housing, health and transportation were the most frequently stated goals.[25] In the SHIP study that surveyed 1,825 people living with psychosis across Australia, financial matters (42.7%), social isolation (37.2%) and lack of employment (35.1%) were identified as the biggest challenges for the coming year.[26] These were followed by physical health issues (27.4%) and uncontrolled symptoms (25.7%).[26] It is clear that priorities for young people with psychosis and their families centre on the daily aspects of life and a return to normal psychosocial functioning, rather than symptoms. Focusing on these aspects may enhance engagement with the service and with individual clinicians providing and coordinating interventions.

In research involving adults with psychosis, perceived competence in daily tasks and pleasure in work and rest activities were positively correlated with subjective quality of life.[27] In addition, young people diagnosed with psychosis identified occupational engagement, relationships, self-care and vocational activities as all being affected by the acute episode of psychosis. They had to 'reconstruct their lives' (in regard to these areas) to find a way forward in recovery.[28] Therefore, for young people to 'achieve' recovery that is meaningful to them, there must be a focus on improvements in social and occupational functioning. Other research has found that overall wellbeing in young people with FEP is enhanced by engaging in highly-valued activities. This improves self-esteem, self-worth, meaning and purpose in life.[29,30]

Being able to live a meaningful and independent life is important to all individuals. Functional and psychosocial aspects of intervention for young people with early psychosis undeniably are essential components for recovery.

Key considerations for functional recovery in early psychosis



Key considerations for functional recovery in early psychosis

Service-level considerations

Culture, leadership, governance and structure

Functional recovery is a core component of the EPPIC Model; as such, a focus on functional recovery should be a part of the treating team's ethos, actively supported by service leads, case managers and medical staff.[2] Service leads should reinforce the importance of functional recovery as a key outcome for young people receiving care. It is primarily the role of the case manager and treating doctor to provide and coordinate interventions. However, in the case of functional recovery it is important that all parts of the service are equally able to respond to the functional needs of young people and their families.[2]

Service leads must ensure that they employ dedicated staff to provide specialised interventions, such as vocational or educational consultants for vocationally-oriented outcomes, and exercise physiologists/physiotherapists and dietitians to provide interventions to target physical health outcomes. Not only does this directly assist young people receiving care, but it allows case managers to learn new ways of helping young people with their goals through a multidisciplinary approach. Ensuring a mix of disciplines to provide a true multidisciplinary approach and cross-discipline learning is essential. In particular, occupational therapy expertise is valuable to support functional recovery interventions in the team.[2]

In addition to team structure and mix, services should ensure that clinical review processes include discussion and consideration of functional outcomes. Multidisciplinary teams (MDTs) can keep sight of prolonged functional recovery needs that may be overlooked by clinicians focusing predominantly on symptoms or risk. Clinical review meetings provide an opportunity to share experience and ideas around interventions for young people. These processes should incorporate checklists or prompts to discuss formulation and progress, in terms of both symptomatic and functional recovery. Services need to develop and include methods of monitoring symptomatic and functional recovery (or non-recovery). This will enable early identification of young people who may need a more intensive approach to intervention, or who may be entering the prolonged recovery phase.

Screening and reviewing problematic recovery

Services should aim to conduct regular screening for prolonged recovery and for young people who present with multiple and complex needs or risk. This can be captured by outcome data routinely collected by the clinical team (e.g. quality of life measures) or other simple forms of early identification (e.g. standard questions regarding current housing and employment). It is recommended that this type of screening be integrated with the usual processes for case reviews or in clinical review meetings. They should aim to 'flag' young people who require more in-depth review of their treatment or specialised intervention.

In-depth review should consist of a specialised review panel or group of senior clinical staff of each discipline (nursing, occupational therapy, psychology and social work) and senior consultant medical staff (ideally more than one). Meetings should be held regularly – ideally monthly but at least quarterly. They may also involve other senior staff from group programs or other specific areas as needed, such as a vocational specialist or exercise physiologist. The mix of disciplines should represent specialised knowledge of the EPPIC Model core components and domains of recovery – both symptomatic and functional. The aim of this review panel is early identification and coordinated intensive treatment and support for young people presenting with early incomplete recovery (usually around 3 months). This is to prevent further decline in functioning and improve outcomes across symptomatic and functional domains.

The review process should involve the case manager and doctor discussing the case formulation and treatment plan, including interventions that have and haven't worked. Service interventions and responses, such as the after-hours team support response, should also be considered during the in-depth review meeting. A supportive learning environment should be fostered, and active support provided to the treating team to carry out the recommendations of the panel if required. The role of senior clinical staff is to discuss possible options for more intensive or coordinated service response to intervention – for example, referring to a specialist family worker for specific family therapy or to the group program to support social recovery. Medical treatment may also be discussed with senior consultant psychiatry staff. Ideally this would involve a psychiatrist not already supervising the case, and potentially more than one consultant psychiatrist on the panel. This review panel may also achieve early identification of young people who may benefit from commencing clozapine if other antipsychotic medications have not been effective. The panel and treating team then set a timeframe for review of the case and intervention plan.

Managers and service leads should consider a service-level commitment to financing the role of coordinating this panel and collecting data. Such a role could be split between clinical and administrative staff members working together. Documenting the review process is equally important. Review panel members and treating teams should keep in mind that their recommendations need to be realistic, and consistent with the principles of early intervention in psychosis.

Group programs are integral to providing interventions that can address a range of activities to support social and psychological goals. Groups may not always have specific functional recovery objectives as their primary goal, but the setting enables therapeutic work to address various functional goals. The leadership group needs to actively support and encourage case managers to consider how group programs may support the young person's recovery. The group program should be seen as a core element of every young person's treatment and care, rather than an optional add-on.

PRACTICE TIP

Functional recovery of young people should be considered the 'norm'. Case managers and doctors should be discussing functional recovery with young people and families from the very beginning of their involvement with the service, and providing every opportunity for review. The young person and their family might fear that they will never be able to 'get back on track', so it is vital to discuss overall recovery. It should be explicit that functional recovery is expected for every young person in the service.

Service-level barriers and enablers

Service leads should integrate consultants (non-case manager roles) into the MDT, to support an integrated approach to functional recovery. This can be difficult if clinicians are not clear about the objectives of the specialised program and how it fits into the overall service approach to this aspect of care. Specialised staff (e.g. vocational consultants, teachers, exercise physiologists, dietitians) require access to training and supervision to support their work.[2] One way to support specialised staff is to have them participate in team and clinical review meetings.

Clinical review meetings offer an opportunity to critically discuss treatment and intervention, and assist the treating case manager and doctor to discuss options. The environment should be optimistic and supportive, encouraging creativity and flexibility. Critically, case managers and doctors must be allowed the time and reflective space to discuss the young person's care and the intervention plan during the clinical review. Although there will be a range of things to 'check off', this needs to be balanced with supporting reflective practice and an MDT approach.

Clinical supervision is critical for all clinicians, and is necessary for good practice. In the case of functional recovery interventions, cross-discipline supervision for specific interventions may be needed, in addition to regular discipline-specific clinical supervision. Clinicians need to be supported to develop skills in functional recovery through cross-discipline learning. Critically, specialised staff also require access to discipline-specific supervision and additional training in both mental health-related topics and training to support their own professional learning.

Psychosocial interventions delivered in the community in the most socially inclusive manner are a crucial part of the comprehensive early psychosis approach aimed at achieving optimal functional outcome.[31] Caseload and complexity can have a significant impact on an individual clinician's capacity to address functional recovery. Typically, interventions may take longer, and need to occur outside of the organisation/service setting, such as in the young person's home, school, workplace or other community places. Service leads need to ensure that clinicians are supported to address functional recovery in the community, by supporting mobile outreach. Lower caseloads and a mix of complexity ensure that clinicians are able to provide interventions to young people and their families, as well as coordinate care.

Models and theories that support functional recovery in early psychosis

A selection of models and theories that provide useful understanding in relation to functional recovery is described in this section. It is helpful for clinicians to understand how these models and theories support functioning, as this will enable them to effectively evaluate and assess functioning and target interventions. The list is not exhaustive; rather, it provides an introduction to the key concepts in the field. The interested reader is encouraged to further explore these models and alternative models.

Phase of life: adolescence and early adulthood

For most young people in Western industrialised countries, adolescence and early adulthood are years of immense change and importance. By the end of this period, most young people will have made decisions and life choices that will have lifelong impacts.[4] The more recent concept of 'emerging adulthood' may be useful to consider: young people in their early twenties may have progressed through adolescence but not yet achieved the same traditional developmental tasks as their parents at the same age, such as marriage, starting a family or buying a home.[4]

During adolescence and early adulthood, a number of key developmental tasks and milestones are typically achieved and developmental changes occur, including:

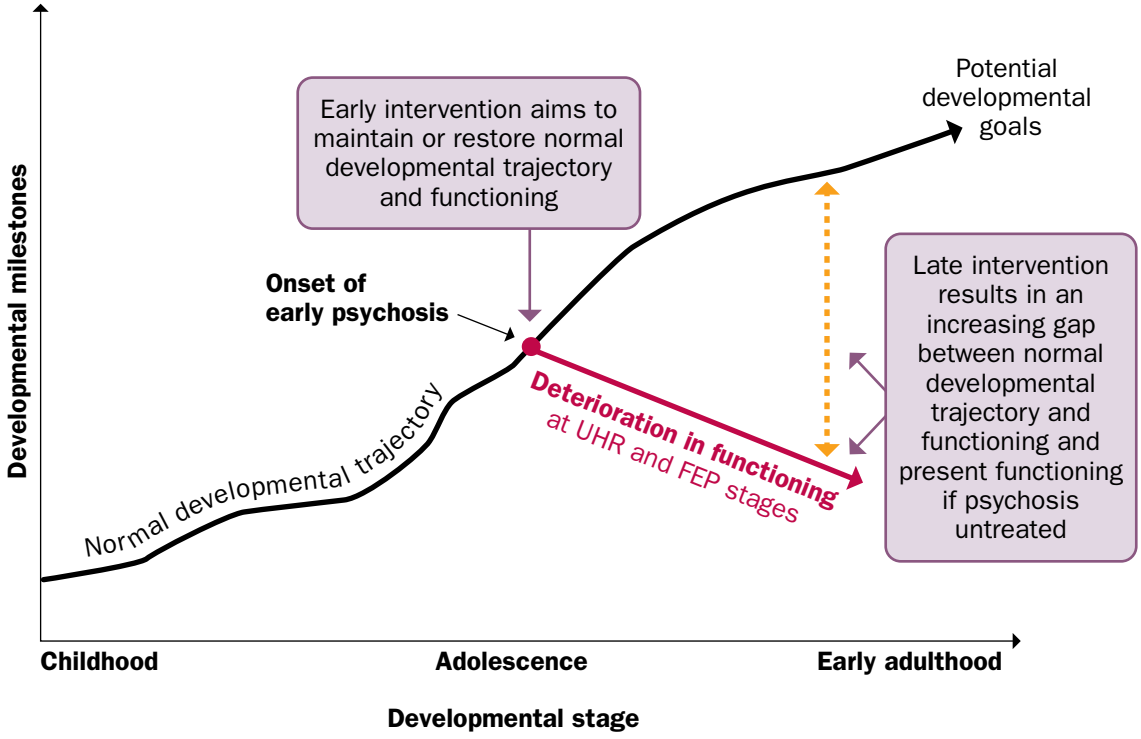
- biological maturation
- hormonal changes
- formation of identity, self-concept and self-esteem
- increased importance of the peer group
- increased independence from family
- psychosexual development (intimate relationships and sexuality)
- vocational identity, through educational and vocational tasks
- functional independence – learning the skills needed to independently manage one's life.

Psychosis has the potential to disrupt a normal developmental trajectory in the following ways:

- Educational and vocational development may be affected by problems with cognition, which may even prevent completion of education and attainment of vocational identity.[17,32,33]
- Social withdrawal before onset or during and after a psychotic episode can affect development of peer relationships.[3,13,34]
- Intimate relationships may feel threatening to a person having experienced a psychotic episode, but are also tied into social withdrawal, so can interfere with psychosexual development.[35]
- Self-concept and self-esteem can be negatively affected by stigma surrounding mental ill health.[36]
- Personality and identity development can be affected by the trauma of the experience and lead to identity diffusion.[37]
- Individuation from parents may be delayed as the young person may need additional support from family, and a reliable and secure environment.[38]

Each individual will have their own developmental trajectory. Some milestones may occur earlier or later, but generally, adolescence and early adulthood is when young people are developing the skills they need to successfully support themselves as adults. As psychosis usually disrupts this development in some way or another, continuing along a normal developmental trajectory is an important goal in functional interventions (see Figure 1 on page 14).

FIGURE 1: **POTENTIAL IMPACT OF PSYCHOSIS ON DEVELOPMENTAL TRAJECTORY**



Phases of psychosis and recovery

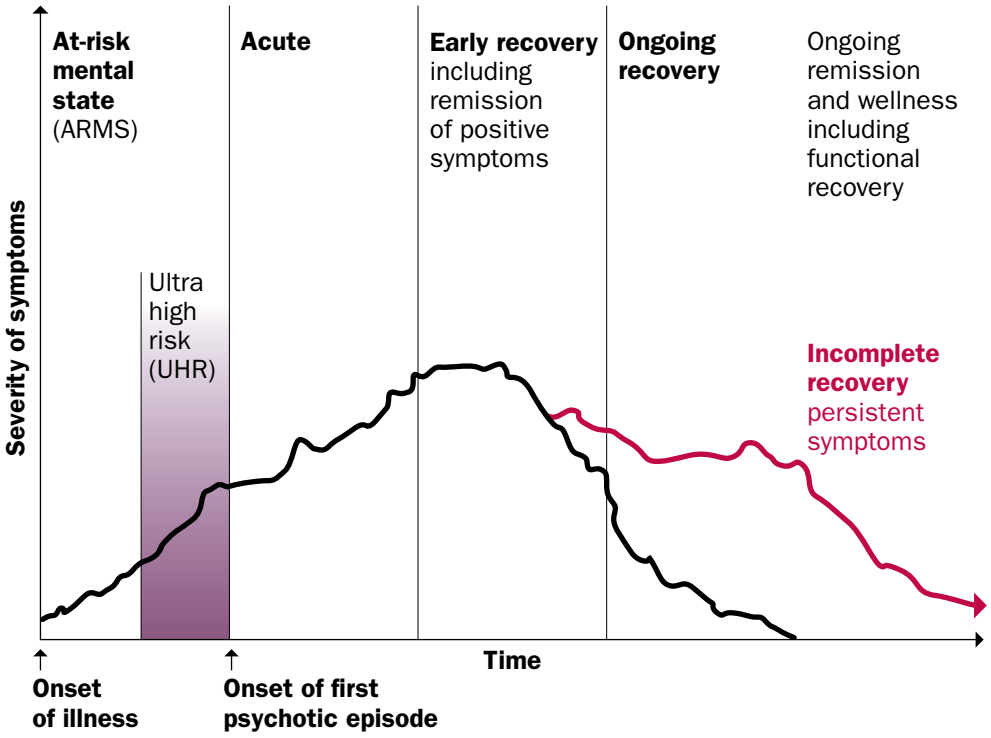
The phases of both psychosis and recovery are important to understand because they will help the clinician to target interventions appropriately (see Figure 2 on page 15).

The 'phases' model provides some structure to interventions and helps to guide the clinician in understanding and anticipating challenges in each phase. The intensity and focus of the interventions offered to young people and their families will generally vary across the phases. In the UHR phase, the level of intensity of support around functional recovery would generally be low. Even though functional decline may have already begun, the focus is more likely to be on preservation of functioning rather than remediation. In general, practical assistance and simple interventions for functional recovery will be the primary focus in this phase. However, it is important to remember that the whole range of functional recovery interventions should be available and accessible to young people identified as UHR for psychosis, and those with FEP.

> 'It took a few months to get to the point where I could look after myself properly again … just learning how to live life again.'
>
> Young person
> EPPIC, Orygen Youth Health Clinical Program

In the acute phase, the treating team might need to proactively address practical needs in relation to functioning. There may be increased need to provide family support and practical assistance to individual family members. In this phase, the aim is also to prevent further deterioration by helping the young person stay connected with educational and vocational activities. This is where it is especially important for the clinical team to take on an advocacy and support role on behalf of the young person and their family. They may not be able to deal with this themselves because of the trauma and stress they are likely to be experiencing. Through these roles, the treating team can maximise the chance of the young person successfully returning to study or work if they choose.

FIGURE 2: **PHASES OF PSYCHOSIS AND RECOVERY**



Early recovery is when functionally oriented interventions are most relevant. This is generally the time to begin discussing and working towards goals for functional recovery. As the young person's mental state improves towards the end of the acute phase, there may be a time when the young person and their family need to 'take stock' to understand and make sense of what has happened. The young person needs to be encouraged to get back into things as quickly as possible. However, it is important to note that a period of 'woodshedding' may occur as part of the recovery trajectory.[39] Woodshedding is when there is 'no apparent improvement while acquiring subtle increments of self-esteem, competence, stamina and social skills'.[40] According to Strauss, following the acute phase there may initially be improvement, but then gains seem to plateau for a period. This is often frustrating for young people and their families.[40] It is during the plateau period that Strauss suggests the young person is gathering enough surplus stamina and skills required to embark on the next major step in their recovery.[39] Woodshedding can occur at any point in recovery, and it is important to understand that these 'pauses' or periods of little apparent improvement may be an important step in recovery.

In the late recovery phase, the young person is typically well advanced in both symptomatic and functional recovery. They may have returned to school or work, socialising and doing other usual activities. It is important for the clinician to remember that returning to normal developmental trajectory is the goal. Supporting young people to continue to achieve developmentally appropriate goals, even in the absence of symptoms or functional difficulty, is the core work of early psychosis services.

If a young person appears to be entering the incomplete recovery phase, interventions need to be more assertive and multi-faceted. Treatment should always be guided by what is most important for the young person and their family. This focus will be especially important if there are multiple unmet needs or difficulties. In this phase, functional goals should still relate to a normal developmental trajectory, although the interventions that are offered will generally be more complex and may involve more than just the case manager and treating doctor. For instance, the young person and their family are more likely to need specific family work to assist them to deal with ongoing symptoms, rather than the more general family work offered in the earlier stages. For more information about family work interventions please refer to the ENSP manual *In this together: family work in early psychosis*.

Strengths-based approach

A strengths-based approach to early psychosis care and intervention emphasises the future ambitions and goals and the young person's personal resources and achievements.[6,31,41] This can be difficult for clinicians who have been trained using more traditional problem-based approaches, in that their orientation might focus on assessment and treatment of symptoms and impairments.[31] The strengths-based approach concentrates on what individual resources the young person brings. It acknowledges that each person brings unique and individual strengths and difficulties regardless of illness. The approach has an intentional focus on what the young person can do, rather than on deficits or difficulties.[33]

The strengths-based approach also aims to develop independence and agency rather than dependence on supports; simultaneously acknowledging that all people are interdependent and rely on each other.[41] The community is viewed as an oasis of resources and is the primary setting for all psychosocial interventions.[41]

Strengths-based approaches should be incorporated as part of the usual way in which clinicians work with young people and their families. For example, using a strengths-focused assessment when developing goals for intervention encourages the young person and their family to talk about their aspirations and needs rather than just perceived difficulties.[31] Development of a truly collaborative and respectful relationship with young people and families is the cornerstone of the approach. This may include a degree of therapeutic risk taking and allowing the young person to be the driver of their own recovery plan.[31] The young person is the director of the interventions, and the relationship between the young person and their case manager is highly influential.[41]

'I talked about things that I do every day and hopes and goals for the future, which was hard with something as inexplicable as psychosis.'

Young person
EPPIC, Orygen Youth Health Clinical Program

Recovery and recovery-oriented practice

Recovery refers to the individual's personal process of recovery and is not the same as rehabilitation or symptomatic wellness. It refers to the personal, self-defined and non-linear journey towards wellbeing. This is not the same as a reduction in physical and psychological symptoms, but may be associated with it.[6] This model shares many of the principles of a strengths-based approach, but also emphasises encouraging and supporting the young person's focus on their individual recovery journey, rather than a diagnosis.

'Recovery is a process, a way of life, an attitude, and a way of approaching the days' challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again … The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution.' [42]

Pat Deegan, 1988

Using a recovery model with young people has been criticised on the basis that recovery means returning to a previous state. Given the characteristic flux in young people's development, this would be undesirable. Some terminology used in the recovery literature is based on the experiences of adults with mental illness and does not apply in the same way to young people. It is important that clinicians understand the concept of recovery and recovery-oriented practice and embed this in their work with young people. Though the language may differ, the principles can be adapted to suit the needs and developmental stage of young people. In the context of functional recovery, the focus is on helping young people to return to previous activities or develop new interests and roles that are valued by them and appropriate given their developmental phase.[6] The emphasis should be on helping the young person to develop a meaningful and fulfilling life, rather than treating what they were doing before as a marker of their recovery (see Box 1).

BOX 1 KEY ELEMENTS OF RECOVERY-ORIENTED PRACTICE[43]

Connectedness

Young people who experience early psychosis often lose connections with peers or momentum in developing important relationships.

Hope and optimism

A pervasive sense of hope for the future and an optimistic outlook for recovery are important for the treating team to discuss and promote with the young person and their family.

Establishing and consolidating sense of identity

It is easy for young people to become defined by their illness experience. Encouraging the development of identity that incorporates roles as a friend, partner, worker or volunteer, sibling or teammate is imperative.

Meaning and purpose in life

It is important to help young people to develop roles and engage in activities that are in line with their beliefs and values, and develop a sense of purpose and meaning for the future.

Empowerment

Helping young people to understand what they need or want in their own recovery, and develop the skills or resources needed to gain this is important.

Motivation theory

Understanding theories and concepts underlying motivation can help clinicians conceptualise how a young person's recovery can be impaired or enhanced. Simply, intrinsic motivation is the inner drive or volition of the person. It is usually connected to the personal reasons, beliefs, values or habits that drive behaviour. Extrinsic motivation is external to the person. Either naturally occurring or artificially constructed cues usually drive behaviour.

When thinking about the young person and functional recovery, it is important to understand their motivation, and link this to where they want to be or what they want to do (intrinsic motivation) in the future. In particular, if the young person is experiencing negative symptoms, it can be especially important to understand intrinsic motivations, and help the young person to structure extrinsic motivators. Making clear links between motivation and short-, medium- and long-term goals is important when working with any young person.

The clinician also brings their own motivations to the therapeutic relationship, and it is important to recognise that this can have a significant impact on the young person's recovery. Craig et al. (2014) provided motivational interviewing to case managers working with young people engaged in individual placement and support (IPS). Individuals in the intervention group (who's case manager received motivational interviewing) were more likely than those in the IPS only group to achieve employment by 12 months (29/68 versus 12/66). The authors concluded that employment outcomes were enhanced by addressing clinicians' ambivalence about return to work by the individuals with whom they worked.[44]

Motivation can also be understood as being driven by need. Maslow's hierarchy of needs describes basic and fundamental needs such as physiological requirements (food, water and shelter) and safety (personal, financial security, health and wellbeing) are to be met before higher-order needs, such as love and belonging or self-esteem, can be achieved.[45] When considered in the context of young people who have experienced early psychosis, it's imperative to focus on the essentials before clinicians and young people are able to engage in more complex goals for functional recovery.

Models of occupational engagement

Models that underpin occupational therapy, such as the Model of Human Occupation (MOHO)[46] and the Canadian Model of Occupational Performance and Engagement (CMOP-E),[47] can also support how clinicians understand and intervene to support functional recovery.

MOHO seeks to explain how activity is motivated, patterned and performed.[46] Within this framework, the individual is seen to be made up of three interrelated components – volition (motivation), habituation (how activity is organised into patterns or routines) and performance capacity (physical and mental abilities and skills). MOHO also emphasises the physical and sociocultural environmental contexts in which the activity takes place. Dysfunction is understood as a mismatch between the person, the activity (occupation) and the environment, rather than simply a problem or deficit in the person.

CMOP-E describes the interaction between the individual, their environment and the activity (or occupation) that is being performed.[47] At the centre of the model is the person, made up of cognitive, affective and physical aspects – at the centre of which is spirituality. Spirituality refers to the essence of the person – their values, beliefs and motivations – rather than religion.[47] Activities or occupations in which the person engages are seen as belonging to three different categories: self-care, productivity and leisure. Occupation is seen as the means by which a person engages with their environment. The environment includes the cultural, physical, social and institutional environments where occupations occur. The model acknowledges that the person can act on their environment, just as the environment can influence the person or the activity.

There are many other models of human occupation that describe the interactions between the person, what they do and their environment. These models provide a way for clinicians to understand function or dysfunction, and to provide interventions to target functional recovery.

Core principles of functional recovery in early psychosis

The following core principles of functional recovery in early psychosis have been derived from the research literature as well as the second edition of the *Australian Clinical Guidelines for Early Psychosis*[48] and are based on more than 20 years of clinical experience in the Orygen Youth Health Clinical Program.

Principle 1 — Functional recovery is an equal primary goal for treatment.

For individuals receiving treatment for psychosis, positive symptom remission can often be seen as the first priority for treatment, especially in the acute phase. However, working towards functional recovery from the very beginning plays a vital role in the overall care of the young person and their family.

In line with the principles of recovery-oriented practice, and taking into account the needs and preferences of young people and their families, functional recovery should be considered just as important as symptom remission as a treatment goal.[6] There are many compelling arguments for this. The most important is that the effects of functional recovery on a young person's life can be lasting. Intervening early to address functional recovery goals may prevent deterioration. This makes it easier for the young person to return to the things that are important to them.

Principle 2 — Understand the hopes, aspirations and goals of the young person to direct functional recovery interventions.

When collaborating with a young person to devise a functional recovery plan, it is important for the clinical team to understand the young person's hopes and aspirations for the future. Although the young person may just be beginning their recovery journey, the team should communicate to them that their life goals or aspirations don't need to change just because they have experienced an episode of psychosis. Often, following a first episode of psychosis, young people may lose confidence in themselves and their abilities. It is crucial for the treating team to support the young person to evaluate what is important in their lives and support the goals they set for themselves.

The team may need to support the young person to attempt goals that may not be entirely realistic, allowing them to experience some failure, but also to use those experiences as opportunities to build resilience.

> 'When we treat man as he is, we make him worse than he is; when we treat him as if he already were what he potentially could be, we make him what he should be.'
>
> Johann Wolfgang von Goethe, German playwright, poet, novelist and dramatist, 1749–1832

Principle 3 — The young person needs to be empowered to drive their own recovery.

Young people should be offered choice, have control and ownership over their goals for recovery. Research shows that for young people who have experienced psychosis, employment and education, relationships and finances are often the most important aspects of their lives.[25] They may have different goals following an episode of illness than they did beforehand. The experience itself may change the way the young person sees themselves and others, or change their priorities in life. It is important not to place too much emphasis on 'getting back to what you were doing before' if this is not their primary goal. Asking the young person to identify what is important in their life or what is relevant for their recovery puts them in the driver's seat.

Principle 4 — Begin functional recovery interventions as soon as possible.

Interventions that target or support functional recovery can, and should, begin as soon as the young person enters the service. Both compensatory and remedial approaches should be used in the overall functional recovery plan. However, compensatory approaches may be more appropriate in the initial stages, especially the acute phase. For more discussion on remedial and compensatory approaches to intervention, refer to the section entitled 'A remedial or compensatory approach?' on page 44 of this manual.

There are three main reasons to begin working on functional recovery as soon as possible. First, young people identified as UHR for psychosis or who have experienced a psychotic episode are likely to have already experienced a functional decline as a result of their mental health difficulties. The earlier this decline is addressed, the less likely there are long-term impacts on the young person's functioning and wellbeing. Delay in addressing functional goals may result in the young person falling further behind their peer group, particularly in relation to social, vocational and educational outcomes.

Second, functional recovery can be extremely important for young people's engagement with the mental health service. Young people may find it difficult to understand why they need to continue their involvement with the service, particularly if symptoms have resolved or insight is affected. Functional goals often have more meaning for the young person and their family, and can be particularly motivating if visible gains can be made in a relatively short space of time.

Finally, early functional recovery is a more important predictor of long-term functional recovery than is early symptomatic recovery.

Principle 5

Functional recovery interventions should aim at restoring or maintaining normal developmental trajectory.

The clinical team should aim to restore normal developmental trajectory and functioning for the young person and their family. Although the young person's specific goals may change following FEP, developmental tasks and the normal trajectory remain an important guide to appropriate interventions. Clinicians need to understand the developmental stage of the young person to appropriately 'pitch' the intervention, building on skills and resources they already have available.

Developmental stage may vary and may not always reflect chronological age. For example, one 18-year old may already be working and living out of home independently, whereas another may be living with their parent(s) and studying.

Principle 6

Functional recovery interventions should take into account the young person's phase of illness and clinical recovery.

Phase of illness and clinical recovery will guide interventions for functional recovery. During the acute phase, interventions will be focused on preventing further decline or 'collateral damage'. In the early recovery phase, the focus will be on improving functioning or returning to activities that may have been interrupted by the acute episode.

Clinical recovery, which includes positive and negative symptoms, must also be considered. The potential impact of symptoms on functional recovery should be kept in mind by the treating team, particularly as a change in pharmacological treatment can affect functional outcomes.

Principle 7

The multidisciplinary team, including the young person and their family, should all be involved in functional recovery planning and interventions.

The MDT includes the clinical team, the young person, their family and other supports. Teachers, work colleagues, friends or other agencies and workers may also be involved in contributing to the development of goals and a recovery plan. The team should consistently and collaboratively work together to ensure that the young person's plan is being carried out. Each party needs to understand what the goal is, what strategies and steps are planned to get the young person there, and their role in supporting the young person's attainment of the goal.

It is important to consider how families, friends and other supports can be involved in helping the young person achieve their goals in a way that is socially, culturally and developmentally appropriate.

Functional recovery in the real world

Functional recovery in the real world

Assessment of functioning

Functional recovery is a highly individualised process, much like the journey of personal recovery. Unlike symptomatic remission, the degree and rate of functional recovery can be difficult to measure. Many variables influence functioning and need to be taken into account during functional assessment. These are physical (skills and abilities), mental (cognitive and neurocognitive), emotional (motivation), environmental (social, physical, political and economic) and contextual (the activity, degree of complexity, prior experience or role modelling).

Restoring functioning is a cornerstone of rehabilitation. To support the restoration of function, we first need to understand exactly what components of functioning might *require* restoration.[49] This is where assessment comes into play, but how do we know what to assess? What exactly constitutes functioning? In reality, it is a broad and complex concept that encompasses an extensive range of psychosocial domains related directly to *what* we do daily, *how* we do it, *how well* we do it and *why* we do it – all in the context of our own environment.

Functioning can be further understood within two separate, but closely related contexts:[50]

- How we function in the context of daily living; more specifically, how we go about performing significant activities of daily living (such as engaging in conversation, parenting, doing the shopping and driving a car) within our own environment.
- How we function within life as a whole, including how we perform in our environment in the context of personal values, beliefs, motivations, hopes and development of self-actualisation.

Thinking about functioning in relation to these two contexts highlights the multidimensional and wide-ranging nature of the construct. Functioning is more than ability. It is being able to do what you want to do, to a self-defined standard, underpinned by meaning and purpose and shaped by personal and environmental factors. Thus, what constitutes functioning will differ from individual to individual. Additionally, clinicians cannot guess what a young person's functional activities, capacities and motivations will look like. Therefore, to ensure an accurate assessment and full understanding of a young person's functional abilities, the scope needs to remain broad and *all* areas of functioning need to be assessed.[50] Only then can we ensure the accurate collection, integration and interpretation of information related to a young person's past and present functioning.[49]

How and what do we assess?

Initial assessment of functioning should take place in the context of the comprehensive biopsychosocial assessment. As with most assessments in the early intervention arena, this is primarily conducted by a clinician (in conjunction with the MDT) through an interview and observation over time. It is generally accepted that the initial, or baseline, assessment phase should be completed within the first 4–6 weeks of a young person's episode of care. This allows sufficient time to gather, collate, document and present the information, and for a young person's

acute symptoms to settle, for intervention planning and implementation to begin. Outlined below are some general guidelines around the functional assessment process. Domains of function – or areas to assess – will be covered in more depth in the following section.

Most young people will have had limited or no prior experience with public mental health services, and with discussing personal and sensitive health and life matters with health professionals. Understandably, this can increase the young person's stress levels and they may be reluct to discuss and divulge information.[51] Conducting assessments in the familiarity and safety of a young person's own environment, and ensuring that a close and trusted support is present during the interview (if possible) can often help to mitigate the stress potentially associated with the assessment. For more information about home-based care and assessment, please refer to the ENSP manual *There's no place like home: home-based care in early psychosis*.

The idea of assessment can be quite daunting for a young person and their family, especially considering their past experiences are likely associated with a 'pass or fail' style of assessment (e.g. school exams, driving tests). Explain to the young person why assessment is conducted and remind them that there are no right or wrong answers – it is all about gathering information, making sense of it and working together to form a plan for recovery. Discuss what the assessment process will be like, what sort of questions might be asked, and the sort of information will be gathered and why. This can help normalise the experience. Prepare the young person for the sensitive nature of some questions and remind them that they do not need to answer questions if they do not want to, or feel uncomfortable.

The ultimate aim of a functional assessment is to obtain a clear understanding of developmental and pre-morbid functioning as well as current functioning (see Box 2 on page 24). Obtaining a developmental history and exploring past functional history will enable a baseline to be established. It can also provide important information around long-term functional performance and problems and help identify any changes in functioning over time.

For more information about general assessment and engagement strategies, refer to the ENSP manuals *Get on board: engaging young people and their families in early psychosis* and *'Let me understand': assessment in early psychosis*.

A semi-structured interview process further informed by collateral information from a variety of sources will provide a significant amount of information. However, case managers should also use clinical and naturalistic ('real life') observation methods.[49] Observing how the young person behaves, speaks, concentrates and interacts – as well as what should be present but is actually missing[53] – can add to the assessment findings and understanding, and act as a prompt for further appropriate lines of questioning.

Behavioural assessment and observation are an excellent way of determining an individual's capacity or ability to perform a task. They provide direct information that is tangible, objective and easily measured, and the results are suitable as outcome measures, which can be useful for monitoring and tracking progress.

Behavioural assessments are often used to determine functional capacity. This is very different to what a person actually does – that is, their performance. Put simply, what a person is able to do and what they actually do in the real world and in the context of their own environment can differ.[55,56] This is referred to as the competence–performance distinction.

PRACTICE TIP

When case managers are assessing functioning, especially in behavioural contexts, this distinction is important to keep in mind because successful demonstration of functional capacity does not always translate into successful functional performance, and vice versa.[56] Case managers should be aware of the environmental variables and personal characteristics that can influence functioning in the real world (e.g. noise levels, social supports, confidence, motivation) and where possible take the time to assess in the context of a young person's own environment.

BOX 2 **CONSIDERATIONS FOR FUNCTIONAL ASSESSMENT**

- Allow for psychotic symptoms to settle prior to assessment of current functioning. Acute psychotic symptoms will have a significant impact on functioning and premature assessment can result in an inaccurate reflection of functioning.[52]
- Assess for and explore functional strengths. This will support the shaping of intervention plans as well as maintaining an atmosphere of hope and optimism essential to the recovery process.[52]
- Gain an understanding of the resources and supports available to the young person that can assist functional performance, skill building and recovery.[49]
- Gather collateral information from a variety of sources. From who to seek information will differ depending on the domain being assessed (e.g. school teachers may be appropriate sources of information around educational and cognitive functioning). Collateral information does not only have to be gathered verbally, it can come in other forms such as past cognitive assessments or file notes and discharge paperwork (e.g. past medical records, school reports).
- Always assess through a developmental lens. Significant developmental changes take place during adolescence, and understanding these will support clinicians in further identifying specific needs, behaviours and problems.[53] Additionally, young people will be less likely to engage and function in certain areas and activities for developmental reasons such as age, lack of experience and/or lack of past opportunity.
- Consider cultural differences. How people engage in activities and the meaning and importance of these can differ from culture to culture. Case managers need to have an understanding of the impact of culture on the way we choose and use our occupations and incorporate this understanding into the assessment process by always checking in on cultural context.
- Explore values, beliefs, meaning and motivation. This can often provide context as to why a young person might be functioning in a certain way in a certain area.

Domains of functional assessment

This section will describe the various functional domains that need to be considered during functional assessment. Each domain is described, and suggested questions and strategies for assessment are explained.

Developmental history

Obtaining a thorough developmental history will produce a deeper understanding of experiences, strengths and difficulties that might be contributing to a young person's overall functioning. Their parents (or significant others with a thorough understanding and/or involvement in their early years) are generally in the best position to provide an accurate account of developmental history. Young people themselves do not usually hold such information. The areas to explore when assessing developmental history are presented in Box 3 across the page.

BOX 3 AREAS TO EXPLORE IN DEVELOPMENTAL ASSESSMENT

Pregnancy and birth

- Was the pregnancy planned?
- Were any medications or substances (e.g. tobacco, alcohol, illicit drugs or prescription medications) taken during pregnancy?
- Were there any complications or illnesses throughout pregnancy (e.g. gestational diabetes, measles)?
- Was the baby born on time, late or prematurely (at how many weeks)?
- What was the nature of the delivery (e.g. breech, caesarean, forceps)?
- Were there any birth complications?

Infancy

- Were there any feeding problems or concerns?
- Was attachment (mother–child or father–child bonding) successful?
- Did either parent experience any post-natal depression?
- Did the child experience any sleep difficulties or illnesses in infancy?
- Did the child exhibit any notable behaviour (e.g. colicky, head-banging, poor eye contact, irritable, clumsy, hardly cried)?
- How was the child's temperament (e.g. active, easily settled, alert, quiet, distractible, adaption to novel tasks/activities)?

Developmental milestones

- Including sitting, crawling, talking, walking and toilet training.

Childhood (physical, cognitive, social and preschool/school history)

- Did the child experience any childhood illnesses (e.g. measles, mumps, chicken pox) or chronic illness?
- Did the child experience any motor, speech, hearing or visual problems?
- Were there any bed-wetting, bladder or bowel issues?
- Were there any surgeries or injuries, especially head injuries or loss of consciousness (if so, for how long?).
- Explore early childhood friendships and social connections (explore quality, quantity, frequency).
- What were family relationships like (parents, siblings, others)?
- Did the child experience any separation anxiety?
- What was the nature of the child's early academic functioning and school history?
- Was the child bullied or did they display any bullying behaviour?
- Were any specialised assessments conducted or was the child seen by any specialists? If so, who, what for and for how long?
- Explore any behavioural issues or concerns, personality and temperament in different environments (as above but also including emotional regulation, frustration and tolerance, happy, affectionate, withdrawn, copes with change, physically aggressive, difference in behaviour/personality/temperament).

Neurocognitive functioning

Cognition essentially means 'thinking' and involves processes that allow one to perceive, acquire, understand and respond to information. Cognitive abilities allow for the receipt, storage, manipulation, processing and output of information required to learn, perform and retain psychosocial skills, and understand the world in which we live and ultimately to function independently within it. To understand cognitive functioning, both interview and observation are useful. Areas to assess and gather information around include:

- attention – the ability to focus and not be easily distracted
- concentration – the ability to focus on tasks over a period of time, especially in activities they enjoy or value
- vigilance – is the young person able to stay alert and concentrate for a sustained period of time (e.g. a movie or a three-hour lecture)?
- memory – long- and short-term memory as well as working memory (the ability to hold and manipulate passing pieces of information to the short-term memory)
- information processing – difficulty with the input, processing and output of information: latency of responses or frequency of requests to repeat questions may indicate difficulties with information processing
- visuospatial skills – being aware of the objects around us and the spatial relationships between them: getting lost in familiar surroundings could indicate a visuospatial deficit
- IQ – has there been any past IQ testing?
- executive functioning – impulsivity and risk taking, planning and problem-solving skills, flexibility of thinking, inhibition and judgement.

Questions and observations that young people may have neurocognitive difficulties are listed in Box 4.

BOX 4 INDICATIONS THAT A YOUNG PERSON MIGHT BE EXPERIENCING NEUROCOGNITIVE DIFFICULTIES

Questions

- Do you have trouble concentrating?
- Do you get distracted easily?
- Does your mind frequently go blank or 'space out'?
- Do you find your thinking has slowed down?
- Do you have trouble completing tasks on time?
- Do you have trouble remembering things?
- Do you easily forget things?
- Do you have difficulty following conversations?
- Do you feel other people don't understand you?
- Do you have trouble organising yourself?
- Do you find yourself acting before thinking?
- Do you make a lot of mistakes?
- Do you feel overwhelmed by new or unfamiliar tasks?
- Do you have trouble organising yourself?

Observations

- Is there a delay in responses?
- Does the young person often ask for the question to be repeated?
- Does the young person often interrupt others while they are speaking?
- Is the young person easily distracted?

Social functioning

As mentioned earlier, those experiencing a first episode of psychosis are often also experiencing difficulties in social functioning. Problems in this area can be quite pervasive, affecting other areas of functioning in a variety of ways. As social relationships are crucial components of normal adolescent development, impairment in social functioning must be thoroughly assessed to best guide treatment and prevent any further disruption to development (for questions to help assess social functioning please see Box 5). When assessing social function, it is important to explore the following:

- Current and past relationships – both core relationships within the immediate environment (family, peers, intimate relationships) – and more peripheral relationships within the broader community (work colleagues, school acquaintances). It is important to examine the quantity, quality and frequency of these relationships.
- Living situation, including where and with whom they reside.
- Experiences with difficult relationships (including bullying), difficulty maintaining relationships and why this might be.
- Locations of social interactions – this often reflects the quality and motivation behind social interactions (e.g. does a young person only socialise at home and at school and is therefore only engaging in incidental or opportunistic interactions, as opposed to initiating and seeking out a range of social opportunities? Are most interactions via social media?).
- Means and preferences for socialising (e.g. SMS, social media, gaming, telephone, face to face), and the quality, quantity and frequency of these interactions (assessed both subjectively and objectively).
- Self-perception of social skills, and the feelings and thoughts that are evoked (e.g. a young person might avoid social situations as they feel anxious, awkward, inept or embarrassed; or they might actively seek out social situations and engage fully, but still have trouble maintaining close relationships).
- Barriers to social functioning, which could be individual (developmental trajectory, beliefs around own abilities), family and cultural (pre-morbid and current family expectations), illness (negative, positive or cognitive symptoms) and environmental factors (stigma, geographic isolation).

BOX 5 QUESTIONS TO HELP ASSESS SOCIAL FUNCTIONING

- Can you tell me a bit about your friends? Are you a person more likely to have a lot of friends and acquaintances or do you tend to have a few, close friends?
- Lots of people socialise online these days; how do you tend to socialise? Do you ever feel awkward or silly when you socialise? Do you ever find yourself thinking about or pulling apart your social interactions long after they're finished? Can you tell me a bit more about that?
- Are there any things that get in the way of you socialising to the best of your ability?
- Sometimes, young people have experienced bullying; have you ever been bullied? Can you tell me a little more about how and why you feel you were bullied and how long it went on for? Have you ever bullied others?

Educational functioning

Education is a key component of adolescent development and a major activity of daily living for young people. Liberman (2009) considers engagement in age-appropriate, productive and constructive activity (e.g. school, TAFE or university) a crucial component of functional recovery.[49] When assessing educational functioning (see Box 6), it can be helpful to explore the following:

- school and educational history (also part of the developmental history)
- historic and current academic function – asking questions around how the young person perceives their own abilities as well as accessing collateral information
- current engagement in education, especially exploring when, where and how much time is devoted to education as well as current self-perception and objective observations on how one might be coping
- educational aspirations
- educational interests and academic strengths
- learning styles and preference – visual, auditory, kinesthetic preferences or a mix
- assess strengths – explore existing skills that could contribute to educational function and indicate levels of past learning such as playing an instrument, first aid training, learning to drive and acquiring computer/internet skills.

Vocational functioning

Gaining paid employment is an oft-cited recovery goal of people experiencing a mental illness.[33] This is no different for young people experiencing a first episode of psychosis, who are generally at an age where obtaining a job is a first step towards independence and the forming of a vocational identity. Experiencing a first episode of psychosis can disrupt vocational development, warranting the need for thorough assessment (see Box 7) that takes into account the following:

- vocational and training history:
  - Has the young person ever engaged in work or training?
  - When was the young person employed or when did they train?
  - What type of training or employment and where? (include paid employment, work experience, working in the family business and volunteering, training courses and certificates)
  - For how long?
  - Why did they leave?
  - Look for any patterns (e.g. only staying in employment or training for weeks at a time, consistently dropping out of training, engaging in and choosing fields of training and employment primarily at the behest of others)
- current engagement in vocational pursuits
- vocational aspirations
- assess strengths and pre-vocational (work endurance and motivation) and life skills (time management, planning).[53] Often these skill-based strengths can be generalised in the workplace. Explore existing skills that could contribute to their vocational function, such as computer and money handling skills
- interests and hobbies.

Questions that clinicians can use when assessing vocational functioning are presented in Box 7.

BOX 6 EXAMPLE QUESTIONS TO ASSESS EDUCATIONAL FUNCTIONING

- Are you going to school/university/TAFE at the moment? Can you tell me a little about what you're studying?
- What are your favourite subjects? What are your least favourite? Why?
- Do you have many friends at school/university/TAFE?
- How do you think you're coping with your schoolwork at the moment compared to, say, a year ago?

BOX 7 EXAMPLE QUESTIONS TO ASSESS VOCATIONAL FUNCTIONING

- Are you currently working? Can you tell me about how that is going for you?
- What sort of job do you see yourself working in in the future?
- You seem to have had quite a few jobs in the past. Can you tell me a little more about these and why you left them?
- Are you enjoying work at the moment? What do you find easy or difficult in your job?
- How has the experience of psychosis affected you at work?
- Have your vocational goals changed over the past 6–12 months? (This question is aimed at eliciting how the young person sees their future.)

Family functioning

Young people experiencing a first episode of psychosis are often residing with their parents, and the impact of their illness can also have an effect (unfortunately a disruptive one), on the way a family functions. Likewise, how a family functions can significantly impact a young person's functional recovery. It is therefore important to assess functioning in the context of the family to best understand how the family can support functional recovery and be supported throughout their loved one's functional recovery. When assessing family function, areas to explore include:

- Does the young person still reside with the family?
- Family relationships – past and present and the quality, quantity and frequency of interactions. Explore how everyone gets along (see the social functioning domain).
- Family stressors (e.g. financial stress) and how the family copes in stressful circumstances and de-escalates stress, tension and conflict.
- Levels of expressed emotion (attitudes, behaviours and emotions expressed by the family or family members to the young person with mental ill health. This can include critical comments, over-involvement, hostility or warmth and positive regard).
- How the family functions as a unit over other domains.
- Common or family interests and hobbies.
- Family strengths.

For a list of potential questions please see Box 8.

For more information about assessing family functioning, please refer to the ENSP manual *In this together: family work in early psychosis*.

BOX 8 EXAMPLE QUESTIONS TO ASSESS FAMILY FUNCTIONING

- Who are you currently living with? Tell me a little bit more about your family. How do you get along with them? Who are you closest to and who would you consider most distant? Why do you think that is?
- Have there been any major changes or stresses in your family recently?
- Do you spend much time with your family? What sort of things do you do together? What sort of things do you *enjoy* doing together?
- Is there much conflict in the family? Can you tell me more about this? How do you feel about the conflict?

Personal and self-care functioning

Possessing the basic skills and abilities required to maintain health and wellbeing is an essential component of functioning in an independent and safe manner. It is important to assess functioning of self-care as these skills and activities (commonly learnt in childhood) form the basic, survival requirements of everyday living. Impairments in these areas will generally need to be prioritised or addressed before other aspects of functional recovery can progress; early in recovery to ensure safety is not compromised. When assessing the following areas, it is important to explore current and past abilities and gain an understanding of the amount of time devoted to each task. Areas to assess include:

- eating and drinking
- toileting
- personal hygiene (e.g. showering, cleaning teeth)
- grooming
- dressing
- sleeping
- walking/ambulating
- taking medication
- past and present capacity and performance
- why a young person might not be engaging in certain activities, which can be explored over three domains:[54]
  - capacity issues such as cognitive issues including motivation or memory difficulties
  - environmental issues including physical, social and legislative
  - the occupation itself: is it very time consuming, complex or dependent on access to and availability of specific tools or resources?
- levels of confidence and familiarity with certain activities
- time use – how much time is devoted to engaging in these activities and is the time being spent commensurate with the activity (e.g. spending over 15 hours a day sleeping)?
- areas of strength and capacity.

Although these areas of functioning seem basic, it is important to understand whether the young person is experiencing difficulties related to each, as this will often have an impact on overall functioning. Potential questions to ask when assessing self-care are listed in Box 9.

> ‘I actually think that my case manager coming to my home showed her insight into the way that my life is. She could see, you know I had a clean house and furniture and you know food in the fridge and she could see that I was doing well … she had a glimpse into my life other than our session times so she could see that I actually was a well-rounded human being in society rather than just someone who pops up once a week to talk to her.’
>
> Young person
> EPPIC, Orygen Youth Health Clinical Program

BOX 9 EXAMPLE QUESTIONS TO ASSESS SELF-CARE

- Tell me a little bit about your daily routine. Start from when you get up and see if you can go through a typical day in the life of you!
- Do you ever find you skip meals?
- Do you ever find you don’t get done basic things like showering or brushing your teeth? How often does that happen? Why do you think it happens? Do you think this has changed compared to a year ago? Two years ago?
- (For family members) – Can you tell me whether your son/daughter has any difficulties with any basic self-care tasks at the moment?

Instrumental functioning

Instrumental functioning generally includes more complex skills and activities. Self-care activities encapsulate the aspects of functioning required to meet basic survival needs, but instrumental activities further enable a person to function in an independent manner, to their own personal standard, in their own environment. These are often skills that are learned and acquired throughout adolescence, which highlights the need to thoroughly assess them to gain an understanding of the young person's developmental trajectory, and prevent further disruption. Assessment of instrumental functioning – mindful of development stage – should cover the following areas:

- domestic activities such as house cleaning (vacuuming, changing the bed), laundry (washing, ironing), gardening and meal preparation
- community-based activities such as grocery shopping, attending appointments, accessing services (e.g. Centrelink, housing services) and using public transport
- use of communication devices such as the telephone and computer
- financial management such as banking (online and in the community) and budgeting
- looking after others (e.g. children, a sick parent, pets)
- past and present capacity and performance
- why a young person might not be engaging in certain activities, again over the three aforementioned domains (e.g. could others be performing them on their behalf? Do these activities lack personal meaning?)
- time use (how much time is devoted to engaging in these activities and is the time being spent commensurate with the activity?)
- levels of confidence and familiarity with activities
- areas of strength and capacity.

For a list of example questions to ask when assessing instrumental functioning see Box 10.

BOX 10 **EXAMPLE QUESTIONS TO ASSESS INSTRUMENTAL FUNCTIONING**

- Can you tell me how you spend a typical day?
- What kinds of things are you responsible for in your house? Are you expected to help out with chores?
- Has your typical day changed in the last 6 months/year/2 years? How has it changed? Why do you think this might be?
- Do you ever look at friends or siblings or others around your age and wonder why you aren't doing or able to do the things that they do? What might some of those things be? How do you feel about this?

Leisure functioning

A large part of what we do and how we spend our time is related to leisure-based activities; more simply, the things that we do for excitement, enjoyment and relaxation. Functioning in everyday life requires a balance between productivity (e.g. paid and unpaid work), self-care and leisure activities. Functional assessment within the leisure domain might include:

- exploring the things a young person likes to do or enjoys doing (e.g. playing sport or video games, reading, watching TV, going to the movies, going out with friends, doing yoga, craft, cooking, spending time with family or a partner)
- exploring hobbies and interests (past and present) and gaining information around why a young person may no longer be engaging in certain leisure activities
- finding out how a person relaxes
- identifying how much time is spent engaging in leisure activities.

Examples of questions to ask young people when assessing leisure functioning are presented in Box 11.

Though these domains have been described separately above, in everyday practice, information gathered will overlap. It is also likely that information gained in one domain will serve to inform another domain of functioning, all of which will support the completion of a thorough and accurate assessment of functioning.

Specialised assessments

In addition to general functional assessment, a range of specialised assessments can further enrich the information already gathered. In some cases, these assessments may form part of the standard functional assessment process. However, in most cases, it is the information gathered over the initial assessment and formulation that highlights gaps requiring further assessment.

Specialised assessment can be accessed over a range of domains such as:

- educational (to identify learning difficulty or disability)
- vocational (vocational questionnaires)
- social (the evaluation of social interactions, role checklist)
- occupational (the assessment of motor and process skills, sensory modulation assessments, MOHO assessments)
- cognitive (neuropsychology assessment)
- psychological (personality assessments, Wechsler Adult Intelligence Scale)
- family or systems assessment
- substance use assessment.

These assessments are often (but not always) more formal in nature and can include standardised measures, checklists, self-report and structured observation. Some specialised assessments can also be used at different time points as a valid method of tracking progress and measuring outcomes.

BOX 11 **EXAMPLE QUESTIONS TO ASSESS LEISURE FUNCTIONING**

- What do you do in your spare time?
- Do you have any hobbies, or other things you do just for fun?
- How do you spend time with your friends?
- When you just want to relax and chill out, what sort of things do you like to do?
- What kinds of activities make you happy?
- Tell me about a day recently that you remember having fun. What did you do?

Measuring and assessing outcomes

Assessment of functioning should not end after the initial assessment. Continuing to assess functioning throughout the entirety of a young person's episode of care will allow for the tracking and measurement of progress. Ongoing assessment does not mean the case manager, young person and family need to undergo a laborious assessment process every few months. It simply involves continuing to measure outcomes and progress to understand what is and isn't working, what is and isn't improving, and what was and is no longer relevant – and to adapt goals, interventions and recovery plans accordingly.

Outcomes and progress in relation to functioning can be assessed in numerous ways including:

- through the tracking of and regular checking in on goals and goal attainment or attainment difficulties
- use of assessment tools as outcome measures
- regular direct observation of skills and close tracking and documentation of changes and progress
- self-report through ongoing communication with the young person, family and significant others – a young person (and their family) will often be able to clearly articulate how they feel their own recovery is progressing and why
- re-formulation
- global outcome measures.

In reality, it is often a mixture (or even all) of the above methods that best allows case managers, families and significant others to measure and assess functional outcomes.

Barriers and enablers to functional recovery

Understanding the factors that can support the implementation of functional recovery can facilitate success and also enable clinicians to address any challenges as they arise.

Enablers

Functional recovery is a key component of the early psychosis model of care. Working in an environment where functioning is part of the service ethos will act as a significant enabler to functional recovery.[2]

Assertive case management is a method of service provision characterised by proactivity and flexibility. Each young person is assigned a case manager as the central clinician directly supported by the MDT. This approach can enable functional recovery because it is conducive to intensive community-based care focused on implementing the majority of interventions in the young person's own environment. In other words, it allows the time and space for the young person to develop and master a range of skills, with close support, in real-life situations. It also supports best functional outcomes by recruiting the assistance of the MDT. This ensures that the young person has access to a range of skilled clinicians in a timely manner and that the case manager, though the primary clinician, is able to draw on the advice and knowledge of other clinicians. Assertive case management is discussed in more detail in the interventions for functional recovery section of this manual.

> 'It's so important to be able to make the time to support young people with their functional recovery goals, and being able to get out and work with them in their own home, school or workplace is essential.'
>
> Senior clinician,
> EPPIC, Orygen Youth Health Clinical Program

Barriers

As with any area of health care service provision, a range of barriers and challenges can hinder the functional recovery of a young person. These will invariably be present or arise throughout the episode of care. Maintaining an awareness of these barriers will allow case managers to anticipate possible difficulties, address them and minimise the impact on the young person's recovery.

Poor engagement with the treating team can have a significant negative impact on functional recovery. Establishing a trusting and strong therapeutic alliance enhances recovery outcomes in young people across a range of areas including improved functional outcomes.[57] The earlier a positive, collaborative relationship is established, the higher the likelihood of sustained engagement in biopsychosocial treatment.[58]

The chance of employing functional recovery interventions *early* in the course of recovery will be greatly improved by early establishment of rapport.

This in turn can lead to timely, successful functional recovery outcomes that can exert a positive effect on the hope, optimism and motivation of a young person. These are all important aspects in maintaining engagement to improve long-term functional gains.

Family can play a vital role in supporting and maintaining functional recovery. Though the family can provide a positive and enabling presence, case managers need to be aware of instances where family factors might act as a barrier to functional recovery. The onset of a first episode of psychosis can affect or change the expectations the family has of their loved one. This can manifest in one of two ways, both of which can affect functional recovery:

- Failure to alter expectations or expecting a return to pre-morbid functioning too early in the course of recovery can result in a level of expectation being placed on the young person that is too high at that time. This can affect functional recovery as the young person may be setting the bar overly to try to meet family expectations.
- A change in expectations following the onset of illness can result in the lowering of expectations. This can affect functional recovery as the family may not be supporting opportunities to practice and develop living skills. The opportunity for a young person to challenge himself or herself may also be less available and the young person has the potential to fall into the 'sick role'.

More often than not, these family expectations, whether too high or low, are coming from a place of love and concern for a young person's future. It is important not to dismiss or downplay a family's expectations but to acknowledge them and support the family in developing a greater understanding of the illness as it relates to their loved one. For more information about family work, refer to the ENSP manual *In this together: family work in early psychosis.*

Positive and negative symptoms can affect a young person's ability not only to function but to improve their functioning. Reduction and remission of positive symptoms as early as possible can support the improvement of cognition, and relieve and reduce stress – both of which will work towards enhancing the ability of a young person to engage in functional recovery interventions.

Negative symptoms can provide a greater challenge as they tend to be more difficult to shift and can therefore linger throughout early and (potentially) later recovery phases. Negative symptoms can have a significant impact on motivation, enjoyment, social purpose and drive. In turn this can affect a young person's function and the progress of functional recovery.[59] Other useful strategies when working with motivational difficulties include the setting of clear goals; a graded approach to skill development; structured problem solving; graded activity scheduling; identification of negative thought patterns; and promoting and celebrating success.[59] Further, case managers need to identify those with protracted symptomatology as early as possible to implement strategies and interventions to combat the detrimental effects of an incomplete recovery on functioning.

Comorbidities, dual diagnoses and dual disabilities can also be barriers to functioning and recovery. First and foremost, a thorough assessment will enable identification of any other physical, mental, developmental or drug and alcohol issues that have the potential to perpetuate the psychosis and affect a young person's functioning. From here, a collaborative intervention plan needs to be generated and implemented, ensuring the aforementioned difficulties are acknowledged and addressed accordingly.

Finally, side effects of psychotropic medications such as somnolence, sedation, weight gain, affective blunting, psychomotor retardation and cognitive deficit can all have a direct impact on functioning. Balancing symptomatic recovery and the impact of side effects on functional recovery can be difficult.[2] Case managers in conjunction with the medical team, family and young person need to assess and check in on side effects regularly. A shared decision-making approach, exploring whether and how side effects are influencing function, can inform the need for appropriate, goal-congruent action.

Goals for intervention

This section will review goal setting approaches and ways to use goal setting as an intervention with young people with early psychosis. It will describe how to set goals that are realistic and attainable, and describe how goals can be used to document, review and track a young person's progress.

Why set goals?

Goal setting is an essential foundation of the recovery process and a key component of service coordination.[60] Setting goals in a collaborative manner and facilitating the identification of personally meaningful, specific goals has been shown to encourage hopefulness regarding recovery, an increase in participation, and satisfaction and motivation when engaging in therapy; ultimately leading to more positive outcomes.[48,61–63] A young person is developmentally at a point in life where choice and control are vital to their growing sense of identity and autonomy. Goal setting offers a way for them to continue with those important developmental tasks by choosing and taking responsibility for their treatment and recovery pathway.

The setting of goals provides young people, their family and the treating team with a joint 'plan of action' – or guide – for intervention and a pragmatic way of recording and monitoring the progress and effectiveness of interventions.

Goal setting approaches

Case managers have a unique opportunity to support young people in the recovery-focused goal setting process at a crucial developmental life stage. Even so, facilitation of goals can be complex and challenging. It is important that case managers feel confident in applying a variety of methods and models to best enable the process. The following section describes a number of approaches case managers can apply that may be useful when working around recovery goals with a young person.

Formulation-based approach

A formulation is a useful framework for developing a shared understanding, or set of hypotheses, as to why a young person might be experiencing their current symptoms and difficulties – plus the factors that might be maintaining these difficulties. It is different to a case history because it attempts to collate and *interpret* the information gathered during the assessment process across biological, psychological and social domains. A formulation aims to answer the questions: Why this person? Why this problem? Why now?[64] It is a strengths-based model that provides an opportunity to address factors that are protective, or that have the potential to mitigate the current problems, and incorporate them into intervention and recovery planning.

Sometimes, like all of us, a young person can have an overwhelming amount going on in their life at any given time. This can make it difficult to know where or how to even begin to set goals. The development of a shared understanding that takes into account explanatory models of illness can form a foundation from which to build clarity and direction around the areas in which a young person might want to set goals. This, in turn, encourages ownership and acts as a simple method for incorporating strengths into the goal setting process.

Finally, a formulation is dynamic in nature. As new information arises or as details become more detailed and accurate, the formulation will change and develop. Regular reflection on the shared understanding provided by a formulation will continue to guide goal setting and interventions throughout recovery, and integrate changes as they occur.

Modifiable factors

Modifiable factors are areas that influence, maintain or – in the context of protective factors – contribute to ameliorating a person's illness. Adopting a formulation-based approach will assist in identifying modifiable factors over biological, psychological and social domains. It is particularly important to be on the lookout for factors that are modifiable. Once these are collaboratively identified, they can provide a starting point for goal setting. Addressing these factors when setting goals makes sense, because as the name suggests, modifiable factors are factors that are malleable, able to be changed through targeted intervention.

Strengths-based approach

As mentioned earlier, a strengths-based approach is a valuable model for supporting functional recovery, with recovery planning and goal setting being fundamental components.[41]

Psychiatry, as with other medical professions, has emerged from a predominantly medical model. Historically, this model has placed greater emphasis on symptoms, problems and diagnoses. As a result, both case managers and young people may find that areas such as strengths, abilities and talents can at times be passed over, or receive less emphasis. This also has the potential to creep into the goal setting process.

A good way to keep strengths on the agenda is to complete a comprehensive assessment of a young person's strengths. By having a thorough understanding of talents, achievements, areas of mastery and areas of familiarity, case managers can work to reframe language or thinking that may be more heavily focused on problems or areas of perceived weakness. They can also work with the young person to facilitate incorporating their strengths into the goals and action plans they set for themselves. Building goals that address, acknowledge and capitalise on the young person's strengths can increase motivation. From a practical point of view, this makes the process feel less difficult, unachievable and daunting.

Collaboration and goal consensus

Collaboration is an essential component of any therapeutic relationship. Evidence suggests that a collaborative approach and the extent to which an individual is active in their own treatment can lead to more positive outcomes.[61,63] The involvement of a young person in decision-making and inclusion of their preferences is thus increasingly being recognised as a core component of practice and recovery.[65]

Collaborative goal setting means working alongside the young person to ensure they are active participants in the setting (and later on, the actioning and review) of *their* goals. It is not the role of the case manager to set goals for, or on behalf of, the young person, but to understand their motivations and vision, encouraging them to be the 'directors' of their own recovery.

Goal consensus can be described as the agreement between a young person and case manager regarding goals and expectations.[63] It is associated with a decrease in distress and symptomatology, and an increase in satisfaction and enhanced treatment outcomes.[61,63] More than likely, case managers will not always share, or prioritise, exactly the same goals as the young people with whom they work. This is normal and to be expected. Be sure to acknowledge and discuss these differences to ensure the process remains transparent and collaborative. Continue to carefully explore the young person's motivations, feelings, needs, wants, strengths and experiences to gain the best understanding of the reasons for their goals; work together to develop a joint plan on how they might go about achieving them.

PRACTICE TIP

Ultimately, working in a collaborative manner, with ongoing consensus over goals, ensures the case manager and young person share a clear and united pathway for treatment.

Promoting goal attainment

The science of goal theory has predominantly emerged from studies in non-clinical populations exploring the factors that contribute to goal attainment.[60] The SMART goal model is a method of formulating and documenting goals that incorporates principles identified in goal theory research.[60,66] From a practical point of view, SMART goals offer an approachable and uncomplicated framework guiding the generation of goals and action plans.

SMART is an acronym for goals that are:

- **S**pecific, and outline exactly what a person wants to achieve and by when, including resources or supports available to assist in attainment.
- **M**easurable, ensuring a measurement of a clear outcome – ideally behaviourally defined.[60]
- **A**greed to (achievable can also be used here) and developed in a collaborative manner aiming for goal consensus between clinician and young person.
- **R**ealistic and appropriate to the young person's current situation.
- **T**imely, in having a clear time line and plan time for review.[60]

Clarke et al. (2009) outline principles, derived from goal theory, that can improve the quality of goals and increase the likelihood of goal attainment. These include:[60]

- understanding a young person's motivations, hopes and dreams and ensuring goals are aligned to these
- ensuring goals are developed collaboratively and are behaviourally designed, allowing for outcomes to be clearly measured
- addressing goal importance and confidence levels, discussing the importance of each goal and how confident the young person feels in relation to it, which supports prioritisation and maintenance of achievability
- setting and documenting clear action plans and pathways

- identifying barriers to anticipate any problems that may arise, along with possible solutions
- identifying social supports that can contribute to the planning and attainment of goals as well as the interventions involved
- setting timeframes for goals and reviews as well as a clear plan for the monitoring of goal progress.

Being mindful of the principles and evidence-based strategies known to encourage goal attainment will support a young person achieving success from day one.

Breaking it down

Sometimes young people outline goals that may initially seem quite difficult to attain. This may be caused by the illness phase, illness-related factors or a lack of support and resources. Taking the time to explore goals in greater depth often reveals that those initially appearing unrealistic or unattainable are actually more long-term goals.

No goal is a 'bad' goal. Just because the goal may have a longer projection does not mean it is less valid than short-to-medium ones. In fact, longer-term goals are often the ones that truly demonstrate to case managers the vision a young person has for themselves and their lives.[41] Acknowledging, exploring and – most crucially – understanding each goal, is essential. Case managers should discuss the short-, medium- and long-term goals and explain the importance of each in guiding recovery and treatment plans. Working with the young person, they can then break down each goal into 'stepping-stones' encouraging long-term goal attainment to begin.

Breaking down goals into more digestible chunks serves an important purpose. The more realistic a goal, regardless of its perceived level of difficulty, the more likely one is to attain and succeed. Small successes will provide a young person with a sense of achievement, which in turn encourages motivation and increased confidence in moving forward.

Involve the family

How the family is involved in goal setting will depend on the young person and their preferences. Families can provide a great deal of support and encouragement to loved ones throughout their recovery. When thinking about goals, family members can contribute by:

- taking part in the collaborative goal setting process
- acting as a resource and support in the actioning of goals (e.g. being part of the intervention and goal attainment strategies)
- being part of the review process
- supporting the young person to track their progress.

With consent, case managers should ensure the family or significant others, are aware of the young person's goals and the plans for action, timelines and measurement.

Documenting, reviewing and tracking progress

Once goals have been identified and formed, they need to be recorded to keep the process transparent and on track.[41] The agreement of goals and plans for intervention within health organisations is most commonly undertaken through an individual service plan. This tool can also document major problems, strategies to achieve goals, people involved in the support of the young person, and their roles and timeframes for achieving goals.[48]

Individual service plans need to be completed as per organisational requirements. This does not mean a young person necessarily wants or needs to take home a photocopied individual service plan as *their* form of documentation. The goals are the young person's – discuss how they want to document them. Documenting goals to suit a young person's preferences fosters a sense of ownership and preserves personal meaning.

Life is constantly changing, so it makes sense that goals will also evolve over time. Regular goal review with the young person should be scheduled to best track progress and move with change. A regular check-in on goals ensures they remain relevant, and provides a forum to 'celebrate the successes' and an opportunity to modify or add other goals along the way. Speak with the young person about how and how often they would like to review their goals. The 2nd edition of the *Australian Guidelines for Early Psychosis* indicate that goals should be reviewed at least every 3 months; although if agreed upon, this does not mean a check-in can't, or shouldn't, occur earlier or more often.[48]

In summary, none of the aforementioned approaches should be used in isolation. The best outcomes will likely be achieved when adopting a number of approaches tailored to suit each young person.

Goal setting barriers and challenges

Supporting a young person in identifying their goals for treatment and recovery can be a highly rewarding experience, but can come with a variety of challenges. Factors such as time constraints, service timelines and missed appointments can make it easy to fall into the trap of goal setting 'for' as opposed to goal setting 'with' young people. It is useful to remember that two or three clearly defined, value-driven, meaningful recovery goals will hold significantly more value and an increased chance of attainability, than numerous goals that hold little or no personal meaning to the young person.

Goals perceived to be over-ambitious can present a challenge, but so too can under-ambitious goals. Take the time to explore in more depth why someone might be under-estimating their ability to achieve. For example, under-ambitious goal setting might purely be due to a lack of goal setting experience. It may also be that a young person feels if they 'set the bar too high' they are setting themselves up to fail, or they may fear a relapse from the stress of trying to achieve a goal. Understanding the motivations behind and the meaning attached to goals enables case managers to assist a young person to set goals that are both challenging and realistic.

There may be occasions when a young person is having difficulty identifying any goals. This is common and can occur at any stage of the recovery process. In the early stages of treatment as mutual rapport, trust and understanding grows, young people often begin to form plans for their recovery naturally. It is important not to rush or impose the process on them as the building and strengthening of the therapeutic alliance in itself can act as a catalyst for the identification and formation of goals.

Language is important. For example, the word 'goal' may hold a different meaning for different people. A young person may associate the word with negative past experiences or it may represent failure. Rather than asking 'What are your goals?' it can be far more valuable to ask curious questions to enable the self-identification of goals. Explore areas the young person is likely to be familiar and comfortable with, such as developmentally appropriate hobbies, interests and activities.[41] Discuss if, how and why pre-morbid time use might differ to current time use. Talk about what they feel they are good at, what they value in life, and past, present and future life roles.

Finally, a young person may continue to have trouble achieving goals. This can lead to a sense of failure and demoralisation and can also damage motivation. Rapp and Goscha (2012) suggest that failure to achieve a goal is rarely due to mental illness, and the reasons are similar for most people.[41] Some examples include:

- fear of failure or fear of success
- shifting priorities
- unexpected change in life circumstances (e.g. pregnancy, illness, relationship break-up)
- too many goals, or goals that are non-specific
- lack of personal meaning attached to the goal (e.g. the young person might be aiming to do something they do not deem important or meaningful to them, to please a family member)
- forgetting about the goal
- lack of resources or social supports.

Normalise the experience by discussing why people may not get around to achieving their goals and take time to reflect upon the goals a young person has set. It can sometimes be useful for clinicians to share their own experiences of goal setting. Explore goals the young person *has* achieved in the past and how they might differ from those not as easily attained. Understanding the specific, underlying reasons for difficulty in achieving goals will allow for adaption of existing goals as required and guide problem solving to avoid similar problems in the future. Finally, checking in on goals regularly should ensure any difficulties in goal attainment are flagged and addressed early.

Interventions for functional recovery

Overview

This section describes a range of interventions and approaches that may be used to improve functioning in young people with early psychosis. The evidence and rationale for each approach is followed by a description of specialist-level and case management interventions. Case scenarios are included to highlight how these interventions might be used in practice.

Although the following focuses on specialist and case management interventions, service leads need to consider how and where these interventions are offered to young people. Interventions that target functional recovery should be offered across the service. This includes during acute inpatient care, by crisis teams, in community recovery programs (groups), by individual clinicians and supported by peer workforce where possible.

The role of the case manager in functional recovery

As a direct result of their role as primary clinician throughout a young person's episode of care, case managers are in a position to contribute significantly to the promotion of functional recovery both by directly implementing interventions and coordinating care in services.[2,67]

The core features of the case management role are further defined below and framed here in the context of functional recovery:

- assessing the young person's functional capacities, performance and needs
- developing a collaborative, comprehensive plan to guide functional treatment and intervention
- coordinating and arranging service delivery to best enable and enhance functional recovery
- monitoring and assessing progress of functional recovery goals and interventions
- evaluating services and follow-up.[67]

Meeting the demands of case management in relation to functional recovery can be challenging. To help manage and support this, the application of an assertive case management approach can be advantageous. The core components of an assertive approach to case management include the following.

Proactivity:[68] A proactive approach should be adopted throughout all aspects of the case management role from engagement through follow-up and working with the family, to the implementation of interventions. Being proactive involves regular, assertive follow-up and communication with young people, their families and supports. A proactive approach aims to avoid people 'falling through the cracks' and can translate practically to regular phone calls and text messages, reminders of upcoming appointments and being readily accessible. A proactive service involves not only scheduling and attending regular home visits and clinic appointments, but sensitive and assertive follow-up if the young person misses an appointment or becomes difficult to contact. It can support engagement, building and establishing of trust, and timely assessment and formulation. These can then lead to functional needs and goals being addressed early to enable best outcomes and limit any further functional deterioration. A proactive approach also encourages the close monitoring and regular tracking of functional goals.

Flexibility in location of care:[68] A key feature of the early psychosis model is providing treatment and care in the young person's own environment where possible.[69,48] This will be typically be their home, but can also include other locations such as the local park, a café or even their school, university or place of work. Being flexible with location of treatment is conducive to functional recovery as it allows the case manager to actively support the young person in developing functional skills *in situ*. For example, a young person may be starting a new job and needs to catch the bus to work. The case manager can accompany the young person and facilitate them working through the steps required, in a 'learning through doing' experience. For more information, refer to the 'Practical support and assistance' section of this manual on page 41.

Smaller caseloads:[68] The rationale behind smaller caseloads is that case managers have more time to spend with young people, enabling assertive case management. This in turn allows for a more intensive and individualised approach to interventions and more time and space for working on multiple functional goals simultaneously (when appropriate).

Multidisciplinary team involvement:[68] Although the case manager remains the central support and 'go to' person, an assertive approach also encourages the involvement of the MDT. A core MDT is generally made up of occupational therapists (OTs), social workers, psychiatric nurses, clinical psychologists

and medical practitioners.[2] Each team member will possess their own understanding and expertise, and can be accessed as required to support and conduct assessments and interventions that promote functional recovery. Clinical reviews can provide a useful forum to liaise with others in the MDT around a young person's functional recovery. No single clinician will have all the answers. Being able to bounce ideas around as a team allows for the sharing of knowledge and a range of different opinions and ideas to be put forward, discussed and actioned as appropriate.

Assessment and formulation

Although assessing function was discussed in detail earlier, it is worth briefly revisiting the role of the case manager in ensuring a thorough assessment of functioning is completed. It is typically the case manager that leads and conducts the assessment of a young person's functioning as part of a comprehensive psychosocial assessment. Case managers need to feel confident in assessing all areas of functioning to best obtain an accurate understanding of the young person's functional abilities and developmental history.

Ensuring all salient information around functioning is gathered will more accurately inform the generation of a shared formulation or understanding that can guide functional goals, priorities and interventions. To maintain meaning and relevance of treatment goals and interventions, assessment of functioning should be an ongoing process and not limited to the first few weeks of a young person's episode of care. Ongoing assessment can also provide a method of tracking tangible progress and outcomes. For further information about functional assessment, please refer to the 'Assessment of functioning' section of this manual on page 22. For further information on assessment in early psychosis, please refer to the ENSP manual '*Let me understand': assessment in early psychosis*.

Service coordination

Case managers are in the ideal position to provide interventions and to coordinate care with other service providers.[2] A large part of the role includes case managers themselves providing a range of targeted, tailored interventions that support functional recovery. Even so, there will be times when the case manager will need to outsource service delivery and coordinate the services of others who possess the skills and expertise required to address certain functional needs and goals that young people present with. The decision to recruit other service providers should be based soundly on the outcomes of the functional assessment, a formulation-based approach to care, and shared goals for treatment (see Box 12).

Case managers should ensure young people are appropriately linked with services or workers that can best support them in meeting their goals for functional recovery. This can be difficult if a case manager is new to an area or just starting out in the workforce and does not yet know other services and how to access them. Often forums such as clinical review and line management or clinical supervision will provide opportunities to learn about internal and external services, their remits and their roles. Taking the time to attend any education sessions around local resources and services is also useful. All of the above will support case managers in being able to present a range of appropriate options to a young person when aiming to meet functional recovery goals. Finally, when coordinating and liaising with other services, always aim to maintain optimal communication and check in with a young person regarding confidentiality and their preferences around communication.

BOX 12 **WHAT MIGHT OTHER SERVICE PROVIDERS LOOK LIKE?**

Service providers can include:

- other people within the MDT such as a specialist family worker, vocational or IPS worker, OT or neuropsychologist
- other agencies such as housing services, financial support services, educational institutions or non-government organisations or workers.

Developing skills for recovery

It is essential to equip a young person with a range of skills that can provide a stable foundation for recovery. The beauty of these skills is that once learned and understood, they can be generalised. In other words, they can be adapted and applied to everyday day situations, with the purpose of supporting sustainable, long-term recovery.

Clinicians should remember that skills take time to develop and the young person should be allowed to practise in a range of different settings and circumstances, including 'real life'. Recruiting family and significant others in planning and intervention will also provide more opportunity and encouragement for a young person to develop and master these skills over time.

PRACTICE TIP

HABILITATION VERSUS REHABILITATION

What is the difference between rehabilitation and habilitation? Rehabilitation occurs when a person is regaining skills following the loss of function. Habilitation occurs when a person may be learning a skill for the first time. From a developmental perspective, it may be more common for a young person to require a habilitative approach when compared to an adult with more life experience and past opportunities. Knowing whether a young person requires support to learn a skill for the first time or is re-learning a skill may affect how a skill is developed, taught and graded.

Practical support and assistance

The word practical implies something that is 'hands on' and applicable in the real world. This is where practical assistance and support can play a large role in functional recovery. It emphasises the 'doing' and provides young people with the opportunity to develop skills that they can apply and use effectively in everyday life. Case managers can take an active role in providing practical support and assistance. They should develop a clear plan with the young person that outlines what support and assistance looks like. They must be ready and willing to 'get their hands dirty' by accompanying the young person; actively engaging in and supporting them in activities in the community and their own environment that will contribute to their functional recovery.

Obviously, young people experiencing an episode of psychosis will need to get better and stay well. Additionally, it is likely they will have a range of practical needs that warrant attention. Identifying, acknowledging, prioritising and addressing these is important, as it will assist with enhancing engagement, building trust and allowing for progress in recovery.[71]

Young people experiencing an episode of psychosis often require practical assistance with:

- managing finances, accommodation/housing and legal or court-related matters
- negotiating government welfare services and paperwork
- negotiating workplace or educational consumer liaison services
- accessing primary physical health care
- accessing public transport.

For example, a young person may have received a fine for speeding that they cannot afford to pay in one lump sum. The payment deadline is approaching and this is weighing heavily on their mind. Supporting them to arrange a payment plan or to go through the legal process of having it waived will allow them to move on and focus on other goals. It will also provide them with the knowledge and ability to address similar problems that may arise in the future.

Goal setting

As mentioned earlier, goal setting is a foundation of the recovery process. Supporting young people to develop skills around goal setting will provide them with a framework for understanding their personal needs, and prioritising and generating their own strategies and plans to meet these needs. For more information on goal setting, please refer to 'Goals for intervention' on page 35.

Problem solving

There are times in all of our lives when trying to find a way to work through our problems can seem confusing and overwhelming. Now think about adding an episode of psychosis into the mix. It makes sense that deficits in problem solving are common in early psychosis and that young people in such circumstances might find it challenging to problem solve their way through difficult life

situations as they arise.[51] Working to develop skills in problem solving has been found to contribute to improved functioning, especially when involving the family in the process.[51]

A problem-solving approach centres on the teaching and development of adaptive, constructive, real life problem-solving skills and attitudes that can play a useful coping strategy role.[72] Structured problem solving consists of the following steps:[51]

1. Clearly identify and break down the problem.
2. List and evaluate all possible solutions. This includes identifying the pros and cons of each solution to support decision-making.
3. Select the most favourable solution based on the pros and cons analysis. Make sure the young person possesses the appropriate resources (e.g. time, money, ability) to proceed with the solution.
4. Collaboratively develop a plan and break it down into smaller, concrete steps to attempt and achieve each step as easily as possible.
5. Be aware ahead of time of possible difficulties in each step and how they might be dealt with.
6. Carry out the plan and review the progress at each step, continuing until the problem is solved.

Over time and with practice, these steps will become natural and automatic. It is also important to remind young people that if they are particularly stressed, the problem-solving skills they have learned may not come as naturally as at other times, even if they feel they have mastered the process in the past. At times of high stress, it can be useful to advise young people to slow down and methodically work through each step again.

Identify and use supports

Developmentally, young people are at a stage of life where they are forming independence and beginning to take control of their own lives and life choices. This can sometimes lead to reluctance when it comes to seeking or engaging the support of others. Encourage young people to identify, expand and use their support networks. Being able to communicate concerns with others will allow for stress, problems or successes to be identified as early as possible and shared with others.

Working with families

The onset of a psychosis can prove extremely stressful for families and evoke feelings of worry, stigma, embarrassment, fear and loss of control.[48] A loved one becoming unwell can disrupt family function and result in significant distress; hence, working with families is a key component of the early intervention model of practice.[8,70]

Involving the family has been found to increase functioning not only in the young person (decreased relapse rates, reduced hospital admissions and increased compliance with medication) but also within the family (reduced burden of illness, increased knowledge and a decrease in expressed emotion).[8]

Working with families to enhance function should include:

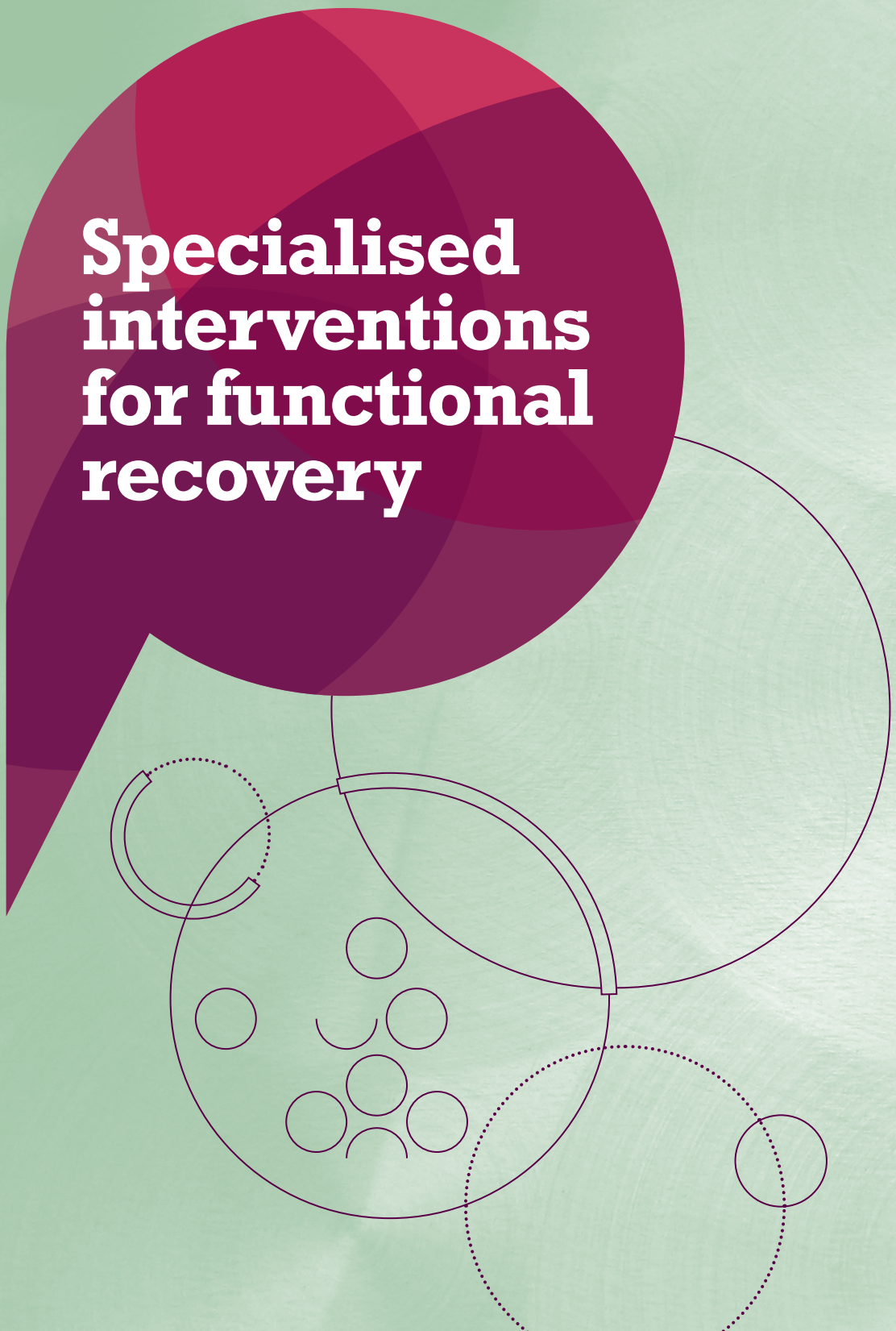
- engaging and collaboratively involving them (if appropriate) from day one
- ensuring families are active members of the treating team[70]
- understanding explanatory models and providing frameworks to support understanding of psychosis (e.g. stress-vulnerability model, formulation)
- providing ongoing psychoeducation, practical support and assistance
- developing problem-solving, coping and stress-management strategies
- enlisting their support in the identification and implementation of early warning signs, and relapse planning/prevention and collaborative goal setting plans
- providing family therapy, which can be delivered directly if the case manager has specific family therapy expertise: otherwise, the case manager can source and refer the family to a family therapist either within, or external to, the MDT.

For more information about working with families, please see the ENSP manual *In this together: family work in early psychosis*.

In summary, case managers play a significant and central role in coordinating and providing interventions to support functional recovery in the young people with whom they work. It is essential to collaboratively choose and use interventions that are tailored to individual needs and engage the support of the MDT, family and significant others (e.g. GP, school).

The role of the case manager is as complex as it is important, therefore, it is recommended that case managers seek and receive regular line and clinical supervision. Engaging in regular supervision will help case managers face and address barriers, challenges and obstacles as they arise.

Specialised interventions for functional recovery



Specialised interventions for functional recovery

A remedial or compensatory approach?

Facilitating functional recovery in young people requires the selection of intervention models or approaches that best suit their needs at any given time. Two such approaches are remediation and compensation; it is likely that most psychosocial interventions will fall into one of these two approaches.[73] Though both aim to improve functioning, they differ in their underlying mechanisms and why one might be chosen over the other.

A remediation approach puts the focus on addressing or improving the *underlying deficits* that might be contributing to the young person's current difficulties. For example, a young person may be experiencing difficulty paying attention in lectures. Remediation approaches might include strategies directly targeting the underlying cognitive deficit – in this case, attention.

A compensatory approach assumes that a person can still improve or regain function despite the underlying deficit not being able to be remediated at a given point in time. Compensatory approaches involve improving function by applying strategies that substitute for the loss of, or poor functioning in, a particular skill, activity or area. Compensation might include modification of the environment, or the development of alternative skills to adapt to a loss or decline in function. In the example above, a compensatory strategy to improve attention in class could include reducing possible distractions and/or scheduling of regular, short breaks during the lecture.

Many factors will influence the decision to choose one method over the other. These could include illness phase or stage, illness acuity, past experience in a psychosocial skill or task, level of resources or supports and level of confidence in the young person's own abilities. It is important to remember that one approach is not necessarily better than the other. Both strategies have the ultimate aim of improving independence through creating opportunities to learn, develop and implement skills required to function in everyday life at a level that meets individual needs and maintains quality of life.

The key to ensuring that intervention is effective lies in having a clear understanding of the young person's psychosocial needs, abilities and goals within their own environment, and appropriately tailoring the intervention and approach. It is also important to consider which approach, or combination of approaches, will allow a young person to function in an independent manner to the best of their ability.

Particularly in the earlier stages of recovery, case managers may find compensatory strategies more effective and that they can in fact act as an enabler for remediation. It is also very common to use both compensatory and remediation approaches together. For example, a young person may have goals around grocery shopping. Due to significant social anxiety, they find it difficult to leave the house. An initial compensatory strategy then involves ordering shopping online for home delivery. The young person is able to achieve the functional

goal of 'doing the grocery shopping' while allowing for remediation-focused interventions targeting the social anxiety to occur, which in time will enable them to go out to do their groceries.

Vocational and educational interventions

Evidence and rationale

Research shows that the main goal for people with severe mental illness is employment.[74] More recently, studies have shown that employment is among the highest priorities for young people recovering from FEP, and their families.[24,25] For young people who experience early psychosis, educational and vocational trajectory can be disrupted, which impairs educational attainment and employment.[16,17] The peak onset for psychosis occurs at a time when young people are developing their career and vocational identity. Disruption during this time has the potential to negatively influence long-term employment.[75]

'I think in all of the interventions that we do in mental health, I don't think there's anything that sends such a powerful message that a person is just a normal member of society as actually winning a job. Being able to go to an interview and somebody saying, "Irrespective of what's going on in your life, I want to hire you for the skills and talents you possess and I'm going to pay you for those." There's nothing we have that's as powerful as that for people.'

Prof. Eóin Killackey
Research head, functional recovery in youth mental health,
Orygen, The National Centre of Excellence in Youth Mental Health

People employed or enrolled in training or education are more likely to have social connections, stable accommodation and be socially and economically engaged.[75] Early functional recovery, including work and education, is a more important predictor of long-term health and functioning than early symptomatic recovery.[10]. For more information about vocational recovery interventions, please refer to the ENSP manual *Working it out: vocational recovery in first episode psychosis.*

Specialised intervention

Supported employment

One of the 16 core components of the EPPIC Model is the provision of specialised vocational recovery via a dedicated vocational consultant (see *EPPIC Model and Service Implementation* guide).

The vocational consultant's role is to engage the young person in competitive employment or education/training without lengthy pre-vocational training (e.g. job search classes).[75] The *Working it out* manual provides a comprehensive overview of how vocational consultants work as part of the wider psychosocial or functional recovery team. The ISP model should be implemented in the early psychosis context.

The role of the vocational consultant involves many tasks. Typically, they carry out an initial vocational assessment to review the young person's previous work and educational history. This also involves an assessment of their skills, interests, motivations and work values; an overview of their health history and how this may affect their ability to gain or maintain work; personal information including their eligibility for income support or external support services; and their disclosure preference.

On completion of the vocational assessment, the vocational consultant moves into an action phase, delivering intensive, individualised vocational support. This can include:

- developing effective job tools
- contacting employers to create vacancies
- assisting with interview skills
- transporting clients to job interviews, career days and training provider enrolment sessions
- performing any other task that supports the young person into employment or education.

Once the young person is placed in employment, study or both, the vocational consultant provides intensive support to ensure they maintain

their place. They must ensure follow-up of the individual's career development plan milestones. Support can include actions such as:

- speaking to employers about supports (e.g. flexible working hours, providing co-worker mental health training, identification of suitable job tasks)
- working with education providers and their student wellbeing service and teachers to ensure supports are in place
- meeting with young people on their breaks to check progress and identify any issues early
- negotiating with case managers to enable the young person to attend clinical appointments and ensure vocational support is delivered in a flexible manner based on individual need.

Supported education

A supported education approach might also be considered part of the specialist-level intervention, targeting vocational and educational recovery (see Box 13). For more information on supported education and the role of teachers in MDTs, please refer to the ENSP manual *School's in: a focus on education during first episode psychosis.*

BOX 13 TIPS FOR WORKING MORE EFFECTIVELY WITH EDUCATION PROVIDERS

- Build positive relationships with school counsellors or welfare coordinators of schools, TAFEs and universities in the local area.
- Attend meetings with the year level coordinator, school welfare coordinator and principal or vice principal when the young person is ready to return to school.
- Discuss minimum requirements for attendance, and understand how the young person can be supported if they need to take time off.
- Develop a collaborative support plan about what to do if the education provider is concerned about the young person's mental health.
- Incorporate stress management and activity scheduling into the young person's goals early on to help them manage the transition back to education.
- Practically address any difficulties the young person is having with getting work done on time. Help them apply for special consideration or extension, and provide medical certificates and supporting letters if necessary.
- Encourage the young person to consider flexible learning pathways and actively address this with the school.
- Provide psychoeducation to teachers, particularly in relation to how mental health difficulties and recovery might affect school performance.
- Use specialised assessments (such as psychological or functional assessments) to inform classroom adaptation and accommodation.

Case management intervention

Case managers are ideally placed to support specialised interventions focusing on vocational and education recovery. Case managers will need to consider how the vocational and educational goals of the young person can be supported through other interventions that might address social or psychological recovery goals.

The case manager can also provide support and assistance to young people engaged in secondary education, training or tertiary study. Specific skill-based interventions, such as public transport training, will assist young people who may not have the skills to get to school independently. Regular meetings with teachers, school psychologists or welfare coordinators can help the school understand what the young person's specific challenges might be, and how the school can support them in returning to education.

In higher education, equity or disability liaison units provide support and assistance to people with significant health or other issues that impact their learning. Each TAFE and university will be able to link the young person with appropriate support to advocate or intervene where necessary. However the young person will probably need assistance to contact and meet with these supports for the first time. In addition, they may benefit from having the case manager present at meetings with lecturers or tutors to help explain how their experience of psychosis, or mental health difficulties more generally, might be affecting their ability to study. Addressing stigma, building mental health literacy and developing understanding about how to support the young person in education are crucial to improving the experience of students.

Case managers also need to keep in mind that appointments with the early psychosis service should interrupt school or work as little as possible. If young people are successfully maintaining work or study, this should be actively supported by arranging for case management appointments to occur at the end of the day. Alternatively, the treating team might offer outreach appointments to take place at the school or workplace at a convenient time.

Many young people coming to the service will be eligible for assistance from a Job Active provider or a Disability Employment Service via Centrelink. It can be helpful for the case manager to contact the employment service, with permission from the young person, to discuss any supports they may need to improve outcomes. Several factors can impact the assistance a young person receives from a job service:

- medical certificates advising they are unable to work at all may prevent the young person from being able to access a service
- lack of supporting documentation from the health service can make it difficult for Centrelink to adequately assess what type of employment support the young person needs and can lengthen the referral process
- non-disclosure of illness can affect a job service's ability to understand supports required or gain necessary funding for the young person to obtain work or study
- failure of young people to attend appointments can result in income support payments being reduced or stopped, and can negatively impact employment service providers willingness to refer the young person to potential employers
- referring young people to the appropriate stream of service or employment provider type can influence how much support the service can provide.

If a vocational consultant is employed as part of the early psychosis service but they are unable to work intensively with the young person, they may be able to provide a one-off consultation and generate a vocational plan. A vocational plan will outline specific strategies and timeframes for supporting the young person with work or study (see Box 14 and the case scenario 'Robert'). It should be incorporated as part of the overall recovery plan and used in sessions to check off completed tasks and mark achievements. When achievements are marked off, it highlights the achievements of the young person since the plan was developed and keeps the focus on moving towards their longer-term career goal.

BOX 14 TIPS FOR WORKING MORE EFFECTIVELY WITH YOUR LOCAL EMPLOYMENT SERVICE PROVIDERS

- Use the jobsearch.gov.au website to search for providers in your service area. You can use this site to check their star ratings and specialisations of service.
- Attend the Centrelink appointment to help the young person engage with the right employment service. If you are unable to attend, provide the young person with a health report to take to their interview.
- Once the young person is linked in with a job service, call and introduce yourself and offer support.
- If the young person requires work-related training, check their eligibility for courses and print information for them to take to their first meeting.
- If a young person is working and is at risk of losing their job, assistance under the 'job in jeopardy' program through the Disability Employment Services can be sought. Search for a service at jobsearch.gov.au and contact the service directly.
- Assist the young person with scholarship applications if unable to access funding for courses through their employment service. You can find application forms on the university or TAFE websites.
- If the young person needs intensive on-site job support, consider supported employment as a starting point. You can search for providers at australiandisabilityenterprises.com.au.

ROBERT

CASE SCENARIO

Robert is a 23-year-old man who experienced an episode of psychosis following long-standing cannabis use. He was hospitalised for 2 weeks, and 1 week after discharge went back to his job in a factory part-time. Robert reported that he was happy with his job, and had been working at his current workplace for 2 years. He held a full driver's licence, owned a car, and was living independently with his housemate and friend, Chris.

Robert eventually returned to work full-time, and as a result was limited as to when he could attend the early psychosis service. He attended a few times during business hours, and was given a medical certificate for his appointments; however, this became more difficult as time went on. Robert accepted the offer of outreach appointments at his workplace. His case management and medical review appointments occurred in the car during his lunch break, on a fortnightly basis.

Robert disclosed to his case manager that he had poor literacy skills, which was part of why he had stayed in factory work. His case manager discussed this with the vocational consultant, who was able to link Robert with a literacy course in his local community. After discussion with his case manager and employer, Robert reduced his hours at work to only 4 days so that he could attend the course 1 day per week. Case management appointments occurred at Robert's house later on the same day. He agreed to meet with the vocational consultant to discuss his longer-term vocational goals.

At the initial meeting, the vocational consultant engaged Robert in a vocational assessment and then set up a time for him to attend a career-testing program with her support. The aim of this was to identify Robert's skills and interests, and potential occupations that would suit him. He attended another appointment with the vocational consultant the following week to review the test results. They discussed his results together, and Robert identified a particular interest in the building and construction industry.

The vocational consultant developed a vocational plan, outlining the short- and long-term strategies to attain his long-term career goal of working in the construction industry. The vocational consultant discussed the plan with Robert's case manager. They discussed the general strategies that Robert and his case manager could work on together, such as getting organised with attendance and being on time for appointments, answering his mobile phone and changing his voicemail message to a more appropriate one. The vocational consultant also discussed the specific strategies and shared a copy of the plan with the case manager. By discussing these plans together, the case manager and vocational consultant were able to work with Robert in a complementary way, minimising the overlap and maximising the effectiveness of their interventions.

Psychologically-focused interventions

Evidence and rationale

Remission of psychotic symptoms is only one aspect of recovery from an episode of psychosis, and in itself does not always lead to functional improvement.[76] Psychological interventions, such as cognitive–behavioural-oriented interventions, are recommended by international guidelines as part of treatment for psychosis.[77-79] This is based on their effectiveness in improving social functioning and ameliorating the effect of early psychosis on a young person's social life, relationships, work, schooling, self-esteem and more. Such interventions can help young people develop strategies to cope with persistent symptoms and associated distress, promote adaptation following psychosis, reduce self-stigma and assist with making plans for recovery.[76] They may also be used to support stress management, and address co-occurring conditions and other psychosocial factors associated with incomplete recovery and relapse. All of these impact directly on functional recovery outcomes.

For a comprehensive overview of the use of psychological interventions in young people with early psychosis, please refer to the ENSP manual *Psychological interventions: why, how and when to use in early psychosis.*

Case management intervention

All psychological interventions should be guided by an individualised formulation of the young person's presenting problems, goals and any predisposing, precipitating, perpetuating and protective factors. When considering the use of psychological interventions it can be helpful to complete a cognitive–behavioural formulation with the young person, to focus on a particular presenting problem or goal that you wish to work on together. This model may assist in developing a shared understanding of specific maintaining factors for current problems, and provide a rationale for using psychological strategies to meet functional goals.

Behavioural activation

Behavioural activation is a common intervention used in the treatment of depressive symptoms, including low mood, anhedonia and low motivation.[80] Behavioural activation may also be used for addressing the effect of negative psychotic symptoms, although the evidence base in this area is limited.[81]

Young people experiencing comorbid depression or anxiety will often discuss a sense of wanting to feel better before attempting to return to previously enjoyed activities. Avoiding and withdrawing from social and occupational settings is common, and young people may become stuck in a vicious cycle that reinforces avoidant behaviour. Waiting for symptoms to resolve before engaging in enjoyable activities may result in prolonged low mood, anhedonia and withdrawal from usual functioning.

The simple premise of behavioural activation is to encourage the young person to identify activities that they previously found enjoyable or rewarding, and to help them gradually re-engage with these activities. If the young person is able to reintroduce activity goals gradually, there appears to be a positive impact on cognition, emotion and physical domains.

To support the young person to identify activities it may be helpful to:

- Enquire about the past. What activities used to be fun or give the young person a sense of satisfaction?
- Work through a checklist of pleasurable activities and ask the young person to circle things they think might work for them.
- Break larger activities into smaller steps if the young person does not feel that they can achieve them at once (e.g. cleaning out one drawer in their room instead of cleaning the whole room).

A behavioural activation plan can then be developed with the young person so that they can achieve a graded increase in activities they enjoy or receive satisfaction from completing. The most important part of this exercise is to include sufficient activity so that the young person can have a sense of achievement, but not so much that the plan is unattainable and they feel disheartened. Ensure that the young person has a way of keeping track of what is planned and for when, and then noting when it is achieved or completed. This may mean using the calendar or tasks list in their phone, a paper diary or a calendar that they can put on the fridge at home (see Table 1).

TABLE 1. **AN EXAMPLE ACTIVITY PLAN**

	MON	TUE	WED	THU	FRI	SAT	SUN
MORNING		Walk with mum for 40 mins	Meeting at school with year level coordinator	Walk alone for 40 mins	Do 1.5 hours of school work		Go to the market with mum
AFTERNOON	Do 1.5 hours of school work			Do 1.5 hours of school work		Friend over for the afternoon	Make some healthy lunches for the week
EVENING	Have a warm bubble bath	Call a friend and invite over for weekend	Watch TV with dad		Family dinner		

Stress management and coping strategies

Stress plays a significant role in the predisposition, onset and maintenance of a psychosis and psychosis itself impacts significantly on functioning.[51,82] Therefore, interventions and strategies that target stress management and promote coping strategies are essential. Stress management aims to help young people understand the role stress plays in their lives, recognise past and potential sources of stress and develop management and coping techniques to combat these. The stress–vulnerability model places significant emphasis on the role of stress in precipitating the onset of FEP, maintenance of symptoms, effect on recovery and risk of relapse.[83]

PRACTICE TIP

RATING ANXIETY AND DISTRESS

Use a rating scale or metaphor that the young person finds helpful. Examples include a distress thermometer, car speedometer or simply a 0–10 scale. Ask the young person to notice and label experiences of anxiety and distress in a quantifiable way.

This strategy sets the scene for further interventions, which rely on the young person's capacity to identify and communicate about the severity of their distress.

Young people usually have an existing range of coping skills and personal ways of dealing with stress.[51] Case managers can work with them to understand, use, adapt and develop these skills further, supporting the process by:

- **Assessing coping:** Everyone has a different way of coping with life's problems as they arise. Talk with young people about how they have handled difficult situations in the past. What worked? What didn't work and why might that be?
- **Understanding past coping styles:** This can support adapting and developing coping skills and allows for reflection on why some current or past strategies may not be useful in the long term (e.g. use of excessive alcohol to cope with social situations, avoidance, smoking tobacco to relax). If young people are still living at home with their family, it can also be useful to assess how the family cope with stress. Young people are likely to learn many of their coping strategies from the people they spend the most time with.
- **Building an awareness of the early signs of stress:** Spend time with young people exploring areas of past and present stress over biological, psychological and social domains. Forming a diagrammatic 'life timeline' that documents life events prior to, at the time of and following an episode of psychosis can be a useful tool for identifying stressful situations. From here, work to understand what feelings, thoughts and behaviours are associated with each stressor, helping young people to form an idea about what signs to look out for. This allows for appropriate strategies to be put in place early. The ultimate aim is preventing relapse, and decreasing stress and further functional decline.
- **Maintaining balance:** It can be beneficial to support young people to appropriately decrease the amount of responsibility they have in their lives to avoid increasing stress, or to decrease current stress levels.[51] This might include taking on fewer shifts at work or reducing the number of subjects studied each semester. The overall aim is to support young people to better understanding their own capabilities and stress levels so they can eventually self-regulate their responsibilities, maintaining a life balance congruent with their functional capacities and supportive of functional performance. Sensitivity when discussing this strategy with young people is essential: suggesting a decrease in responsibilities could be perceived in a negative light. Case managers should take time to normalise this strategy and discuss with the young person its ability to be used as a short-term coping mechanism.
- **Relaxation and breathing techniques:** Stress can take a large emotional toll. Development of emotion-focused coping skills such as breathing techniques, distraction, positive self-talk, meditation and relaxation strategies can be useful additions to young people's stress management skill set. These techniques can take a role in managing a range of stressors including coping with the stress of positive symptoms and that brought on by everyday life.[67]

Relaxation and coping interventions are likely to be useful when young peolpe demonstrate fear or worry about the experience of anxiety itself. Normalising the experience by introducing the concept of 'fight or flight' – physical and psychological effects of anxiety – can also be helpful.

Emotion-focused strategies can also play a pragmatic role in everyday life. With a little practice, they can be put into action in everyday situations with minimal impact upon a person's engagement in a particular activity and without others even knowing they're being implemented. For example, if a young person is on the train and finds they're becoming increasingly overwhelmed, they can discretely engage in a breathing exercise or pop in earphones as a distraction technique.

PRACTICE TIP

RELAXATION AND DISTRESS TOLERANCE STRATEGIES

Most relaxation and distress tolerance strategies rely on quite simple skills. These include slowed breathing, counting each breath, tensing and relaxing muscles, or purposeful noticing and awareness of the senses.

These strategies are most effective when the young person understands how and why they are effective and when they are practiced regularly while in a less anxious state (i.e. a rating of 6/10 or less on the distress scale).

Cognitive restructuring (working with unhelpful thoughts)

At the core of many psychological interventions – particularly cognitive–behavioural therapy – is the notion that our emotions and behaviour are driven by appraisals, thoughts and underlying beliefs. Cognitive restructuring aims to modify unhelpful thoughts and beliefs. This is done through an examination of evidence for particular thoughts as well as their use.

As discussed earlier, the impact an episode of psychosis can influence a young person's view of themselves in their functional roles (as a student, a friend, an athlete or an employee) as they experience disruption in these areas. As a result, many young people may develop self-stigmatising views, or concerns about what it means to have experienced psychosis, now and for the future.

Cognitive restructuring involves a range of strategies, including among others:

- gathering evidence for and against the belief
- exploring alternative explanations
- developing more realistic balanced beliefs
- working with the core beliefs and schema.

A full discussion of cognitive interventions is beyond the scope of this manual. For more information on specialised interventions, please refer to the ENSP manual *Psychological interventions: why, how and when to use in early psychosis.*

Socially-focused interventions

Evidence and rationale

Young people who develop psychosis often fall out of step with their peers and can become socially isolated. They may experience changes in their sense of self and maturation of the personality.[38] Identity formation is one of the first major tasks of adolescence and early adulthood. Developing social interactions with others is an important component of this process in terms of the development of a good sense of self-esteem and self-worth.[43]

Friendships and intimate relationships are a key milestone of adolescence and early adulthood. They enable the development of emotional autonomy and identity formation, romantic self-concept, and exploration of sexual identity.[4] Social skills and interactions span the spectrum of daily activities and tasks that young people are expected to develop during this key phase of life. It is usually during this phase that young people move away from talking with friends about what they are doing or have done, to abstract concepts, ideas and aspirations for the future.

> 'In my work as a case manager, you're often busy supporting the young person with managing symptoms, and getting back to work or study … you can't let social recovery drop off the agenda.'
>
> Senior clinician,
> EPPIC, Orygen Youth Health Clinical Program

Social cognition includes the perception, interpretation and processing of social information, which underlies all social interactions.[84] Impairments in social cognition may result in difficulties with emotion recognition, theory of mind and social perception.[85] As a result, young people with early psychosis may be more likely to misread facial expressions or make inaccurate judgements about another person's motivations or emotions.[85]

Social support has been shown to predict functional outcomes independent of other variables such as education, symptoms and functioning at first presentation.[86,87] Social cognition can be impaired from as early as the UHR phase and have a detrimental effect on social, community and independent living skills.[84,88,89]

Young people are likely to be spending the majority of their time in educational or employment settings during this phase of life.[38] They may spend more time with an intimate partner than they do with family or friends; by early adulthood, romantic partners typically overtake parents and close friends to become the primary sources of support.[90] Adolescents and young adults lay the foundations for romantic relationships and partnerships in adulthood, and develop emotional independence from their parents.[90-92] At a time when young people are figuring out their sexuality, romantic relationships have a significant effect on ongoing emotional and social development.

Specialised intervention

Few specialised interventions have been tested in early psychosis populations. Social skills training (SST) and social cognition and interaction training (SCIT) are two structured interventions that can be used to help young people to further develop their social skills and interactions.

SCIT is a manualised 20-session group intervention program comprising three distinct phases: emotion recognition training; recognising attribute styles and figuring out situations; and integration of these skills into real life situations.[93]

SCIT is effective in individuals with schizophrenia.[94] In young people with FEP, SCIT has significant benefits in overall social and occupational functioning as well as emotion recognition.[93] In addition, SCIT was seen to be acceptable and could feasibly be integrated into group programs in an early psychosis service.[93]

SST has been used and researched in both adults and young people with severe mental illness. However, there is little evidence to support its use with young people with early psychosis.

SST uses the principles of behaviour therapy to teach communication, assertiveness and other skills necessary for independent living. SST is often taught in groups, with role modelling and practice of the component skills, and an opportunity for participants to receive feedback on their skill performance. SST needs to be very closely aligned to a specific goal. For instance, social skills training for gaining employment will differ to the social skills needed for establishing a romantic relationship.

The Centre for Clinical Interventions (www.cci.health.wa.gov.au) offers free resources for clinicians to assist implementation of structured SST.

Case management intervention

Typically, clinicians will not have the time or resources to offer the manualised treatment approaches described above. However, the case management relationship is unique in that it offers an ideal way for young people to learn about social skills and social interactions through direct modelling and practice.

Understanding relationships

Social skills develop significantly over adolescence and early adulthood. In the earlier years it is more common for young people to talk about what happened yesterday or what they are planning to do tomorrow, which are relatively concrete topics. As young people mature, their conversations naturally move to talking about abstract topics such as aspirations for the future, ideas and concepts. For young people who experience early psychosis, social disconnection might mean that they fall behind their peers and become less skilled in talking about these topics.

PRACTICE TIP

Case managers can discuss relationships and relationship difficulties with young people to help them problem solve difficulties they may be experiencing. Young people may need to discuss romantic, peer and family relationships to assist them to develop and grow.

Social skills development

Having and maintaining a strong social network of family, friends and significant others is associated with higher levels of functioning – specifically community functioning – and with positive mental health outcomes.[34,95,96] However, those experiencing early psychosis are known to have fewer friends, smaller social networks and fewer people to turn to in a crisis.[34] Some hypothesise this could be related to underlying problems in social skills.[51,97] Humans are social beings and spend a great deal of time conversing and interacting with others. Problems in social cognition and social skills can have a direct impact upon a young person's ability to function socially. In turn this can affect their overall recovery.

Working with young people to develop, learn and re-learn social skills – defined as interpersonal skills and competencies – can be done in a variety of ways.[51] A case manager can work one-on-one with young people to directly teach and develop a range of skills. These include eye contact, personal space, noticing and responding to non-verbal cues, assertiveness, starting and terminating conversations, following conversation, conveying positive or negative emotions and conflict management. Case managers can facilitate the development of these skills by:

- directly modelling these skills
- role playing and rehearsing the skills together in appointments

- breaking social behaviours down into their smallest parts then practicing each part separately
- providing young people opportunities to practice skills in their own environment in real life, developmentally appropriate situations
- understanding the role of social technology in a young person's life and social interactions (e.g. Could use of social media be a beneficial re-introduction to the social world? Is the use of social media currently detrimental to a young person's social functioning?)
- providing constructive, honest (but sensitive) feedback on social skills and interactions
- providing positive feedback
- recruiting the family and other important people to practice at home and provide feedback (as appropriate)
- linkage and referral to psychosocial group programs.

Social media is increasingly an important issue for young people. It is a way for them to connect with their peers, meet new people and keep up with their interests. Social media can present a new set of previously unchartered challenges for young people with early psychosis. Increasingly, clinical practice has demonstrated that young people who become unwell may post offensive, impulsive or psychotic content online. The shame, embarrassment and stigma a young person may feel when they realise this can be isolating and debilitating. Similarly, for young people looking for work, their digital footprint may be a hindrance. Posting photos or other material online that can be freely seen by potential employers may affect their ability to find employment. Clinicians may need to discuss the potential for an online presence to be a barrier in their recovery.

Developing roles in community and society

Life roles are a way of defining who we are within society, and what we do.[46] Each role is defined by a certain pattern of behaviour involving rights, responsibilities and actions that are expected and encouraged by both society and the individual engaging in the role. Identifying with a life role means adopting the attitudes and actions that society attributes to the role, but also the personal interpretation of the role in the context of an individual's values, beliefs, interests, experiences and motivations.[46]

Engaging in and identifying with life roles is important because they help to shape the things we do and provide us with a sense of who we are.[46] From a developmental perspective, this is especially important for young people in the process of figuring out where they fit in life and society and discovering and actively shaping their individual identity.

Experiencing an episode of psychosis can affect a young person's ability to occupy chosen roles. A lack of meaningful life roles impacts negatively on psychosocial wellbeing and can lead to loss of identity, self-esteem, purpose and structure in everyday life.[46]

Case managers should take the time to explore and be aware of the developmentally appropriate, normative roles that a young person held in the past and currently, and strives to identify with in the future (e.g. friend, student employee, child, sibling, sportsperson). Identifying these roles can provide information to inform and guide intervention planning. Case managers can also use this information to support a young person in reconnecting with and developing new roles within society. They can achieve this by:

- using a 'role checklist' as a prompt for young people who may be having difficulty independently identifying roles
- understanding, recognising and in effect breaking down the personal and societal tasks and requirements of each identified role
- working to set goals around developing performance skills required to meet personal and societal role tasks and requirements (e.g. operating a cash register to fulfil the role requirements of a cashier or being able to complete an end-of-year exam to fulfil the role of a student)
- beginning work on re-establishing pre-morbid roles as early as possible[12] to avoid any further disruption to the developmental trajectory and ongoing functional decline
- working to establish developmentally appropriate role engagement
- working within a cultural framework to develop roles that are culturally meaningful.

Occupation-focused interventions

Interventions that are based on and focus on occupations – or the tasks and activities we do to live our everyday lives to the fullest – play a vital role in restorating function and promoting functional recovery. Functional outcomes are often based on a person's ability to perform a chosen occupation to a suitable standard. This will, in turn, enable them to function in everyday life, within their own unique environment. Therefore, occupation, and engagement in a specific goal-oriented occupation, is often the end product.[98] When thinking about occupation-focused interventions we can instead consider occupation as 'the means'. Occupation or the things we do in everyday life can be used as a therapeutic tool. The following section will discuss how both OTs and case managers can use occupation-focused interventions to facilitate functional recovery.

Evidence and rationale

OTs work on the premise that occupation, or the activities in which we engage, can have a positive effect on health and wellbeing.[99] Engaging in meaningful activity for young people treated for psychosis has many benefits, such as:

- providing experiences of making meaning
- expressing thoughts and emotions
- changing physical, emotional and cognitive states
- cultivating skills, strengths and virtues
- connecting and belonging with others
- making a contribution.[29]

Young people with early psychosis have identified that wellbeing encompasses psychological, physical, emotional, moral, financial, spiritual and social dimensions of wellbeing.[99] These are all enacted or changed through engaging in occupations.

Specialised intervention

OTs are clinicians trained specifically in promoting health and wellbeing through occupation. The goal of occupational therapy is to enable people to participate in the activities of everyday life by working to enhance their ability to engage in the occupations they want, need and are expected to do. They focus much of their work on identifying and eliminating environmental barriers to independence and participation in daily activities. Interventions can include adapting the environment, modifying tasks, teaching skills and educating the individual and their family to increase participation, in and performance of, daily activities.

OTs can support functional recovery by assisting young people to:

- build daily routines
- maintain a daily schedule
- manage medication
- participate successfully in education and employment
- improve community access and participation
- engage in leisure pursuits
- develop money management skills
- develop self-care and hygiene skills
- practice social skills
- develop and harness intrinsic and extrinsic motivation.

OTs may assist young people to engage in daily activities more successfully through:

- skill development and training of activities of daily living essential for independent and safe living
- task analysis and breakdown
- grading
- environmental adaption – working to adapt a young person's environments (home, school, work) to promote optimal functioning, which can include the modification of the environment to support sensory processing.

Case management intervention

Case managers can take an active role in using occupation-based interventions as part of supporting functional recovery in young people.

Development of habits and routines

A great deal of daily life involves habits and routines as a way of organising what we do. Habits are defined as automatic, repetitive patterns of human behaviour and, along with routines and life roles, they play an important role in promoting function.[54] Habits and routines help to meet needs by depending on tried and tested ways of doing things that are known to reliably accomplish our goals.[46] They present a method of moving through our daily lives in an efficient and structured manner.

With the onset of psychosis, a young person can suddenly find their normal way of 'doing' dramatically altered. Their trajectory may be significantly altered or even derailed. This can create difficulties engaging in the activities and occupations they

engaged in prior to be becoming unwell. This disruption can also affect habits and routines, which, according to Kielhofner can result in 'disorientation … and being shocked into a sudden consciousness with no clear footing in what is ordinarily a familiar and taken-for-granted world'.[46]

The reconstruction of habits:[46] Sometimes the onset of an illness makes pre-morbid habits ineffective or unrealistic. In such cases, young people will have to find new ways and patterns of doing things. Even so, the very nature of a habit means it can be resistant to change, so the formation of a new one can initially feel awkward, foreign and be extremely stress provoking.[46] Clinicians can support the reconstruction of habits by:

- normalising the process, discussing with a young person how difficult habits can be to re-form and adapt in everyday life, let alone with the added burden of psychosis
- facilitating the development of new skills or helping a young person to adapt their existing skills and strengths. Clinicians should work closely with them to provide safe and supported opportunities to practice these skills in everyday life and allow plenty of time for the 'new ways of doing things' to evolve into familiar habits.

Routine establishment: Routines create stability and order in daily life. The onset of an episode of psychosis can significantly affect young people's daily routines. Young people are typically at a life stage where they are engaging in activities such as going to school, university and work. Occupations like these require some form of routine to be successfully performed.

For example, a young person needs to be at TAFE on Monday to Friday from 10am–4pm. Every weekday they wake at 7.30am, shower, shave, get dressed, eat breakfast and drive the 30 minutes to TAFE. Then, this same young person experiences an episode of psychosis. Suddenly, they are unable to attend TAFE. This in itself is a huge loss, but the loss extends far further than this to include the routine associated with attending TAFE. If the young person no longer attends TAFE, there is a high risk that they will also no longer engage in the routine associated with getting ready for TAFE.

A lack of routine can result in a young person feeling out of control, disorganised (also a common consequence of psychosis) and overwhelmed. Particularly in the earlier stages of recovery, they often have an idea of which activities and occupations they need and want to incorporate in their daily lives, but have difficulty structuring their time use. Clinicians can support young people in routine establishment through a number of strategies:

- Re-engagement – provide support to engage and re-engage in developmentally appropriate tasks and activities as early as possible following the onset of psychosis.
- Start off small – trying to establish too many routines in too short a time can be overwhelming. Prioritise one simple routine and allow time to establish this. An example might be scheduling of case management appointments at the same time each week. Build up the number and complexity of routines over time.
- Repetition – routines take time to establish and will only be established through practice and repetition.
- Use practical strategies – these can include development of a daily planner written up and placed in an easily accessible and highly visual location; setting the alarm clock; writing a to-do list and recruiting the support of the family to help establish and maintain routines.
- Understand the individual barriers (e.g. negative symptoms, lack of meaning) that might be impeding the establishment of routine – this will enable appropriate strategies to be put in place to combat these barriers.

Meaningful activity

Occupation, or all the activities we do in everyday life to occupy our time, are a primary source of life's meaning.[100] It makes sense that why we do what we do is shaped by, and inherently connected to, personal meaning. This in turn has a direct effect on function and quality of life.

For example, two young people are studying for a Bachelor of Nursing. Person A has plans to travel overseas and provide aid to a third world country. Hence, her nursing degree holds a great deal of meaning. Currently, her grades are high and her social circles and identity are closely linked to her degree. Person B has a lifelong goal of becoming a musician but went into nursing because her mother, father and aunt are all nurses, she got decent high school results and her parents expected she would go to university. Her nursing degree holds a lot of meaning for others but less personal meaning. Her grades are below average and she has no close connection or real identity connected to her degree. Neither is displaying *dysfunction*, but the way in which they function within these activities and meet the role expectations of being a nursing student differ. This difference can be largely attributed to personal meaning.

'Being able to work with someone to get back to doing something they previously enjoyed, or were really good at, like basketball or something, is incredibly satisfying. It's really about what it means to that person, more than anyone else, but it can make such a difference to the way they see themselves.'

Senior clinician,
EPPIC, Orygen Youth Health Clinical Program

Experiencing an episode of psychosis can result in an inability to engage in occupations and, by extension, personally meaningful occupations. A lack of personally meaningful occupation can also affect function and quality of life.[100] Case managers should work with young people to identify meaningful occupations and support them in the reintegration of these into everyday life. This will instil a sense of quality, purpose, self-worth, choice and value in life – all of which are important aspects of recovery and restoration of function.[100]

Case managers can support young people to engage in meaningful activity by:

- Understanding personal meaning – what is meaningful for one young person will not necessarily be meaningful to the next. A thorough assessment and formulation will ensure activities of meaning are identified.
- Understanding that meaning can change – don't assume that if a young person has engaged in certain activities in the past, these still hold meaning.
- Developing skills – work with young people to develop and utilise a range of skills required to engage in activities of meaning.
- Providing practical support and assistance.
- Engaging supports – identify and connect young people with services (e.g. the disability liaison officer at university) that support their engagement in meaningful activities and help to develop a range of skills to engage in these activities (e.g. catching the bus to university).

Supporting life balance

Engaging in a range of valued, obligatory and discretionary occupations can support improved functioning (including physical and social), health and wellbeing.[54] On the other hand, too many or too few activities is undesirable as it can act as a stressor[51] and increase the risk of ill health.[54] Case managers can support young people in maintaining life balance by:

- encouraging participation in meaningful activity (see above for strategies to support this)
- asking a young person to keep a time-use diary to demonstrate the amount of time being spent on certain activities, helping to identify areas of imbalance as well as encouraging engagement in a range of activities
- supporting the establishment of routines and habits that promote balance
- exploring values and considering what a young person feels they want or need to do to maintain function. This can assist a young person in identifying what is really important to them. Activities that fit into this value system can then be prioritised and used as a first step in achieving and maintaining balance.

Grading

When supporting the re-learning or development of new skills the concept of grading is important. Grading is a therapeutic strategy that can facilitate change through altering activities over time to fit the capacity and performance of a person. This most commonly involves increasing the difficulty of an activity over a period by modifying variables such as time or duration, number of steps required, and amount of support and assistance provided. For example, a young person might be linked into a weekly art therapy group in the city. They require the use of public transport to attend. For the first appointment, the case manager might work on developing skills around how to buy and top up a train ticket, and use the ticketing machines. They may then drive the young person to and from that first appointment. On the second appointment, the case manager might travel to and from the appointment on the train with the young person. On the third appointment, the young person might travel in with the case manager and home independently on the train. Finally, on the fourth appointment, the young person will travel independently to and from the appointment.

Grading allows a person to remain adequately challenged yet still achieve small successes, increased confidence and increased independence as they gradually work towards developing the skills required to achieve their goal.

Neurocognitive interventions

Neurocognitive functions are the thinking skills or mental operations of an individual that are not directly observed, but are inferred from their behaviour (either informally or based on performance on formal objective neuropsychological measures). They can be likened to a computer in that they are an individual's capacity for input, storage, processing and output of information.[101] Apart from overall intelligence/IQ, fundamental neurocognitive functions include:

- language abilities
- visuospatial/non-verbal abilities
- attention/concentration
- working memory (the ability to hold and mentally manipulate information)
- speed of information processing
- verbal and visual learning and memory
- executive functions (higher-level abilities such as planning, organisation, mental flexibility, reasoning, problem solving).

A neurocognitive impairment or deficit is usually determined in one of two ways:

- a performance that is below what is expected based on the average performance of healthy individuals of a similar age, gender or educational background (often defined as performance 1–2 standard deviations below the mean for the normative population)
- a performance that is below what is expected based on the individual's pre-morbid or present level of intellectual functioning. For example, average pre-morbid intelligence and achieving of good grades at school, but current performance well below average on tests of attention and memory, might indicate deficits in these domains.

Neurocognitive *strengths* are determined in the same way and are evident when an individual is performing above expectation compared with a normative population, or are based on the individual's general level of pre-morbid or current intellectual functioning. For example, an individual's pre-morbid intelligence may be estimated as below average but they perform above average on tests of visuospatial ability and visual memory. This would suggest they think and learn best via visual (rather than verbal) means. Knowledge of both neurocognitive impairments and strengths is highly valuable when working with young people and tailoring interventions.

Evidence and rationale

Disturbances in cognitive functioning, such as poor concentration and memory, reduced speed of information processing, or difficulties organising one's thinking are commonly experienced during an acute phase of psychosis. In some cases, such cognitive disturbances improve with symptom alleviation. This indicates they are 'state-based' disturbances that co-occur with psychiatric symptoms. However, extensive research indicates that widespread stable impairments are also frequently present in early psychosis.[102] These impairments are usually evident during the UHR phase. In this case by the time FEP is diagnosed the impairments are of similar severity to those seen in individuals with chronic schizophrenia. Cognitive deficits are therefore considered a core feature of psychosis.

Cognitive impairments are strongly associated with poorer functional outcomes and disability (independent of symptomatic state).[103] This is perhaps the most relevant aspect for treatment planning and prognosis. There is also evidence that they may limit the benefit the young person might gain from psychosocial interventions like the IPS outlined earlier.[104]

Specialised intervention

Clinical neuropsychologists provide assessment, treatment recommendations, and interventions for people experiencing neurocognitive or behavioural difficulties. Specialised neuropsychological input may be useful for determining the psychological and biological significance of neurocognitive dysfunction and its relationship to psychiatric symptoms or syndromes. It can aid in identifying the likely role of neurocognition (among biological, sociocultural and other clinical factors) as a developmental risk factor and/or outcome of psychopathology.

Importantly, neuropsychological evaluation provides a comprehensive profile of an individual's neurocognitive strengths and weaknesses. This can help determine the effect of neurocognition on everyday functioning (e.g. social and vocational roles) and guide treatment approaches. A neuropsychological assessment involves an in-depth clinical interview and the administration of several neurocognitive tests/tasks. It can range from a brief consultation to a detailed comprehensive evaluation involving several hours of face-to-face contact.

Two main types of specialised non-pharmacological interventions that aim to address neurocognitive impairments in psychosis are cognitive remediation and cognitive adaptation training. These are briefly described below. For more general discussion about compensatory and remedial approaches to intervention, refer to page 44.

Cognitive remediation

Cognitive remediation therapy (CRT) is a behavioural training-based intervention. It aims to directly improve or restore neurocognitive processes (e.g. information processing speed, attention, memory, executive function).[105] CRT usually involves computerised drill and practice exercises undertaken at high frequency and intensity (e.g. for 40 minutes, 2–4 times per week).

CRT may also involve coaching in strategies for improving neurocognitive functions. One example may be teaching an individual to 'chunk' information so it is more easily remembered. There is strong evidence that CRT improves neurocognitive functioning in psychosis, including early psychosis.[105,106] It is less clear that CRT leads to improved functional outcomes on its own; rather than when delivered in combination with other psychosocial interventions.[105-107]

Cognitive adaptation

Applying compensatory strategies and environmental supports can help an individual 'work around' their cognitive difficulties. An example of this is teaching an individual to use a calendar to aid memory, planning and organisation. The main focus of compensatory interventions is improving daily functioning. A prime example of this approach is cognitive adaptation training (CAT).[108,109] Compensatory approaches directly improve functional outcomes: activities of daily living, vocational functioning and behaviours important for functioning, such as remembering to take medication and motivation.[110,111]

A useful analogy for the difference between the two approaches is vision impairment, which can be addressed with laser surgery (remediation) or prescription glasses (compensation). Both approaches ultimately aim to improve functioning, but compensatory and adaptation approaches address this more directly than do remediation.

Case management intervention

In most cases, cognitive remediation programs will not be readily available to clinicians or the young people they work with. Many programs are available online, but they can be costly. However, many relatively simple compensatory interventions can be implemented by case managers. Table 2 describes some of the neurocognitive impairments that commonly occur in young people with early psychosis (both UHR and FEP). It also lists corresponding compensatory and adaptive interventions that may lead to improvements in functioning. A focus on building upon strategies already used by the young person and implementing approaches they are most likely to use is important. The strategies need to be personally meaningful and in line with their goals. Thus goal setting and strategy selection should be implemented collaboratively as a first step, but also in an ongoing and flexible way. Involving of the family and significant others is recommended whenever appropriate and possible.

To effectively use the strategies in Table 2, the case manager or treating team first need to identify the cause of the young person's neurocognitive functioning difficulties. In the absence of specialised assessment, Box 15 on page 64 outlines signs that indicate neurocognitive impairment may be an issue.

TABLE 2. **NEUROCOGNITIVE IMPAIRMENTS AND POSSIBLE INTERVENTIONS**

IMPAIRMENT	POSSIBLE INTERVENTION
Attention/ concentration difficulties	**Self-management strategies:** • self-instruction or self-verbalisation of task steps to keep on track • schedule rest breaks in line with attentional threshold • focus on one task at a time. **Environmental supports or modifications:** • remove or reduce distractions in environment (e.g. turn TV or music off when visitors arrive or when studying) • prompts, cues or alerts (e.g. labels, checklists or alarms such as vibrating watch).
Processing speed difficulties (i.e. slowness)	**Find a more efficient way of doing the task:** • some tasks can be broken down into steps repeated multiple times • short-cuts can sometimes be found that don't compromise quality of output • over-learn task via repeated practice so it becomes more automatic (i.e. faster) • deliver less information (i.e. one instruction at a time) • deliver information more slowly • consider special consideration for a student (e.g. more time in exams).

IMPAIRMENT	POSSIBLE INTERVENTION
Learning and memory difficulties	**External memory aids ('second brain'):** • write information down (notepad and pen in pocket or by the phone, take photos on phone) • make 'to-do' lists and tick off tasks when complete • training in use of a diary, organiser, calendar or mobile phone • voice recorder • camera • phone applications (e.g. Woolworths app for iPhone, train timetables). **Environmental supports or modifications:** • signs and labels • checklists • alarms • dosette box • environment organised to provide reminder (e.g. tablets next to toothbrush) • everything has its place ('memory spot'). **Mnemonic strategies (internal memory aids):** • repetition • paraphrasing (ask young person to repeat back what was said in their own words) • association (e.g. when learning someone's name) • visual imagery (e.g. when remembering a shopping list) • chunking or categorising (e.g. when remembering a shopping list) • repetition and spaced retrieval, expanded rehearsal (e.g. for studying) • over-learn task so it becomes automatic. **Mode of delivery may help:** • verbal or visual information (based on person's cognitive strengths or learning style).
Executive dysfunction (e.g. poor planning, problem solving, organisation, concrete thinking)	**Strategies include:** • routine+++ (make things predictable) • establish a routine to help offset difficulties with attention, processing, memory and executive dysfunction • daily use of calendar, diary or organiser • to-do lists or checklists • everything has its place ('memory spot') • develop 'rules of thumb' to prevent problems or respond to common problems (e.g. not putting notes in register until change has been given to avoid being accused of giving wrong change) • learn how to recognise and get help when problems arise (troubleshooting) • recognise signs something is wrong • identify trusted 'problem solver' or 'helper' • skills training to practise asking for help • break complex tasks down into smaller manageable steps • practise 'stop, think, do' for impulsivity.

BOX 15 HOW DO YOU KNOW YOUNG PEOPLE MIGHT BE EXPERIENCING NEUROCOGNITIVE DIFFICULTIES?

They tell you:

- 'I can't seem to concentrate'
- 'I have stopped reading or watching TV because I can't follow or remember the story'
- 'My memory is like a sieve'
- 'I can't hold down a job because I get too overwhelmed with too many tasks'
- 'I have trouble keeping up with conversations'
- 'I get easily distracted'

Family members or significant others tell you:

- 'I ask them to do a few chores and they do one, but forget the rest'
- 'My son gets really distracted and can't seem to focus on anything'
- 'My daughter's thinking seems slower than it used to be and she takes longer to do things'
- 'She is so forgetful these days'
- 'He just does things without thinking'

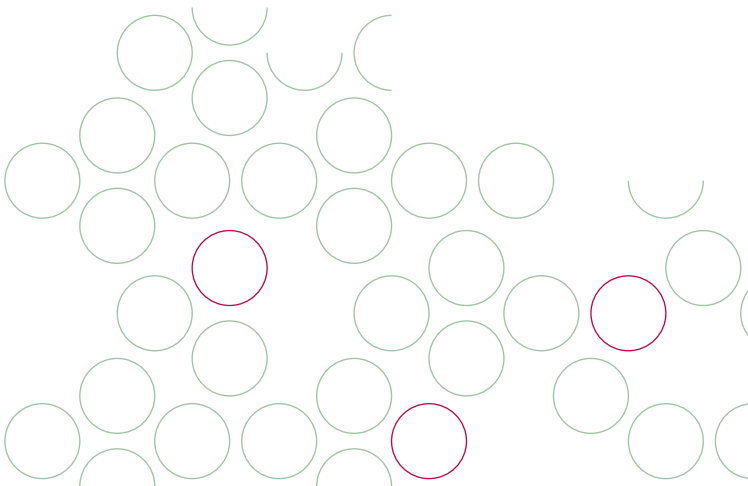
You observe:

- They are frequently late or miss appointments.
- They forget to take their medication.
- They don't seem to take in what is discussed in therapy.
- They get distracted easily.
- You often have to repeat yourself.
- Their employer complains they do not follow instructions.

There is evidence in their pre-morbid history:

This might include results of previous cognitive or neuropsychological assessments, academic difficulties or school failure, developmental delays, learning difficulties or multiple job losses.

If the young person responds 'yes' to a question, you can ask specific questions to determine how long they have been experiencing these difficulties. These include whether they have got better or worse over time, what effect this has on the young person's life, and what helps or makes it worse. The case scenario 'Sarah' is an example of a young person with early psychosis and neurocognitive impairments and the strategies used to support her functional recovery are described in Table 3.



SARAH

CASE SCENARIO

Sarah is a 23-year-old university student who experienced a significant decline in functioning over a period of 12 months prior to experiencing FEP. With medication her positive psychotic symptoms resolved. However, she continued to experience difficulties with daily functioning, including attending to her self-care and keeping up with the demands of university. Her pre-morbid intellectual functioning was above average, but since experiencing psychosis she presented with significant neurocognitive difficulties. These included slowed processing speed, poor concentration, poor memory and problems with organisation. She decided to drop out of university and look for a job. With the help of an employment consultant she found part-time employment at a fastfood restaurant and as a receptionist at a medical centre. However, ongoing neurocognitive difficulties made it challenging for Sarah to retain her employment and she was at risk of losing both jobs. A number of strategies were put in place to help support her neurocognitive difficulties to maintain her employment, with some examples described in the table below.

NEUROCOGNITIVE AND WORK DIFFICULTIES	STRATEGIES USED
Slow processing speed affecting ability to keep up with the demands of a fastfood restaurant	Requested shifts during 'quieter' periods, rather than the lunchtime 'rush'
Disorganisation affecting punctuality and being late to work	Trained in using an alarm clock, working out what time she needed to get up and which bus she needed to take to get to work on time – implemented as a daily routine
Poor attention to grooming – warning from employer about dishevelled hair and pants revealing buttocks	Purchased new pants with higher waist Established routine of 'checking self' in mirror before leaving home each morning, with note on the door saying 'how do I look?'
Trouble remembering tasks given by employer at receptionist job	Taught to carry pen and notepad and write things down to remember Training in using a calendar or diary to record appointments and deadlines, and to-do lists to cross off tasks when complete
Forgetting what to say when answering the phone in receptionist job	Display a written script on her desk to read when the phone rings

Lifestyle interventions

Evidence and rationale

Physical activity, diet and healthy lifestyle have wide-reaching benefits for all people. The most obvious are improved physical health and reduced risk of developing cardiovascular disease, cancer and diabetes. People with psychosis have a 20–30-year reduction in life expectancy, primarily due to obesity and smoking.[22,112] Lifestyle interventions targeting healthy eating, exercise and behaviour modification are a major part of the prevention and treatment of obesity and related comorbidities.[113]

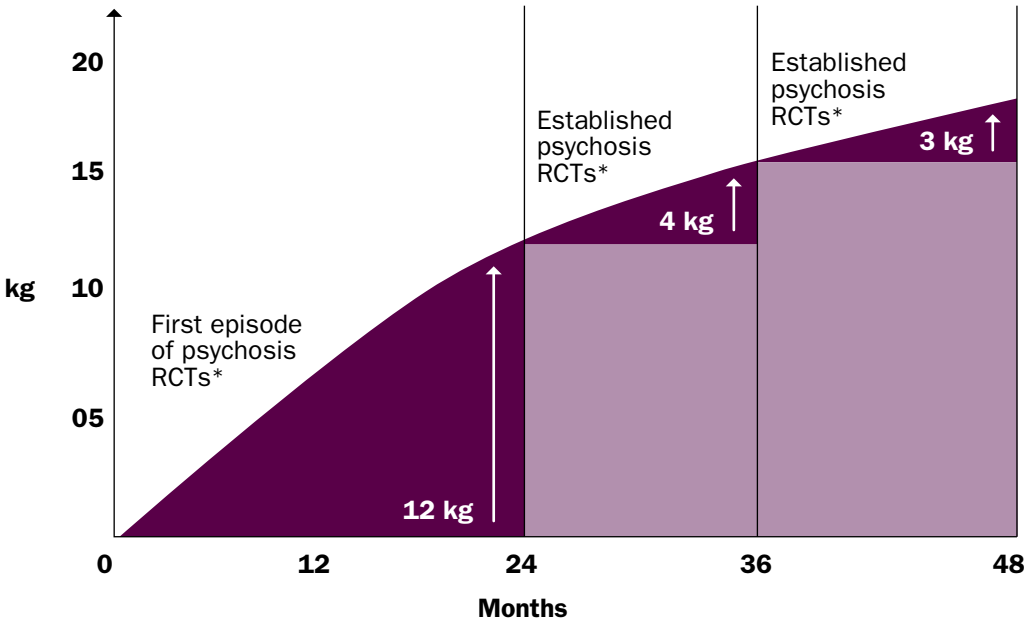
Physical activity and exercise may also have a role in improving mental health symptoms, overall functioning and cognition in people with serious mental illness.[114-119,120] As such, lifestyle interventions are important in functional recovery of young people with early psychosis.

Physical health

Individuals with schizophrenia have significantly higher rates than the general population of death and morbidity from cardiovascular disease and diabetes.[22,112] Although many young people with early psychosis will not go on to develop a chronic mental illness, the use of antipsychotics in treatment increases risk for metabolic syndrome early on.[121] Focussing on health for these people provides a unique opportunity to reduce or prevent physical comorbidity and the accumulation of long-term risk factors associated with physical health problems and premature death. Figure 3 shows that the majority of weight gain secondary to antipsychotic medication occurs in the first 2 years of treatment. Physical health is thus a clear priority for early psychosis services.[122]

Although physical health benefits are obvious, clinicians also need to consider the interaction between physical health and functional recovery.

FIGURE 3: **ANTIPSYCHOTIC WEIGHT GAIN**



*RCTs = randomised controlled trials.

Figure derived from Alvarez-Jimenez et al. *CNS Drugs* 2008; 22 (7): 547–562.

Symptoms, functioning, cognition and quality of life

Weight gain and associated physical health issues are particularly pertinent for young people, given the high risk of body image issues and associated treatment compliance. Young people commencing antipsychotics for the first time are particularly susceptible to rapid and pronounced weight gain, which could interfere with the recovery process.[36] These side effects may result in reduced adherence with pharmacological treatments in a population that is already less likely to adhere to medication regimes. Additionally, the physical changes produced by weight gain may result in social discrimination and stigma. This may negatively affect self-esteem and self-concept at a critical time in a young person's development.[36]

Physical activity has a positive impact on the mental health and overall functioning of people with psychosis.[116-119] Being physically inactive predicts poorer functioning at 6 months compared with baseline in FEP.[120] It has been suggested that early intervention for psychosis should target improving physical activity levels, which subsequently may help overall functioning.[120]

Increases in aerobic fitness are also associated with improvement in neurocognition.[123,124] One study reported improvements in reasoning, problem solving, social cognition, speed of processing and working memory.[124] There is also evidence to suggest that exercise improves symptoms (including psychotic and mood symptoms) and quality of life for individuals with psychosis.[115-117] Physical activity and exercise has been shown to reduce symptoms of depression, and positive and negative symptoms of psychosis.[119,123,125]

There is good evidence that physical activity improves cognition, symptoms and physical health that may contribute to improvements in overall functioning.[120] The exact relationship between exercise and symptomatic and functional outcomes is unclear. However, it has sufficient benefits to support inclusion of lifestyle interventions to address functional recovery in early psychosis.[23,116,123,126]

Specialised intervention

Specialised interventions that target physical health outcomes in young people with early psychosis rely on the expertise of dietitians and exercise physiologists or physiotherapists working alongside the mental health treatment team.

Dietitians can provide expert nutrition and dietary advice to individuals and groups. They are qualified to identify, assess and monitor the mental and physical health risks associated with food and nutrition. They can plan and manage nutrition and dietetic care, lifestyle and wellbeing for individuals with mental illness. Dietetic interventions, as part of an integrated lifestyle intervention, have the potential to reduce obesity in young people with FEP.[127]

The Dietitians Association of Australia recommend that a dietitian should be involved in the care of young people in early psychosis services, if they:

- have pre-existing metabolic comorbidities
- are at risk of metabolic syndrome
- have an unrelated acute or chronic illness
- have developed metabolic syndrome
- are commencing antipsychotics
- would like assistance with weight management.[128]

Exercise physiologists and physiotherapists should also be involved in specialised consultation, assessment and interventions for young people with early psychosis. The Australian Physiotherapy Association and Exercise Sports Science Australia have clear guidelines related to the role of physiotherapists, some of which include:

- prescribing individualised exercise programs to promote physical and mental wellbeing
- delivering interventions to address physical issues for people with mental health diagnoses, which hinder social participation and recovery (e.g. minimise or counteract side effects of some medications)
- delivering interventions to address impaired body awareness and reduce dissociation associated with poor mental health
- developing and delivering individually tailored lifestyle and weight management advice and programs.[129,130]

Treating teams should consider involving these professionals in the care of young people when they:

- have any unrelated acute or chronic physical health or musculoskeletal condition
- are at risk of developing metabolic syndrome
- are commencing antipsychotic medication
- would like assistance with weight management or fitness.[129]

Curtis and colleagues (2015) described and evaluated a lifestyle and life skills program to prevent antipsychotic-induced weight gain in FEP.[131] This 12-week individualised intervention was delivered by specialised clinical staff in the early psychosis service at the Bondi Centre, Sydney. It showed that initial weight gain after commencing antipsychotic medication can be significantly attenuated in young people with FEP. The 12-week intervention comprised health coaching, dietetic support and supervised exercise prescription, and was individualised based on Australian best-practice recommendations.[131]

This program specifically involved a dietitian and exercise physiologist as part of the intervention, which itself was evidence based. Importantly, the dietitian not only provided advice, but also participated in shopping and cooking tours to help participants develop skills in cooking healthy meals.[131] A clinical nurse consultant provided a motivational framework to help participants engage with and adhere to treatment.[131] Two youth peer-wellness coaches were involved in the intervention, acting as positive role models for participants, and providing motivation and encouragement. Over the 12-week program, only 13% of participants experienced clinically significant weight gain, compared with 75% in the standard care group. Although the study only measured physical health outcomes, there is good preliminary evidence for the inclusion of specific lifestyle intervention programs in early psychosis services to address physical health and functional recovery.

Occupational therapy interventions may also help young people incorporate significant changes into their lifestyle and routines. Specifically, in relation to lifestyle interventions, OTs can:

- facilitate development and maintenance of new activities
- facilitate lifestyle redesign with individuals to create and maintain ways of living that support wellness
- assist young people to develop practical skills for healthy living, including planning, organising and engaging in daily activities such as shopping and cooking
- provide expertise in developing routines and habits that support wellness.[132]

For more information about the role of occupational therapy and the therapeutic use of activity, please refer to page 56.

Case management intervention

Simply providing general advice about healthy eating or exercise to young people is ineffective. It does not adequately address the main aim of lifestyle intervention in functional recovery. Lifestyle interventions should be implemented effectively as part of addressing functional recovery in early psychosis. This requires that specialised interventions aimed at physical health are accepted and valued by both young people and staff members.[113]

Case managers are in a key position to support specialised interventions in addressing physical health. For example, the clinical team can actively support the young person to acquire practical skills (such as cooking and meal planning) and to create daily routines and habits to incorporate exercise. The case manager can also provide motivational interviewing to encourage young people to engage in lifestyle interventions and continue with healthy eating and exercise routines.

Regularly talking about barriers and enablers to healthy eating, and addressing ambivalence towards exercise can help young people address barriers to good physical health. The combination of physical exercise, specific nutritional intervention and behavioural modification interventions (such as motivational interviewing) are likely to have the biggest impact if they are used together in a tailored approach.[133]

> ‘A lot of the medications that we do eventually get put on cause things like weight gain and increased risk of diabetes and heart disease. I really think that it is an area in our care that isn’t addressed properly a lot of the time … So I really think that they um need to really up their inclusion with that aspect of your health.’
>
> Young person
> EPPIC, Orygen Youth Health Clinical Program

Case managers also need to address physical health education as a priority with young people who are prescribed antipsychotic medication. Young people are often unaware of the broad impact of diet and exercise on general health and wellbeing, and its more specific effect on cognition, mood and psychotic symptoms. Equally, education for families about the effects of medication may be beneficial. Case managers are able to help families understand the importance of good physical health. A family's concerns with mental health can result in physical health being overlooked. Speaking with family or other supports about getting involved with the young person's goals can also help to facilitate progress. For example, if the young person is trying to lose weight by changing their eating patterns and habits, family members and others in the household can support this goal by changing their own eating habits.

Case managers can also support the young person to develop habits and routines that increase incidental exercise. Walking or riding to work or school, or getting off public transport earlier and walking the remainder of the way are some ways to increase physical activity incidentally and should be a fundamental component of any physical activity program.[134] Exploring community sporting groups with the young person, or facilitating practical and financial access to health clubs or gyms, can also address some of the social and financial barriers experienced by young people.

In addition to diet and exercise, case managers can support young people to stop smoking. For more information on interventions to address smoking, please refer to the ENSP manual *A matter of substance: working with substance use in early psychosis.*

A final key way in which case managers can be involved in preserving and promoting physical health is through regular monitoring of the physical health of the young people with whom they work. It is vital that all case managers know how to measure height and weight, and take blood pressure readings.

AMRITA

CASE SCENARIO

Amrita is a 20-year-old young woman of Indian background living with her uncle in Australia. She was studying marketing at university when she experienced her first episode of psychosis, and dropped out of university. She had a prolonged recovery and was started on clozapine for ongoing positive symptoms of psychosis. Amrita's positive symptoms subsided but she gained approximately 20 kg as a result of the change in medication. Amrita complained of weight gain, sedation and lack of motivation, while acknowledging that her current medication was effectively treating the psychotic symptoms. Amrita was not motivated to go back to study. However, it was very important for her to get married, and her uncle had already begun searching for a suitable match. Amrita was concerned that her weight gain might affect her ability to find a husband. She had always been a slim young woman who took pride in her appearance.

Amrita had begun exercising daily on the advice of her case manager. She was taking a daily walk for around 30 minutes around her local area. However, Amrita had not noticed any significant change in her weight. She agreed to see a dietitian and exercise physiologist as part of her treatment plan.

Consultation with the dietitian resulted in a personalised dietetic plan. Amrita saw the dietitian five times over the 3-month period, for assessment, education and to monitor her progress. She was advised to increase her intake of whole foods, such as vegetables and fruit; increase her lean protein intake (lean meat, fish and tofu); and slightly decrease her intake of refined carbohydrates (white rice), which formed

AMRITA

CASE SCENARIO (CONTINUED)

a large portion of her diet. Each appointment focused on making small, sustainable changes to her diet. The dietitian provided recipes for Amrita to follow and try at home.

Consultation with the exercise physiologist resulted in a personalised exercise prescription, combining resistance and cardiovascular exercises. Amrita saw the exercise physiologist once a week to engage in the program and monitor progress. In addition to this, the case manager was able to secure funding for a gym membership, and so Amrita went to the gym and did her program twice more during the week with the support of her uncle. She continued to go for daily walks as she had previously, but incorporated this into other functional tasks, such as grocery shopping, going to the library or visiting her friends.

Amrita and her case manager worked together to make some of the recipes at home that were in line with the dietitian's recommendations. The case manager provided education to Amrita's uncle about proactively supporting her goal by getting involved in cooking and grocery shopping, and by considering changing some of his own eating habits. Amrita and her uncle went grocery shopping together once a week with the guidelines and shopping list provided by the dietitian. Amrita's case manager helped her to create a routine around shopping, mealtimes and exercise, incorporating these into a weekly timetable, to which Amrita added social and other tasks such as housecleaning.

Over 6 months, Amrita lost 14 kg and her metabolic profile improved. She reported subjective improvements in sleep and energy throughout the day. Specifically, she reported that she was able to wake more easily in the mornings than she had previously, and felt more rested. Amrita's uncle noted that she was more self-motivated, engaged in household tasks with minimal prompting or reminder and no longer slept for long periods during the day. Amrita also reported improvements in mood. She felt more confident and her self-esteem had improved as a result of her weight loss.

Summary

Functional recovery is a core component of the comprehensive biopsychosocial approach to recovery in early psychosis. Retaining and regaining the ability to successfully and independently function and live a meaningful life is incredibly important for young people and their families. Symptomatic recovery, although important, falls short in preparing young people to move forward in their lives or to get back to things that were once important or have been disrupted by the experience of psychosis.

This manual provides an overview of current research that supports functional recovery in young people with early psychosis. A range of interventions and intervention approaches are also described to support clinicians to implement these into their clinical practice. This includes both general and specific interventions that are provided by the case manager and specialised interventions that can be provided and supported by the multidisciplinary team.

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