‘Let me Understand’ Assessment in Early Psychosis

Orygen YOUTH Health
Research Centre

EPPIC
Early Psychosis Prevention and Intervention Centre

The EPPIC National Support Program of Orygen Youth Health Research Centre has produced this document as part of its work to support the scaling up of the EPPIC model within headspace, the National Youth Mental Health Foundation, in Australia.

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Contents

Introduction

The onset of psychotic symptoms is likely to be a traumatic period for the young person and their family. A first episode of psychosis most commonly occurs during adolescence and early adulthood, a time of significant growth and change in a young person's life. Onset of a psychotic episode has the potential to significantly disrupt the young person's developmental trajectory and is often associated with social and vocational dysfunction. Early detection of a first episode of psychosis and subsequent intervention can change the course of the episode and has the potential to assist the young person to maintain their developmental trajectory.

How a young person's initial contact with an early psychosis service is arranged can help to reduce the immediate impact associated with the episode of psychosis and establishes a basis for future recovery. The process of assessing a young person's mental state from this initial contact onwards is crucial to the ongoing care of a young person in an early psychosis service. It can be the first opportunity that clinicians and services have to engage the young person and their family. Assessment of young people with suspected mental health issues can be an ongoing process and should involve responsive clinical work that is youth-friendly, optimistic and engages both young people and their families with the service.

Context of this manual

This manual is aimed at mental health professionals working with young people with early psychosis and individuals responsible for early psychosis service development. The content of this manual has been derived from international evidence and more than 20 years of experience of implementing and delivering services to young people and their families with early psychosis at Orygen Youth Health.

How to use this manual

This manual has been developed as part of an overall training program delivered by the EPPIC National Support Program (ENSP) that also includes face-to-face training and online learning modules. It should be read in conjunction with the other manuals in this series. *'Let me understand...' assessment in early psychosis* focuses on developing clinical assessment skills; specific intake criteria for young people with first episode psychosis and those at ultra high risk of psychosis can found in the *EPPIC Model and Service Implementation* (1.2.2 EPPIC Assessment Guide).

The ENSP is assisting with the implementation of the Early Psychosis Prevention and Intervention Centre (EPPIC) Model in early psychosis services. The EPPIC Model has been developed from many years' experience within the clinical program at Orygen Youth Health and has been further informed by the Early Psychosis Feasibility Study Report written and published by the National Advisory Council on Mental Health in 2011 which sought international consensus from early psychosis experts from around the world.[1] It is based on current evidence, the experience of other early psychosis programs internationally and shaped by real-world considerations. 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.

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 and attitudes and decor)
- a spirit of hope and optimism that is pervasive throughout service
- a family-friendly ethos contained in all aspects of service
- a service culture and skills that facilitate culturally sensitive care to all patients and families
- a high level of partnerships with local service providers.

This manual consists of four sections. 'Assessing young people in an early psychosis service' defines assessment and provides a rationale for conducting an assessment in early psychosis. The section entitled 'Core considerations for assessment in early psychosis' describes the important aspects to consider when performing an assessment of young people with possible early psychosis. While 'How to perform an assessment' is a practical guide on how to conduct a comprehensive assessment, including a risk and crisis assessment, of a young person with early psychosis. 'Assessment and the service culture' describes the service culture, leadership and staffing resources that are necessary for effectively assessing young people in an early psychosis service.

Please note: the term 'family' refers to the level of support the young person receives from a relative, partner, friend, or significant other in this manual.

Assessing young people in an early psychosis service

Assessing young people in an early psychosis service

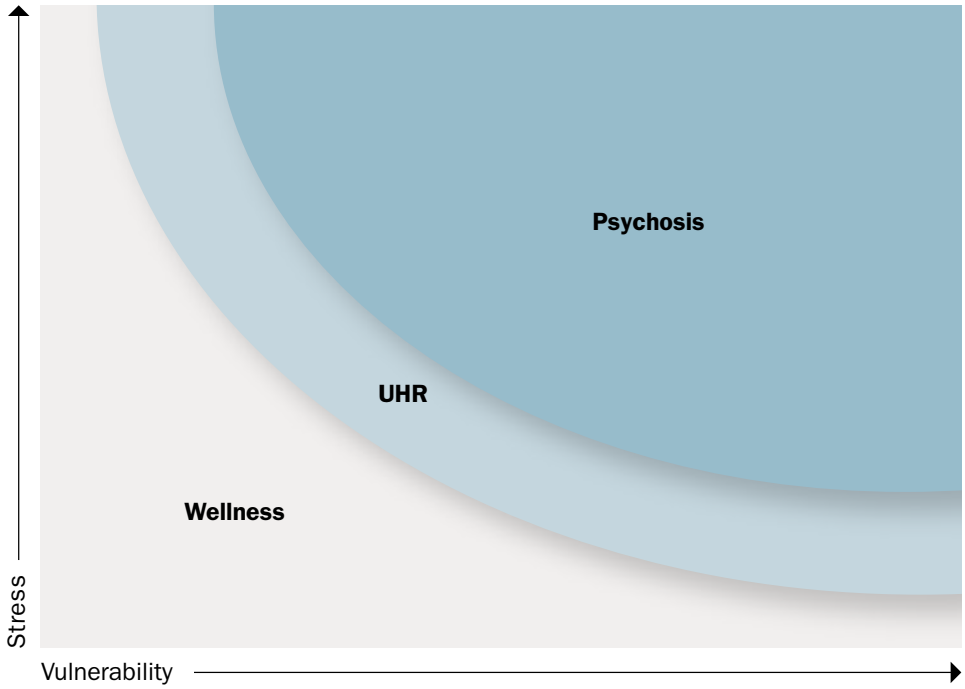
What is early psychosis?

Early psychosis is defined as the early course of a psychotic disorder. It is the period from the emergence of an 'at-risk mental state' through to the first episode of full threshold psychosis and the 'critical period' of up to five years from entry into treatment for the first psychotic episode.[3]

The at-risk mental state (ARMS) is often a heterogeneous clinical state thought to indicate an increased risk of imminent onset of psychotic disorder. This is prominently characterised by attenuated positive psychotic symptoms that are frequently accompanied by functional decline. Criteria to define ARMS were developed following analysis of retrospective accounts of the psychosis prodrome.[5] These criteria became known as the 'ultra high risk'[6] criteria and accurately identify young people who are at incipient risk of psychosis. The Comprehensive Assessment of At Risk Mental States (CAARMS) is an instrument used to assess psychopathology and apply these operational criteria and achieve an acceptable level of validity and reliability in their assessment.

The development of psychotic symptoms can be caused by a variety of factors that can be grouped into three main domains: biological, psychological and social. Biological factors are an individual's genetics, biochemistry, physiology and general constitution. Psychological factors include the emotional experiences and the upbringing of the young person, and social factors are the young person's cultural and social background. The stress–vulnerability model of psychosis (Figure 1) forms the basis of the treatment approach to young people with early psychosis. It incorporates biological, psychological and social factors in understanding the development of psychotic disorders. A central assumption is that environmental stressors such as relationship issues, substance use or lifestyle factors can precipitate illness in vulnerable individuals. The more vulnerable an individual, the less stress is required to trigger the onset of symptoms. Consideration of biological, social and psychological stressors, protective factors and underlying biological vulnerability can guide the development of individualised treatment plans. This model implies that implementing appropriate coping strategies may reduce the person's vulnerability to psychotic disorder. The course of an episode of psychosis may be described using two models: the staging and phases model. These two models are similar but differ in terms of foci.

FIGURE 1. **STRESS–VULNERABILITY MODEL OF PSYCHOSIS.**



The staging model of psychosis

The staging model outlines the stages of development of a disorder and proposes that early intervention may be both: safer than those used during the later stages of disorder due to less invasive treatment and more effective due to shorter duration of active illness. The clinical staging model of psychosis differs from conventional practice by defining psychosis as a continuum; where treatment interventions are used at specific stages to prevent progression to the next stage of the disorder in addition to promoting recovery. The differentiation of early and milder clinical phenomena, from those that accompany illness progression lies at the heart of the concept, which makes it especially useful in adolescence and early adulthood, when most adult-type psychiatric disorders emerge for the first time. The different stages of disorder are determined by symptom severity, level of distress and disability. For example, the identification of young people with sub-threshold psychotic symptoms (stage 1b) means identifying young people at an earlier stage of disorder and tailoring treatment to this stage (see Table 1). If the young person progresses to a first episode of psychosis, their treatment needs will change and differ (Table 1).

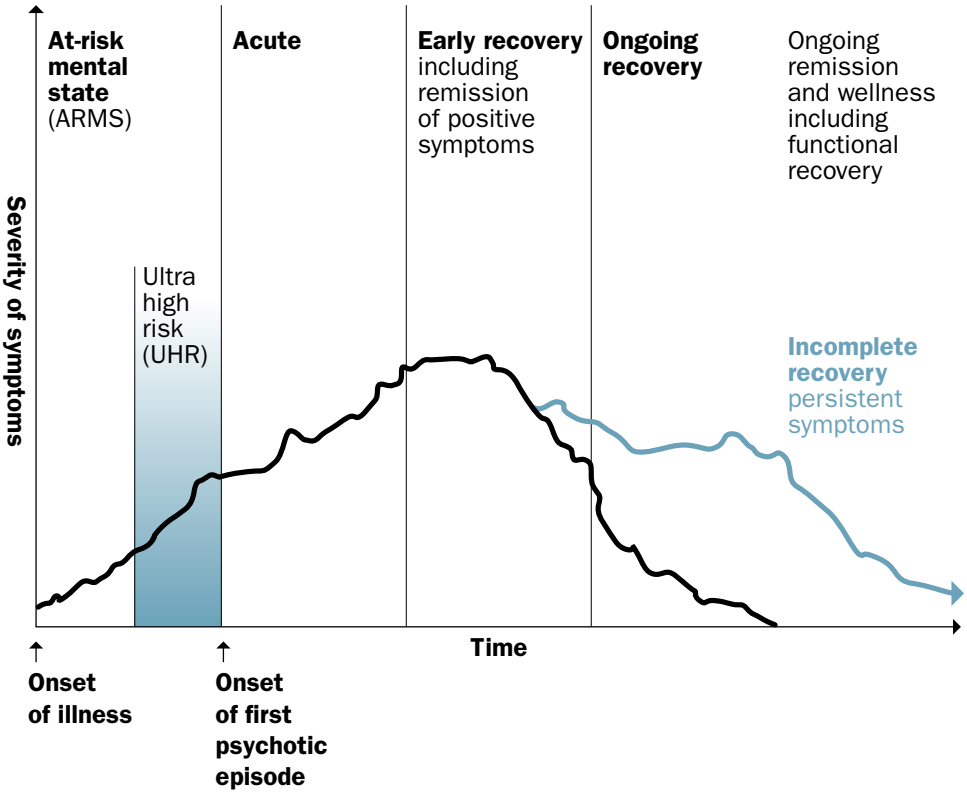
TABLE 1. **THE STAGING MODEL OF PSYCHOSIS**

STAGE	PSYCHOSIS	TREATMENT
0	Increased risk/no symptoms	Indicated prevention of FEP such as: improved mental health literacy, family education, drug education
1a	Mild or non-specific symptoms and functional decline	Indicated secondary prevention such as: formal mental health literacy, family psychoeducation, cognitive-behavioural therapy, active reduction in substance use
1b	UHR – sub-threshold	Indicated secondary prevention such as: psychoeducation, cognitive-behavioural therapy, substance use work, omega-3 fatty acids, antidepressants
2	FEP – full-threshold	Early intervention for FEP such as: psychoeducation, cognitive-behavioural therapy, substance use work, atypical antipsychotic meds, vocational rehabilitation
3a	Incomplete remission from first episode of care	Early intervention for FEP such as: for stage 2 plus additional emphasis on medical and psychosocial strategies to achieve remission
3b	Recurrence or relapse stabilised with treatment but still residual symptoms	Early intervention for FEP such as: for stage 3a plus additional emphasis on relapse prevention
3c	Multiple relapses with clinical deterioration	Early intervention in FEP such as: for stage 3b but with emphasis on long-term stabilisation
4	Severe, persistent or unremitting illness	As for stage 3c but with emphasis on clozapine, other tertiary treatments and social participation despite ongoing disability

The phases model of psychosis

The phases model of psychosis describes the course of illness and recovery using a phase-based approach. For an individual the phase model description of their illness may be completely included in a single stage of the stages model. However, the phase model is a more qualitative and clinically informative way of describing where an individual is in the course of their illness and treatment. It includes the at-risk mental state, acute, early recovery and late recovery phases. Not everyone who is at the at-risk mental state will transit to a first episode of psychosis and for those who do, it is with a view that some people may go onto make a complete or incomplete recovery. The primary intention of this early identification and treatment approach is that young people will make a complete recovery and return to their normal developmental trajectory. The presentation of young people at the different phases has different characteristics and warrants a treatment approach that is mindful of the phase of illness and tailored to meet individual needs.

FIGURE 2. **THE PHASES MODEL OF PSYCHOSIS**



Duration of untreated psychosis

There is often a delay between the onset of psychotic symptoms and a young person's accessing services and receiving targeted, evidence-based intervention for psychosis. This delay period is referred to as the 'duration of untreated psychosis' (DUP). There is considerable variability in the literature around how DUP is defined and measured. DUP is a retrospective assessment, occurring after the young person has presented to services. Therefore, measurement is complicated by the usual limitations of retrospective assessment, such as differing accounts between young people and families of events, difficulties with definitions regarding the threshold for onset of a psychotic episode and the variability of standardised assessment tools.[7] The majority of studies define DUP as the time from onset of psychosis until the first effective treatment is initiated.[7] Literature reviews indicate that the mean DUP is approximately 2 years,[8] while 6 months appears to be the median time interval.[9]

DUP has been shown to be significantly associated with positive symptoms and quality of life, and it has been suggested that DUP has an independent role in determining symptomatic and functional outcomes.[10,11]

A longer DUP predicts negative treatment outcome over the first few years.[8,9,12] In addition to improving outcomes, DUP needs to be reduced in early psychosis because young people often experience symptoms, such as hearing voices, paranoia or unusual ideas, during the DUP that may cause them to withdraw from relationships and school and disrupt early careers, sometime with long-term consequences.[13]

DUP should be measured as part of the initial assessment process for a number of reasons:

- It has been shown to predict long-term outcome, with longer DUP associated with poorer outcome.
- DUP included as part of the aetiological case formulation will help prioritise treatment targets.
- It may assist with an earlier diagnosis of psychosis where diagnostic categories specify a length of time that symptoms are present.
- At a service level, DUP provides valuable service evaluation data, including:
  - enabling the measurement of the impact of early psychosis service provision on average length of DUP over time, and
  - as a possible key performance indicator for early psychosis services when measuring the accessibility and responsiveness of a service.
- For more information on how to assess DUP please see 'How to perform an assessment' on page 33 of this manual.

What is 'assessment'?

Assessment in an early psychosis service is the ongoing process of gaining sufficient information from a young person presenting with possible psychotic symptoms to enable a diagnosis, guide treatment planning, facilitate the development of a therapeutic alliance and enable aetiological case formulation. The foundations of assessment include engaging the young person and their family and understanding the personal context of the ultra high risk or first episode of psychosis. An assessment can occur in many forms, including over the phone or face-to-face and in many settings, such as in the community, at a young person's home or in a clinical setting (e.g. a hospital). Talking to the young person and their family, making clinical observations, gathering collateral information or reading past notes can all be considered part of an assessment. An assessment of a young person can be carried out by different staff members of the multidisciplinary team working within an early psychosis service, including intake and assessment team members, case managers or medical staff; the types of assessment will vary depending on the clinician's role and function within the service.

A comprehensive assessment of a young person with early psychosis includes the biological, psychological and social assessment of that young person. It should not be restricted to just initial entry into an early psychosis service: assessment should be a continuous process throughout the young person's engagement with the service as a platform to negotiate the most effective treatment and support for the young person and their family. A thorough assessment enables clinical staff to construct comprehensive aetiological case formulation that will guide priorities for treatment and intervention; case formulation is a process where a set of hypotheses is generated about the aetiology of an individual's presenting symptoms and guides subsequent specific interventions.[14]

Why is assessment important?

The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization (WHO) International Statistical Classification of Diseases and Related Health Problems are diagnostic classification tools based on crystallised forms of disorders with clear symptoms and duration criteria. These nosologies assume that a syndrome is 'concrete' and stable across all stages of a disorder, and symptoms may be mixed and varied. They list specific psychotic disorders rather than psychoses or psychotic disorders more broadly. Psychotic disorders identified by DSM-V are schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, substance-induced psychotic disorder and psychotic disorder not otherwise specified. The threshold for treatment is meeting the diagnostic criteria for any of these disorders, and diagnoses for these disorders require clear symptom profiles and a specific duration of these symptoms.[3]

However, distinguishing between diagnostic categories during the early phases of psychosis is difficult due to fluidity of acute symptoms, and diagnoses may change over time.[3] Young people with first episode psychosis (FEP), or identified as being at ultra high risk of psychosis (UHR) present with a range of non-specific symptoms, such as anxiety and sleep disturbance, or with attenuated or brief intermitted psychotic symptoms that do not meet the threshold for psychosis. Although such symptoms do not fall under the diagnostic criteria for psychosis, they may represent a high risk or psychiatric comorbidity, making young people presenting with these symptoms diagnostically confusing.[15]

Treatment of early psychosis is often challenging, as many young people do not receive treatment immediately after experiencing their first symptoms of psychosis.[13]

Early detection, diagnosis and treatment of disorders reduces DUP and allows young people and their families to hope for better clinical outcomes.[15] Doing this not only requires easy access to early psychosis services, but also initiation of treatment as soon as possible. A thorough assessment of a young person and their family should therefore be conducted quickly as for clinicians, the young person and their family.

EASE OF ACCESS

Early psychosis services should have a low threshold for face-to-face mental health assessment, with a policy that a young person does not need to be in crisis to be seen by the service and does not need to have a clear mental health presentation to qualify for an assessment. There should be an emphasis on 'screening into' an early psychosis service rather than 'screening out'. This means that young people (and their families) who present at a service receive assistance or referral, if required, to other appropriate services.

Young people should receive assistance with any issues such as financial or legal problems if that is what they need, and be actively linked to appropriate services. Not only does this help with engagement, but it can also considerably reduce the stress that the young person is experiencing, which can have significant benefits for their mental health. Providing immediate practical assistance to young people and families is important because the onset of early psychosis is often a traumatic and confusing time. In the face of this confusion, young people and their families will be dealing with symptoms and may be learning the ins and outs of the mental health system, and may have less capacity than usual to deal with everyday problems.

Assessments should be timely, responsive and flexible. To aid with this, a mobile outreach team should be available to conduct assessments outside of the service offices. Assessments should take place at a location and time that is suitable and accommodates the needs and preferences of the young person and their family. To be accessible to people who work or have other commitments during business or school hours, assessments need to be offered after hours and on weekends. Clinicians carrying out assessments need to be flexible and able to undertake assessments at various locations and times of the day that suit the young person. In light of this, clinicians need to be supported so that they can respond quickly to requests for assessment, especially initial and crisis-driven assessment.

Core considerations for assessment in early psychosis

Core considerations for assessment in early psychosis

The influence of developmental stage, working collaboratively and engagement

This section will discuss adolescent development, working collaboratively and engagement, and how these three factors influence assessments of young people.

Developmental stage

The first presentation of early psychosis generally occurs during adolescence and early adulthood. This is a period of significant transition for a young person that includes changes in physical, psychological, social, cognitive and emotional development. Additionally, this is a period for development of autonomy, independent identity and self, psychosexual identity, and self-esteem and self-efficacy. Many young people obtain a level of training and education that will provide the foundation for their income and occupation for the remainder of their adult lives during this period. Normal development during adolescence is characterised by an increase in risk-taking and peer-directed social interactions that promote adult independence. The changes that occur during this time happen quicker than the development of regulatory and executive skills and can often result in a mismatch; this means that young people may act without realising the full consequences of their actions.

A psychotic episode can have a significant impact on the normal developmental tasks of adolescence.[16,17] It is important to intervene early so that young people get back to their normal trajectory to reduce the potential long-term negative effects of early psychosis. Regarding assessment, an understanding of adolescent development provides clinicians with some important considerations for working with young people in early psychosis.

Children and younger adolescents

Generally, children and younger adolescents may not have adequately developed language or intellectual skills to describe their experiences, thus the assessing clinicians need to focus more on gathering a detailed developmental history and description of family life, and changes in functioning and behaviour of the young person from multiple sources. More importantly, children and younger adolescents are less likely to have established or persistent patterns of behaviour than that seen in older adolescents and young adults. There are also significant challenges associated with assessing psychotic symptoms in younger adolescents and children.

EVALUATING SYMPTOMS OF PSYCHOSIS IN CHILDREN AND YOUNGER ADOLESCENTS

Clinicians need to consider the younger person's developmental stage when evaluating symptoms of psychosis, both longitudinally and currently at intake. It is important to maintain a high index of suspicion because children and younger adolescents are not likely to report psychotic symptoms.[18] In addition, hallucinations have been described in both a variety of childhood psychiatric conditions and in healthy children.[19]

Research has indicated that hallucinations have been associated with schizophrenia, reactive psychosis, bereavement, depressive disorders and temporal lobe epilepsy (as reviewed by Schreier 1999).[19] Hallucinations have also been reported in children suffering severe social and psychological deprivation and/or those reared in an environment of mystical belief, children with conduct and emotional disorders and anxious, socially inept children with adjustment reactions.[19]

Poulton et al. (2000) found a significant relationship between psychotic symptoms reported at age 11 and diagnosis of schizophreniform psychosis at age 26 years in a 15-year longitudinal study.[20] Post-traumatic stress disorder diagnosis has also been found to be significantly correlated with brief psychotic disorder or psychotic disorder NOS,[21] and symptoms of psychosis were relatively prevalent in a sample of children and adolescents referred for treatment to a mood and anxiety disorders clinic.[18]

Young people with epilepsy are also at increased risk for psychosis and this psychosis can be related to seizure remission or iatrogenic effect.[22] Additionally, the clinical picture is difficult to distinguish in children with autism spectrum disorders or other pervasive developmental disorders and associated lower IQ.

Mature minors

Clinicians need to be aware of the complexities of assessing whether or not a young person can be considered a mature minor in addition to the complexities of assessing the younger spectrum of adolescents.

When a younger adolescent wishes to make their own decisions about treatment without the involvement of parents or guardians, the young person should be reviewed by a nominated consultant psychiatrist and discussed with the treating team. According to Australian law, people aged 18 years are able to consent to medical treatment, while consent must be provided by a parent or guardian for people younger than 18 years.[23] When a young person is involved with medical treatment, the doctor needs to assess whether the young person can be considered a mature minor. In most cases, this will involve an assessment of maturity, covering the capacity to understand and appreciate the treatment and consequences of treatment, the possible consequences of not receiving treatment, and the gravity of the presenting issue and family issues.

The treating team should always refer to their relevant state or territory legislation and their own organisational policies around this issue. Young people should continually be encouraged to involve their families or parents in their treatment.

The effect of dynamics on working collaboratively in assessment

Working collaboratively with young people and their families is a core principle for interventions in early psychosis, and the relationship between the clinician and the young person is an important factor to whether this can be done effectively.

Clinicians need to pay careful attention to the ways in which issues such as body language, behaviour and environment might affect the assessment. How comfortable the young person is with a clinician during assessment will influence engagement and how much information the clinician can elicit from the young person regarding their experiences and symptoms. Clinicians also need to be mindful of how young people may perceive the role of clinician, as some might have a developmentally normal 'anti-authoritarian' view of the world (although others may not).

The relationship between the clinician and the young person can be influenced by where the assessment takes place: assessments can take place in the young person's home, a neutral environment such as a park, cafe or an emergency department or at the service (the clinician's environment). A young person coming into the service, regardless of how youth-friendly and accessible it is, may feel intimidated which can influence engagement and the assessment process. Clinicians should be aware of this influence and offer young people choices about where the assessment can take place. Asking questions like 'Where should we meet? Would you like to sit inside or should we go outside for a walk?' allow young people to be involved in choosing the location of the assessment. A young person may feel more comfortable in their own home environment as it may make them feel empowered having familiar things around them, which again can help with engagement and the assessment. On the other hand, it is also important for clinicians to be respectful of a young person's space when entering their home environment, as the young person may feel vulnerable when clinicians ask questions they may not want to answer. Asking the young person's permission to enter their home (e.g. 'Is it okay if I come in? Where can I sit?') allows the young person to make a decision about the clinician being in their environment. Clinicians need good communications skills and should provide an explanation about why they are visiting the young person in their home particularly if the young person is not keen to be assessed. Please see the ESNP manual *There's no place like home: home based care in early psychosis* for further information.

Equally, having a genuine connection with the young person will affect the relationship and help to work collaboratively with them and in turn facilitate engagement and assessment, for example, allowing the young person to teach you about an area of interest (see the case scenario Marty).

ALIGNING WITH THE YOUNG PERSON

Many dynamics can be made clear or identified during the initial set-up to assessment. When interviewing a young person in a highly restricted environment (e.g. a police station or an emergency closed/safe room), discussing the external restrictions and aligning with the young person in the assessment can be helpful: 'I am sorry that we have to meet here and that most of your choices have been taken from you. I have been asked to see you because the staff members here are concerned about you.'

A risk in this situation is that alignment may slip into creating a barrier between the referrer and the clinician; this is very significant when the referrer is a family member or another person with an ongoing relationship with the young person.

Safety and risk can also impact on working collaboratively, at times, as ensuring safety may be the first priority in high-risk situations. It is also important to note that in a situation where there is acute, imminent risk of harm to the young person, acute aggression or risk of harm to others, it can be difficult to conduct a comprehensive assessment as the focus must necessarily be on the immediate concern of risk reduction.

CASE SCENARIO **MARTY**

Marty was a 17-year-old young man who was seen at home after his family referred him to a youth mental health service following a 6-month decrease in functioning. He was previously successful in school but had become increasingly distracted. His parents had noticed obvious changes to his behaviour such as him isolating himself to his bedroom and talking to himself. His parents also noticed that, at times, Marty was possibly having auditory hallucinations.

Marty's family was very concerned about his wellbeing and had urged Marty to talk to someone. Initially, Marty was reluctant to talk to Jan and Peter, the youth mental health workers who visited him at home; however, in the end he agreed to do so. The two workers were invited into his room, which was untidy but clean, with a large collection of vinyl records, CDs and music equipment such as turntables and CD players. Marty was obviously very interested in music. As Jan was interested in music, she engaged Marty about the music he was creating. The assessment was productive and plans were made for follow-up over the next few days.

For the next meeting Jan was unavailable, but Peter was able to attend. Peter's understanding of music was very limited, which became obvious as he tried to engage Marty about music. Rather than changing the conversation, Peter engaged Marty in helping him understand how he made music and allowed Marty to be the expert in this situation. An agreement was made with Marty that he would help Peter to understand music better and Peter would help Marty explore his experiences that led to referral. This recurring theme over the next few meetings allowed a genuine connectedness and empowered Marty in the relationship. When allocating Marty a case manager, a person with an interest in music was identified and during his time with the service Marty chose to be heavily involved in various music groups.

Although it would seem a simple process of offering equality in the relationship, Marty was acknowledged as having genuine expertise in an area of interest.

When initially meeting with a young person, understanding factors that may impact on engagement improves the chance of gaining sufficient information to complete the clinical assessment.

Engagement

Engaging the young person during the assessment process is crucial to successful treatment. It is an important step in the process of intake and assessment; however, there are many barriers to this, including denial by the affected young person and their families and symptoms such as social withdrawal and suspiciousness.[24] The first contact the young person and their family have with a mental health service is highly influential, as it guides future interactions with clinical staff and the service. General principles such as warmth, empathy and respect should be applied when engaging young people and their families. The home, education, activities, drug use and abuse, sexual behaviour, suicide risk and depression (HEADSS)[25] assessment is a tool that guides clinicians through an interview with a young person and includes tips for engagement during the interview. It also provides prompts around youth-friendly language and questions when asking about symptoms, family and social functioning. More specific questions can be asked such as:

- 'Have you felt like people are talking about you, or watching you in an unusual manner?'
- 'Have you noticed anything suspicious going on around you?'
- Then follow-up to an answer to such questions with 'Tell me more about it, what happened?' later in the assessment.[26]

For more information please see 'Asking questions during assessment' section of this manual.

The development of a trusting relationship and therapeutic alliance between the young person and the clinician is an important determinant of attitudes towards treatment, treatment adherence and engagement, which subsequently influence recovery, relapse, long-term symptomatic and functional outcomes and quality of life.

Engagement in acute assessment

It is important to recognise that during the acute phase the young person may be nervous, wary or not keen to see mental health professionals, and engagement with the young person may be particularly challenging. Psychotic symptoms may distort perceptions and interactions of young people. In particular, young people who experience paranoia or other psychotic symptoms may find it more difficult to trust the assessing clinician. Clinical staff should ensure that they listen carefully and acknowledge and respect the young person's viewpoints during assessment. Appropriate body language (sitting alongside the young person and allowing personal space) should be used when interviewing young people who may be paranoid, aroused or experiencing manic symptoms.[24]

'Starting where the young person is at' is an important principle. The clinician may need to locate the initial assessment wholly within the perspective of the young person to come together and agree on a plan. For example, a clinician may ask 'What has brought you here today?' and 'How can we help you today?' Or 'I work with young people who may be having some unusual experiences and wonder if we can see if this is happening for you?'

One of the main aims of the first contact with the young person is to have the young person return for second contact, it is important to ask yourself, 'How am I going to get this young person to come back and see me again?' Engagement should be in the forefront of the assessing clinician's mind, as it is pointless obtaining all the necessary information that you need if the young person has been discouraged in the process and refuses to see you or any other clinician in the future. It is recommended that the clinician's focus should be on making the experience as helpful and positive for the young person as possible, and this might mean sacrificing some of the information that you are able to gather in the first instance, and focussing only on establishing rapport.

Using breaks and checking in with the young person throughout the assessment process is important as it ensures that they continue to feel safe and able to continue. The impact of acute psychotic symptoms on the young person's ability to pay attention, in addition to level of distress due to symptoms means that the assessment may need to be broken up into smaller periods of time.

Consider who is in the room (and who needs to be in the room) during an acute assessment. This will often influence the quality and content of information that a young person feels comfortable to share. Some young people may feel more comfortable with a family member or friend, while for others this may mean that they conceal information due to embarrassment or other consequences (e.g. information about substance use or self-harm). There are obvious limitations depending on the context of the assessment (hospital setting, emergency department, home or outpatient clinic) and safety and risk factors for clinician, young person and others, which may necessitate the presence of additional people (e.g. police, ambulance, extra clinician). In these instances, it is important to explain to the young person the roles of others who may be present in a way that they can understand. As a general rule, if the 'others' are not completely necessary for the interview, the young person should be asked to consent to them being present during the interview. In this case, it is best to ask this question privately if possible, to avoid the young person feeling pressured or coerced into consenting. If it is not possible (e.g. due to family members being at home during the interview), then give the young person an opportunity to be seen on their own, so that more sensitive topics might be raised. The clinician may need to be assertive about this, especially where family or others insist on being present. This will need to be decided on a case-by-case basis and will be influenced by the setting, the nature and acuity of symptoms and any risks involved.

Please see the manual *Get on board: engaging young people and their families in early psychosis* for more information on engagement with young people with early psychosis.

TIPS FOR ENGAGEMENT IN AN ACUTE ASSESSMENT

- Use youth-friendly language
- Listen carefully
- Use appropriate body language
  - Sitting alongside the young person
  - Allowing personal space
- Start where the young person is at
  - 'What has brought you here today?'
  - 'We work with young people who might be having some unusual experiences. I am wondering if this is happening to you?'
  - Aim for second contact
  - May need to establish rapport rather than gather all the information
  - Consider who's in the room
  - Include breaks in the assessment process

Engagement during crisis assessment

During a crisis assessment, assumptions should not be made that a young person will understand who the clinician is, where they are from, or why they are there. This information needs to be clearly communicated in a calm and respectful manner. Clinicians may need to reiterate certain messages to a young person, this is particularly important if police/ambulance staff members have been called and are also present. A common misperception leading to an escalation of aggression/distress by young people is that they are in trouble and that the involvement of clinicians (and police or other services) is a form of punishment. Clinicians need to consider who is present and who needs to be in the immediate space. An explanation about why certain people are present in the young person's surroundings may need to be given to the young person.

It is important for clinicians to give the young person a safe 'time-out' space if possible, even if this is a verbal rather than physical time out (e.g. negotiating this openly by saying 'we can just sit for a moment and I won't ask any questions until you feel okay to continue', or perceiving a need for time out and taking a few minutes to talk about neutral topics with the young person). Understanding and accepting that the young person may feel unsafe or threatened in this situation is important during a crisis assessment. Clearly stating that the young person may not feel safe and comfortable, and normalising it, can be helpful for the young person.

Having a person that the young person trusts present during the assessment process may also help during a crisis presentation, and clinicians should specifically ask the young person 'Is someone you trust that you would like to be involved right now?'

ENGAGEMENT TECHNIQUES IN CRISIS ASSESSMENT

- Use clear, plain language. Avoid the use of medical terms and jargon. Using questions such as 'What is happening for you Tim?' What is something I can do to help you feel safer/calmer/clearer?'
- Explain the rationale for steps and course of action along the way. For example, 'I'm concerned that some of the things you have spoken about might put you at risk. I think it would be a good idea to talk about some of the options to keep everyone safe.'
- Be aware that a crisis assessment can be dramatic in presentation and clinicians need to feel safe to be helpful to the young person. It is important to use other staff members or environments that promote safety to aid engagement. The young person will sense if you, the clinician, are scared or uncomfortable, or whether you are connected and paying attention.
- Discussing neutral topics such as music or television shows can be useful, but in the acutely unwell person experiencing active psychotic symptoms, chit-chat may be misinterpreted and it is advisable to stick to clear, simple questions and instructions.
- Repeating questions and limiting questions/requests to essential topics is important. A person in acute distress needs to be and feel respected. Using a person's name and re-introducing yourself, reorientating a person who is profoundly distracted, may be required.
- Be obvious in your listening, with regular reflected comments such as 'That sounds scary Tim, I can see why you are worried, we going to try and help with that.'
- It is important that the young person knows that you are there because you are concerned for them and their family and are trying to help.
- Try to connect the assessment outcome with something useful for the young person. For a young person who is acutely psychotic, focusing on practical support and immediate assistance is helpful. The clinician needs to find a way for the young person to feel that they have gained a positive outcome from the interaction and that it would be helpful to see the assessing team again. Often there are difficulties with sleep or anxiety for the young person and a focus on how this can be addressed can be particularly helpful.
- Clinicians may need to make a decision for the young person if the young person is unable to decide for themselves what to do, by saying things like 'I think if we go into this room that will help Tim,' or 'It would help if you took your mum's advice to come to the interview room.'
- If police or ambulance need to be involved, it is important that clinicians are clear about who will be involved and how before they go into the meeting with the young person.

Assessment over time

Assessment is an ongoing process. The fluidity and plasticity of symptoms in early psychosis means that the young person's presentation is likely to change and clinicians need to ensure a dynamic ongoing assessment occurs to take this into account. Following the initial assessment meeting and acceptance of a young person into an early psychosis service, further assessment is often required, which may take up to 6 weeks to complete, in some cases longer if there is diagnostic uncertainty or if engagement is difficult.

The assessment process can be used as an opportunity to allow the young person to discuss their experiences and to help them make sense of what has happened. For the young person and their family, having a supportive environment to discuss their concerns is incredibly important, as the experience of psychotic symptoms is traumatic for everyone. Clinicians involved in assessment have a unique opportunity to assist the young person and their family to make sense of their experiences and begin to help shape their explanatory model.

Often therapeutic interventions can begin during the ongoing assessment. Thus 'assessment' can also mark a crossover into treatment. It may be an opportunity to begin psychoeducation about early psychosis, in particular using the stress–vulnerability model, which is often one of the earlier interventions, regardless of the chosen ongoing treatment approach. It will be important for the young person and family to understand what is happening and for clinicians to gain insight into explanatory models. At the same time it is also important to recognise the need to work at the pace of the young person and their family, and bear in mind what is most important to them during the initial phase of assessment/treatment.

> 'It might be good to do it [the assessment] over a few sessions because it's very draining for us. They'll ask you like a hundred questions like "What's your name?" "What are your parents' names?" "What are their jobs?" A lot of this stuff is like paperwork questions that maybe you could just take away and fill out [a form] rather than sit there for 1 or 2 hours in a long draining session.'
>
> – Young person,
> EPPIC, Orygen Youth Health Clinical Program

Collateral information

Families, friends and relevant others can be a valuable source for collateral information that should be explored as quickly as possible when assessing the young person. Information about family history, neurological disorders, early developmental problems and premorbid functioning must be obtained and reconfirmed from these sources.[15] Clinical and personal history should be verified by talking to relatives, friends and significant others. The assessment of personal history should be performed chronologically and adapted to suit the young person's actual mental state.

The young person may be unlikely to know all the information about their developmental history but the family and significant others can provide information from a different perspective that will enrich the clinician's understanding of the young person and their context. For example, a young person might give their opinion that their primary schooling experience was normal, however, family or significant others may reveal that the young person experienced bullying or anxiety or had trouble focussing in class – information they might have received from the teacher, that may not have been communicated to the young person as a child.

Understanding the personal context of psychosis

Understanding the personal context means gaining insight on how the onset of early psychosis has affected the young person and their family, and the impact psychotic symptoms have had on the functioning of the individual and their family.

The personal context of illness can be a good place to begin an assessment because it commences the assessment with what is important to the young person and the family. Understanding the experience of the young person and their family provides a context for the signs and symptoms of their illness and helps with engagement, and is another overall objective of assessment. This also means understanding how the young person and/or the family conceptualise what has happened/is happening (i.e. their explanatory model).

Understanding the personal context of the young person's psychotic episode involves the assessment of the individual biological and psychosocial predictors of early psychosis (family history, early developmental delays, traumatic events), the consequences of the episode for the lives of the young person, family members and friends (drug use, disruption of functional development, duration of symptoms, stressors) and the resources the young person has (social strengths, coping skills, family support).[15] For an example of a complete assessment, please see Appendix 2: Assessment example.

The recognition of early psychosis and of the form of the psychotic symptoms, together with diagnostic formulation, is a longitudinal process based on psychosocial and biological investigations.[15]

'Clinicians often ask you very specific questions like "How many times have you self harmed in the last month?" Well I don't count them. Sometimes they tend to ask impossible questions like "How many times have you had hallucinations in the last 2 years?" It's like asking someone how many times they've had bolognaise in the last year. Those questions make you feel like you have to just spit out a stupid number just to answer the question. I think better questions are more about the impact of symptoms rather than just ticking a quantitative measurement for it.'

– Young person,
EPPIC, Orygen Youth Health Clinical Program

Communication with young people and their families

General principles

A friendly, respectful and non-judgment tone should be used when speaking to young people and their families during assessments. The choice of the language used during assessments is important and can influence the assessment process. It is important to remember that young people and their families may not be familiar with mental health terminology.

Confidentiality and duty of care

Confidentiality should be discussed with the young person at the beginning of the assessment and if family members are involved in the assessment this needs to take place (or repeated) in their presence. Generally, young people experience barriers to accessing health services, and perceived lack of confidentiality has been identified as a key barrier.[27] The Privacy Act and other Australian health information laws do not stipulate an age at which a young person (aged under 18) is presumed to give consent to the disclosure of their health information.[27] When deciding whether to disclose information to a parent or guardian, clinicians need to consider whether the young person is able to understand and appreciate the consequences of sharing or not sharing information, the gravity of the presenting issue and treatment, and potential family issues.[27] In most cases, involving parents is encouraged and supportive parents can often be a key element of successful intervention.[27] Limits to confidentiality and duty of care should be carefully explained to the young person. The young person should also be informed that information must be shared with specific individuals when their safety is at risk. It is recommended that clinicians discuss the nature of the information that will be shared, who it will be shared with and for what reason as long as this discussion does not increase the risk for the young person. Clinicians are encouraged to weigh up the situation and make a clinical judgement on the next course of action. Clinicians should be guided by their state and territory Mental Health Acts as well as the Privacy Act, and in conjunction with their local service policies and procedures. For more information on sharing information with families, please refer to the ENSP manual *In this together: family work in early psychosis*.

How to discuss confidentiality

Confidentiality should be addressed as a standard part of the young person's entry to service and assessment process. Young people should be provided with written information about their rights and responsibilities, and have an opportunity to discuss what information can be shared with their families. When working with an acutely psychotic young person, this is difficult as their capacity to understand and ability to evaluate the information provided may be impaired, even so confidentiality should still be addressed and raised again as their mental state improves.

In the situation where a young person has the capacity to make decisions about their treatment but does not give consent to disclose information; this should be continually addressed as part of their routine treatment. This may mean that the clinician needs to address or explore reasons for not wanting to share information, or reluctance about talking with family. Often it is helpful to discuss the risks and benefits of sharing information with particular references to the type of information that is to be shared. For example, the young person may consent to family being informed about treatment but does not want them to know about substance use. It is important to continually talk about this with the young person, and discuss the pros and cons of information sharing.

Cultural barriers

Aboriginal and Torres Strait Islander people have lower rates of access to mental health services when compared to the general population. Data suggests that Aboriginal and Torres Strait Islander people have higher rates of hospital admissions for mental and behavioural disorders compared with non-Aboriginal people.[28] Rates of death from suicide in the Indigenous Australian community is two-and-a half times greater than in the non-Indigenous Australian community, and the death rates are especially high for Indigenous Australians aged 34 years and younger.[29] The Australian Clinical Guideline for Early Psychosis has identified key principles for working with Aboriginal and Torres Strait Islander communities that include learning about the culture and their concept of mental illness. It is important for clinicians to understand what is considered culturally appropriate communication and to use the community and family to support the young person. Clinicians should always develop local understanding and resources that take into account this context. Partnerships with local indigenous cultural programs and advisors are particularly helpful. For more information please see *The Australian Clinical Guidelines for Early Psychosis*.[3]

People from culturally and linguistically diverse (CALD) backgrounds have lower access rates to mental health services compared to the general population. An important part of providing treatment and care to this population is facilitating communication in situations that involve young people with limited English proficiency. There are effective guidelines to follow when working with interpreters, young people, relatives and significant others available from the Mental Health in Multicultural Australia website (www.mhima.org.au). The Australian Clinical Guidelines for Early Psychosis provides some good practice points when working with interpreters in mental health settings. A brief overview will be provided in the box below.

WORKING WITH INTERPRETERS

Ensure that you are aware of the language spoken by the young person and their family.

Ensure that you are aware of whether there is an ethno-political divide between the young person, their family and the interpreter.

Ensure that the gender of the interpreter is appropriate to the interview.

Ensure that the interpreter is aware of the purpose of the interview and is aware of the confidentiality associated with the interview.

Clearly communicate to the young person and their family that the interpreter is bound by confidentiality.

Ensure enough time for questions and answer to be interpreted.

For more information please see *The Australian Clinical Guidelines for Early Psychosis.*[3]

Transparency and collaborative decision making

Transparency is important when establishing a collaborative working relationship with the young person, their families and the service. This should be established in the beginning, preferably during the first contact, as a way of interacting with the service that will be helpful in the longer term.

Always attempt to involve young people in decision making about their treatment; to do this, young people need to be as informed as possible about what is occurring with their mental health. As mentioned previously, this needs to be explained in such a way that the young person can understand and make sense of, for example, there is no point in saying schizophreniform psychosis because this doesn't really mean anything to a young person and may just confuse them. The same principles of using plain language and no jargon should be applied in this instance.

It is important that young people are involved in this collaborative decision making process, even if the clinician doesn't think that the young person has capacity to consent or make decisions. It is important to recognise though that young people may not be able to be involved in making all decisions about their treatment but can still be offered choices or options and it is a respectful approach to them. For example, when making a time for another assessment allow the young person to choose whether this occurs at home or at the service. Part of this is recognising that there are always some areas that the young person is able to make decisions about.

Involving young people in decision making reduces potential negative experiences. This is especially important in the adolescent/young adult age group because this is often a time where young people want to take more control of their lives, so completely appropriate in terms of developmental phase for many of the young people that we see. Clinicians always need to explain to young people what their treatment options are and take time to explain things is such a way that allows them to weight the pro's and con's of each option and make an informed decision. Families should also be included in this process if the young person consents. Please see the ENSP manual *In this together: family work in early psychosis*.

How to perform an assessment

How to perform an assessment

The aims of the initial assessment process

The overall aims of an initial assessment in an early psychosis service should be to:[24]

- assess the mental state of the young person
- assess the safety of the young person and their family or significant others
- engage and build a therapeutic alliance with the young person and their family
- gather information to develop a management plan to reduce the symptoms of psychosis and disturbed behaviour, and assist with recovery from an acute episode
- promote long-term wellbeing
- reduce the risk of relapse.

The specific aims of an initial assessment are to monitor signs and symptoms, including onset, severity and duration. Factors such as the urgency of need for intervention (based on the severity of symptoms and safety issues) and the extent to which the young person and their family can be engaged can influence the initial assessment.[24]

As the initial assessment can be an emotionally charged period, clinicians should aim to use a calm, reassuring, friendly and professional manner to negotiate the best outcome. Clinicians should also understand how to discuss and explain the assessment process to young people and their families, using statements or questions such as:

- ‘We want to understand what is happening for you.’
- ‘Some of these questions might seem odd or strange, and it’s ok if you don’t know or don’t have an answer.’

Initial assessment is also the optimal time to determine DUP. Part of the mental state examination will be to determine the length of time that the symptoms have been experienced, and when they first occurred. This can give the clinician a sense of how long the person may have been experiencing DUP. Collateral information should also be used to inform any assessment of DUP.

Important factors to consider when assessing DUP during the initial assessment phase include:

- an assessment of how quickly the onset of psychotic symptoms occurred
  - was the onset sudden or gradual?
  - were there any clear precipitants (such as drug use or trauma)?
- length of time individual symptoms have been occurring
  - when did the first clear psychotic symptom first occur?
  - can a psychosis threshold be determined?
- chronology of symptoms
  - in what order did the symptoms appear?
  - over what time period did the symptoms appear?

This information can be used to make a clinical assessment of DUP; however, it is important for services to come to a consensus about how to consistently measure DUP. Standardised tools such as the Royal Park Multi-diagnostic Instrument for Psychosis[30] can be used to standardise the measurement of DUP in a service. For a brief discussion about importance of DUP and the difficulties associated with its measurement, see 'Duration of untreated psychosis' section above, or refer to Chapter 8 in *The recognition and management of early psychosis: a preventive approach* by Jackson & McGorry.

Planning an initial assessment

Planning the initial contact with the young person is important for early psychosis clinicians. All existing sources of information should be gathered as quickly as possible before the initial assessment. The choice of appropriate setting that enables the highest possibility of engagement, safety and successful initiation of treatment is important to consider when arranging the first assessment.[15] The clinician conducting the first assessment needs to consider how they will introduce themselves and the early psychosis service to the young person and their families. The introduction should be clear and easy to understand, and it is advised that clinicians prepare this before meeting the young person, using opening statements such as:

> 'I'm a worker from xx service. We focus on helping people around your age who might be having trouble with their thinking or are feeling confused. I don't know if this is what's happening for you, but maybe we could talk about it. Is that okay?'
>
> OR
>
> 'Hi, I'm from xx service. Judy, your school counsellor mentioned you to me and she thought that we might be able to help you. She mentioned you had talked about me coming to see you. Is it okay if we catch up for while?'

As part of the opening conversation with the young person, the clinician should also explain the reasons they are there.

Setting – planning for home-based assessment

Assessments can occur in a variety of locations, including a clinician's office, the young person's home, an inpatient unit, emergency departments, police stations, or more neutral environments such as a local park or café. Many young people are happy to attend office-based appointments, while others are more circumspect about talking with mental health clinicians and may not want to attend such a location. For young people who are very reluctant to attend an office-based appointment, or who cannot attend due to reasons related to their symptoms or mental state, a home-based assessment is an important alternative to consider.

A home-based assessment has several advantages over assessment in the service:

- It can be more familiar and potentially more comforting for the young person, particularly if they are feeling anxious or paranoid regarding contact with a mental health service as some young people are.
- It increases the likelihood of involving family members or significant others in part of the assessment process and in supporting the young person.
- It can serve to reduce the power imbalance between the young person and the clinician, which for many young people is a significant hurdle in engaging in an assessment.
- It can provide important information to the clinicians regarding the young person's functioning and how safe, supportive, stressful or appropriate the home environment might be.

The home-based assessment can also give the clinician some clues as to the interests of the young person (e.g. a bedroom with surfing posters, music playing or other items indicating personal interests), which can assist with trying to engage the young person in a conversation that is about them as an individual, not just as the subject of an interview that they may be wary of or reluctant to engage with. This can enable some sense of personal connection, providing the connection is based on a genuine interest of the clinician, between the young person and the clinician, which can help make the meeting feel like a more 'normal' social meeting, where strangers try to establish some common ground before entering into a more personal discussion.

Regardless of setting, it is important for clinicians to use a number of strategies to help facilitate a 'smooth' assessment. The emphasis should be on trying to engage the young person in conversation regarding how their life is at the time they present. Some suggested strategies are presented in the box below that may be useful for both a home or service-based initial assessment. These tips come from a discussion with a senior clinician with 20 years' experience working with young people with early psychosis.

TIPS FOR WORKING WITH A YOUNG PERSON IN THEIR ENVIRONMENT

Take the time to introduce yourself to the young person and their families/friends/relatives/significant others.

Scan the environment to help start or keep the conversation going when you first meet with a young person.

> 'I once did an assessment on a young woman who denied all psychotic symptoms, and in the absence of any firm referral information regarding such symptoms we were unsure how to proceed. I noticed a music poster near her bed and we started talking about the band. During this discussion it became clear she had a complex delusional system involving the band members. This involved some luck – that is, picking the right prompt – but was essential to establishing a connection to her inner world. Self-deprecating humour can also go a long way in this regard. It can give a sense that we (as clinicians) are not taking ourselves too seriously, and can function to decrease the power imbalance between the young person and the clinician.'

Have the capacity to keep on talking to try and start a conversation with young people.

> 'Part of assessments involves the capacity to keep talking, to keep trying to build rapport even when the young person is silent. Many young people are looking for clues as to who we are and whether they can trust us as people, let alone as clinicians. I often comment that I too would be reluctant to talk to a stranger who came unannounced and unwanted into my house and started asking a bunch of personal questions.'

Establish a common ground.

> 'As clinicians we can represent authority, and for many young people and in particular adolescents, authority is to be avoided, opposed, resisted or in some cases simply obeyed. We are trying to establish some common ground – this should also involve using the client's language to talk about their experience. It is also important to stay with the process of describing their experience, rather than interpreting it or putting into jargon or labels. This can serve to alienate the young person from us.'

Use the young person's language.

> 'Another aspect of establishing common ground is to use the young person's language, to use the words they might use to describe their experience. 'Freaking out', 'spinning out' or 'stuck in the game' can be more meaningful than 'psychotic'. We can explain how we might interpret their experiences and language later in the assessment.'

Table continues over page

TIPS FOR WORKING WITH A YOUNG PERSON IN THEIR ENVIRONMENT
CONTINUED

Vary the way you ask a question.

'Young people are not familiar with mental health assessment and may not understand what you are asking them. Adapting your language to suit the young person is important – the way you ask questions will vary from person to person. Additionally, asking questions about the same experience more than once, but slightly differently each time, may provide information that you may not gain if you only asked it once.'

Pay attention to all aspects of body language, from the big picture to subtle things.

'I interviewed a young man at home who was referred to us with depressive symptoms, suicidal ideas and some violent ideas. There were no family members at home at the time of the interview. During the assessment he was happy to talk and denied all psychotic experiences. He did however keep making slightly unusual movements with one of his shoulders. We kept talking about the suicidal thoughts and what had been happening that might have been making him feel annoyed, irritable, angry. It was only when he made a brief mention of not watching TV and showed us his room that we started to access any psychotic symptoms. Despite having covered his mirrors and having an odd totem object on his TV he denied psychotic symptoms. Shortly after this we sat outside as he smoked a cigarette and he gestured to the trees in his backyard – "This is where the angels live during the day," he told me. Assessing for first episode psychosis can take a lot of time, persistence, and patience.'

– Senior Clinician,
EPPIC, Orygen Youth Health Clinical Program

The interview

To begin with…

The interview is the fundamental tool of assessment. Interviewing involves 'hearing' the young person's story, assessing their mental state, understanding their individuality and reasons for seeking help, and finding information that can help to reach a diagnosis. As part of the interview, a mental state examination should be performed to assess several aspects of mental functioning (see page 44).

Clinicians should keep in mind that many young people are unfamiliar with relating their thoughts, feelings and inner experiences to others, particularly to a stranger. A personal connection is important in developing the trust required for the clinician and the young person to explore the young person's internal world. Young people tend to guard access to this world, which is developmentally important as part of individuation. In an initial assessment interview, young people are being asked to reveal parts of themselves that they might even feel wary about discussing with their friends. Clinicians therefore need to respect the ambivalence many young people may have about the assessment process.

General considerations for conducting the interview are:

- how the setting of the interview needs to modify the style of questioning used during an assessment interview (e.g. time constraints imposed on interviews in the emergency department compared with to those carried out in the inpatient setting or outpatient clinic)
- other modifying factors such as the young person's age or cultural background.[31]
- the importance of language: clinicians should avoid closed or 'leading' questions or psychiatric terminology; instead, simple, plain language will help young people and families understand what is being asked (see 'Asking questions during assessment' on page 38 for more information).

An important initial consideration is who is or should be present during the interview. Whether the young person is seen alone or with a family member, partner or friend present can greatly influence how and what type of information is gathered during the interview. It can be helpful to ask the young person whether they would prefer to be seen on their own or in the presence of another person. This gives the young person a sense of control in decision-making in the assessment process, and may also give the clinician insight into the nature of the young person's relationships with those around them.

'I found the assessment repetitive, which was annoying. It could actually be quite triggering because you're just repeating stuff that's really upsetting. I think they should just check in with the young person as they're asking questions by saying you don't have to answer that if you don't feel comfortable. I also found it frustrating that when I saw the YAT team or the assessing team when I first came here and there was a medical student in the room. I felt quite intimidated and that the assessment sort of felt like an interrogation. I also felt like I had to say yes to having so many people present because I felt like was the only way I could get the help I needed.'

– Young person,
EPPIC, Orygen Youth Health Clinical Program

At the end of an interview, feedback should be provided to the young person, and they should be given options for the next step. The family will also be informed. This will be discussed later in the manual in the section 'Feedback from assessment.'

> 'The assessment would be better if it was organic because it's very dehumanising to sit there and feel like you're just checking boxes. I've looked at my files and they're just hundreds of questions where you fill in the circles and we're not doing an end of year exam. I felt pressured in terms of how I answered certain questions. I felt that each question could have a certain reaction and case managers are very good at being a blank canvas which is very frustrating because you feel as if there is a right answer but you're just not getting any response from the case manager about what are saying.'
>
> – Young person,
> EPPIC, Orygen Youth Health Clinical Program

Asking questions during assessment

When asking young people questions about symptoms of psychosis, it is recommended that open-ended questions be used such as 'Has anything happened lately that has upset you?' or 'What is the most important thing you would like help with?' This style of questioning helps organise disorganised thinking and offers young people a chance to share their concerns.[26] The clinician conducting an assessment with a young person should be comfortable discussing or asking about psychotic symptoms and consider how the approach and language they use for this. Young people may be reluctant to describe their symptoms to the assessing clinician if they feel they are being labelled as 'crazy' or 'weird'. Statements such as 'Sometimes young people I see have told me that they find it difficult to concentrate because they are hearing voices' or 'Young people have told me that they find it hard to answer questions because they are unsure about what I will do with the information' are helpful when direct questioning such as 'Do you hear voices?' does not elicit a response from the young person.

Clinicians should aim to explore the experience of the young person in the period leading up to the interview, including initial identification symptoms (by young person or family), help-seeking and arrival at the early psychosis service. A curious and inquiring stance will help collect a collateral history, which is essential to understand the course of the young person's experience of possible psychotic symptoms and to identify any changes that the young person themselves may not have been aware of at the time.

It can be very difficult to ask questions about some topics, particularly sexual ideas or experiences (the gender of the assessor is very important in this situation) and substance use, when other family members are present. The young person may be embarrassed, ashamed or fearful of the consequences of disclosing such information. A good resource to use is the *Beyond awkward* that is available from www.oyh.org.au. Additionally, suicidality and risk issues can also be difficult to ask about (please see risk questions in Appendix 1). It is important to frame questions about risk in terms of safety of the young person and others, and place an emphasis on the importance of everyone's safety.

Interview techniques and strategies

While it is easy to ask questions during an interview, it is not always easy to get an answer, or an answer that is true or useful for assessment. This section outlines some strategies and techniques that might be useful for improving the validity of the information gained through the interview process.

Normalise the experience

It is advised that clinicians use language that helps to normalise the young person's experience in the context of the stress–vulnerability model. It is often helpful to start the interview by implying that the behaviour is understandable given the stress that the young person has been experiencing.[32] This technique can help the young person to feel less embarrassed about what they are experiencing, and less likely to conceal or minimise the experience.[32] 'Sometimes when people are experiencing more stress than usual, they can notice that things don't seem quite right, or that unusual things are happening to them. Have you ever felt like this?'

Symptom expectation

Symptom expectation (or assumption) is similar to normalisation in that it communicates to the young person that behaviour is in some way normal or expected, encouraging a straightforward and honest response.[32] It also helps to explain to the young person that the clinician has some understanding and knowledge that can provide a sense of relief. This technique is best used when there is a reasonable suspicion that the young person is having some psychotic spectrum phenomena or behaviour.

Example questions that use symptom expectation are:

- For suspected non-adherence medication: 'How many times do you think you've missed your medication in the last week?' (rather than 'Have you forgotten to take your medication?')
- For suspected under-reporting of symptoms: 'How many times would you have had that experience in the last day or two?'

This technique is often used in conjunction with **symptom exaggeration** to elicit an accurate report of how often a potentially embarrassing or shameful behaviour might be occurring. It involves suggesting that the clinician expects the severity of the behaviour to be high, so the young person feels that their actual level of severity is less than expected.[32] For instance, if a young person reports daily cannabis use, you might say 'Can you tell me how much you have been using each week? Is it half an ounce, an ounce a week, two ounces a week?'

Use familiar language

Using familiar language can also increase the likelihood that young people will accurately report behaviours that they may perceive to be socially unacceptable or difficult to talk about.[32] This is particularly true for substance use in this population. Suggestions include:

> Instead of: 'You mentioned that you have used heroin in the past. Do you use intravenously?'
>
> Use: 'You mentioned that you have used heroin in the past. Do you ever shoot up?'

This needs to be used judiciously, as it is very obvious to a young person if you are not being genuine or trying too hard to be a young person; matching the young person's language in this instance can back fire.

> 'Sometimes clinicians will say so you're having psychotic episode and ask how long were you having that episode for? It's difficult because I don't know, I wasn't looking at the clock. I was in a different world so I can't tell you properly what was going on for that period of time. That makes me very frustrated it makes me want to tell them that I don't know.'
>
> –Young person,
> EPPIC, Orygen Youth Health Clinical Program

Open ended questions

Young people can have difficulty expressing their emotions and experiences and consequently can be very good at answering questions with yes/no responses.[32] Open-ended questions will help avoid this (see box following) and it is also useful to use broad examples to prompt the young person, such as 'other people I have talked with, when they were stressed, have told me they had unusual experiences. 'Has this ever happened to you?' In addition, it can be useful to offer a number of broad options when asking questions 'When these experiences happen to you, is it your voice or someone else's? Is it a man's voice or a woman's voice that you hear? Does it sound like someone you know?' (In this case moving from options [your voice/someone else's, man/woman] to more specific questions 'Is it someone you know?'). However it is always important to allow the young person to explain their experience in their own words. When asking questions about the past 'Have you ever experienced …?' These questions should be followed up by asking about the present 'Is this happening now' or 'How recently has this happened? When was the last time you think this happened?'

During assessment, it is important to be cautious about asking 'why' a person may be experiencing particular symptoms. Firstly, it can make the young person feel as though the veracity or validity of their report is being questioned. Secondly, these questions are often met with confusion on the part of the young person, who usually has no idea why he or she is experiencing what they are. It is better to ask questions such as 'How did you work out that this was happening?' or 'Do you have a sense of what is causing you to feel this way/causing these experiences?' as these questions will assist the clinician to maintain rapport as well as provide more detail about the experience itself. During assessment, it is important to ask the young person questions to tease out what their current explanation for their circumstances are. This will assist the clinician to assess the level of insight and understand the young person's explanatory model, both of which are extremely important when beginning psychoeducation.

OPEN-ENDED QUESTIONS

An open-ended question is one that cannot be answered by a simple yes/no answer, or a specific piece of information. They are usually designed to encourage the respondent to answer with the information that they feel is relevant to the question, and often may be phrased as statements rather than questions. Examples are:

- 'Tell me about at time when…'
- 'What do you think about…?'

These sorts of questions can be useful for eliciting information from young people during assessment, and may be more useful than closed-ended or 'yes/no' questions.

'Could they [clinicians] maybe have more of like a guided conversation with you instead of just them sitting there with a piece of paper with questions that makes you feel like you're being interrogated or like they're cross examining you to see what's going on with you. It would be a lot less intense and clinicians probably would actually get more of a feeling of how the young person is rather than shooting questions one by one.'

– Young person,
EPPIC, Orygen Youth Health Clinical Program

The interview process

During the process of assessment, it can be useful to conceptualise the questions you ask a young person in terms of a 'funnelling process', starting with very broad questions and gradually narrowing down as the young person provides information. This can be a helpful process to keep in mind when asking about each of the domains of the interview, as well as when asking about specific symptom domains. For example, if a young person attends a clinic-based assessment voluntarily, you might open with 'I'm wondering if we can talk about how it came about that you're here today?' or 'I wonder if you could tell me about what's been going on for you lately?' Both of these questions allow the young person to choose what is most important for them to talk about, as well as being broad enough for the clinician to start building engagement.

Similarly, when asking about specific symptom domains, it can be useful to start broad, then narrow the questions to obtain more detail about the experience. The case scenario 'Jane' shows an example interview asking about possible auditory hallucinations, along with a deconstruction of the interview techniques used by the interviewing clinician.

CASE SCENARIO **JANE**

INTERVIEW/CONVERSATION	INTERVIEW TECHNIQUES USED
Clinician: 'Jane, have you noticed any changes in your five senses – hearing, sight, taste, touch or smell?'	– The clinician begins the questioning with an **open-ended broad question**.
Jane: 'Not really. Though sometimes I think I have a sensitive nose ... '	
Clinician: 'I'm curious Jane, what do you mean by sensitive?'	– The response does not seem to indicate the presence of perceptual disturbance, but the clinician asks for **clarification**.
Jane: 'I don't like to wear perfume because the smell is really strong to me.'	
Clinician: 'That's pretty common I think. What about your hearing? Is that sensitive? For instance do you ever hear things and you're not sure where it's coming from?'	– The clinician **normalises** what the young person has reported, and **uses the young person's language**, but asks a more specific question, and gives an example.
Jane: 'Yeah, that does happen sometimes ... '	
Clinician: 'What kind of noise is it?'	– The young person endorses the experience, however the clinician now asks for more **information about the quality of the experience**.
Jane: 'It's hard to explain, but is sounds a bit like someone is whispering or mumbling something ... I'm not sure.'	

CASE SCENARIO **JANE** CONTINUED

INTERVIEW/CONVERSATION	INTERVIEW TECHNIQUES USED
Clinician: 'That sounds stressful. Is it ok if we keep talking about it a bit longer?'	– Clinician has decided to try to gain **more detail**, however asks the young person for **permission** before delving further, in order to **maintain engagement**.
Jane: 'Yeah it's ok.'	
Clinician:' Can you tell me more about it, like when does it happen?'	– Further **probing questions** used to elicit detail.
Jane: 'I get freaked out. It's happened a few times. Last time was when I was in my English exam. I could hear someone whispering to me ...'	
Clinician: 'When was the exam?'	
Jane: 'Last week ... Thursday I think?'	
Clinician: 'It might be hard to remember this Jane, but can you think back... Did it sound like your own thoughts, or like the sound was coming from somewhere else?'	– Clinician **acknowledges difficulties**, but asks young person to provide some more detail.
Jane: 'No I remember thinking that someone was standing behind me, but when I looked there was no-one there. The room was silent and everyone else was looking down at their exam papers. I couldn't work it out.'	
Clinician: 'Can you remember if it happened just that one time in the exam?'	
Jane: 'No it happened a more than once. It kept happening the whole time the exam was on and afterwards as well.'	
Clinician: 'How long did that last for?'	– Young person is coping well with answering questions and so **clinician probes again**.
Jane: 'A couple of hours I think, but I'm not sure really.'	
Clinician: 'Do you have any ideas about what is causing this or where it is coming from?'	– Clinician feels that they have gained a reasonable initial account of the frequency and duration of the experience and now asks the young person about the **meaning of the experience**.
Jane: 'Not sure, but I think it might have something to do with God.'	

At this point the clinician must use their clinical reasoning to determine whether or not to continue with questions regarding perceptual abnormalities, or whether it may be better to go with what the young person has just disclosed around their beliefs. Either way, in this example, further exploration of both perceptual disturbances and possible over-valued ideas or delusions is warranted.

Mental state examination

The mental state examination (MSE) is a structured clinical assessment in mental health and is the systematic appraisal of the behaviour and cognitive functioning of an individual. Descriptions within the MSE include appearance, behaviour, level of consciousness and attentiveness, motor and speech, mood and affect, thought and perception, attitude and insight, cognition and judgement.[33] MSE is a cross-sectional, systematic assessment of the individual's experience of signs and symptoms that allows an objective view of the young person's presentation.[31] The MSE focuses on all symptoms, signs and behavioural disturbances related to non-affective and affective psychosis and other psychiatric comorbidities. It is sometimes difficult to differentiate whether a symptom belongs to the psychosis itself or another comorbid psychiatric disorder. The features of a MSE are outlined in Table 2.

TABLE 2. **FEATURES OF A MENTAL STATE EXAMINATION**

MENTAL STATE EXAMINATION	
General appearance and behaviour	Hair, makeup, clothes Grooming Demeanour Eye contact Other non-verbal communication e.g. sitting comfortably in a chair
Speech	Ease of conversation Rate, volume, quality, quantity and tone of speech
Affect and mood	Range (e.g. blunted or flat) Appropriateness, stability Elevated, irritability, anxious, depressed, ashamed
Thoughts	Delusions, preoccupations, depressive thoughts, self-harm, suicidal Highly irrelevant comments, frequent changes of topic, excessive vagueness Anxiety, obsessions
Cognition	Level of consciousness, orientation to reality Memory functioning, literacy and arithmetic skills Attention and concentration, general knowledge and language Ability to deal with abstract concepts
Perception	Hallucinations, illusions and dissociative symptoms
Insight and judgement	Acknowledgment of a possible mental health problem Understanding treatment options and ability to comply Ability to identify pathological event Problem-solving ability

It is important to remember that mental state can vary in response to different setting and clinical staff members. Additionally, young people learn quickly how to conceal some psychotic symptoms to avoid treatment or a longer hospital stay. There may be variation in clinical signs depending on many factors.[24] If a young person is experiencing lack of sleep or an increase in psychosocial stressors, they may present with an increase in symptoms. Similarly if these issues are resolved, symptoms can dramatically decrease.

In addition to the areas of mental state examination in Table 2, clinicians need to keep in mind that it may be the subtleties of the report that provide clues, especially in an emerging psychotic disorder. In particular, for the following symptoms it is important to ask about:

Paranoia

- Who or what is the focus of the paranoia? Is it generalised or specific? Where does it occur?
- Conviction – how certain is the young person about the belief? Maybe try to rate it as percentage.
- How does the young person react in a situation where they are paranoid? Confrontation or avoidance? (This is also helpful in understanding judgement and risk)
- Intent of others – does the young person feel that they are being made fun of, monitored for a specific purpose or will others harm them?

PARANOIA AND COMMUNICATING WITH YOUNG PEOPLE

Paranoia is an important experience to consider when using the young person's language. The word 'paranoia' is frequently used in a colloquial and non-technical way; it can refer to a variety of experiences, many of them drug or anxiety-related. Asking a young person directly whether he or she is paranoid can result in lengthy stories about drug use or anxiety from some people who may not be considered clinically paranoid. Young people who are clinically paranoid tend to deny paranoia when asked directly. Enquiring about what the young person has been doing and how they are feeling, or speculating about how they may be feeling based on what they have told of their recent experiences, can lead to a questions such as 'what might be making it difficult to leave the house?' 'What sorts of things get you down?' 'What has happened that you stopped seeing your friends?'
The idea is to help young people build a story of their current experiences; this can involve asking direct questions that may be met with a flat denial, disengagement and non-participation.

Delusions/beliefs

- Conviction: what degree is the young person convinced in their belief?
- Behaviour: has the belief altered the person's behaviour? If so, in what way? Have others noticed this change?
- How did the belief arise? Out of the blue or as a result of another circumstance or situation?

Hallucinations

- Quality and characteristics: what does the hallucination sound like? Voice, noise etc? Positive/negative? Male/Female? Familiar/Unknown? Ego-syntonic/ego-dystonic, how many?
- Location of auditory hallucinations: inside head, outside head, through ears, though body?
- The interpretation of the origin (especially for auditory hallucinations) – is the voice coming from someone/somewhere else or from self? Is it the voice of someone you know? Deceased person or alive?
- When do they occur? How often (frequency) and for how long (duration)? What time of day? Does it occur when falling asleep or waking up?
- Content: if verbal, what does the voice say? Command, commentary, first/second/third person? Talking to or about the young person?
- Power and Omnipotence/Omniscience: does the voice have power? Does the young person perceive the voice to have complete power over them? Does the voice 'know' everything?
- Compliance: to what degree does the young person feel they have to comply with commands or requests? Have they complied in the past, and what were the circumstances?

For any symptoms that may indicate psychosis, assessing clinicians should keep in mind:

- Whether the thought, behaviour or symptoms is experienced as ego-syntonic or ego-dystonic? For example, is the thought my own or not my own?
- If there is a question about odd behaviour or a change in behaviour – what is driving it? What precipitated the change in behaviour or what is perpetuating it?
- Insight – to what degree does the young person understand that their beliefs, symptoms or behaviour are odd or strange? What do they attribute it to?

For an example of a MSE in the context of an initial assessment, please see Appendix 2.

Adapted from Romme and Escher *Making sense of voices*. London: Mind Publications 2000. Chadwick, Birchwood and Trower. Cognitive *Therapy for Delusions, Voices and Paranoia*. Chichester: John Wiley & Sons.

A cognitive-behavioural framework may be useful for delving into a specific problem or symptom during assessment; clinicians should use their clinical judgement about when is the appropriate time to do this. A cognitive-behavioural model is useful if you are trying to tease out patterns of thoughts or behaviour that might be occurring for the young person. This is useful not only for assessment of psychosis, but also for assessment of mental health problems more generally.

Using this model, the starting point in the discussion can be anywhere; however, clinicians may find that the situation or the consequence are the easiest things for a young person to talk about as being problematic. Please see Table 3 below.

TABLE 3. **A COGNITIVE-BEHAVIOURAL FRAMEWORK FOR ASSESSING SYMPTOMS**

SITUATION/ CONTEXT	THOUGHTS/ EMOTIONS	BEHAVIOUR	CONSEQUENCE
Description of a specific incident, or environmental context (where, how, how often, etc) the symptom occurs.	What are the young person's thoughts? How do they feel in the situation?	What do they do in response?	What happens when they respond in the way they do? What effect does it have?
Went out a month ago, and noticed that I was being followed by a red car. It stopped behind me at the traffic lights and kept following me almost all the way home.	Felt scared and frightened. Thinking that people are following me and monitoring my whereabouts – it could be undercover police.	Avoids situations that make me feel uncomfortable or unsafe. Previously carried a knife with me for protection.	Now don't leave the house at all. Got into trouble with police.

Adapted from Chadwick, Birchwood and Trower. *Cognitive Therapy for Delusions, Voices and Paranoia*. Chichester: John Wiley & Sons.

Risk assessment

Risk assessment should always occur within the context of a mental state examination and the wider initial biopsychosocial assessment. The major goal of risk assessment is to minimise the risk for the young person, relatives, clinicians and the general community. Risk assessment covers the risk of suicidal attempt or completed suicide, risk of death (unintentional), risk of violence and aggression, risk of victimisation and neglect, risk of non-adherence to treatment and service disengagement and risk of absconding from hospital.[15] In general terms, risk assessment for each of these domains should take into account:

- nature of the risk and potential severity
- likelihood that the behaviour may occur in the near and distant future
- drivers or triggers for the behaviour:
  - how do these triggers relate to each other?
  - what are the most sensible modifiable factors?
- when is the risk most likely to occur (imminence)
- reversibility.

All young people with FEP, especially new FEP, should be assessed for risk regularly. Risk assessment should be initiated as early as possible during the initial assessment phase and be as comprehensive as possible, although will undoubtedly be built upon during later assessments.[34]

Suicide risk

The Australian Clinical Guidelines for Early Psychosis recommends that risk assessment should be performed (and documented) at every review and include routine assessment of depressive symptoms, hopelessness, suicidal intent, and the role of psychotic features on mood.[3] Risk assessment should allow for the fluctuating nature of suicidality in young people. The importance of assessing for suicide risk should not be underestimated as young people with FEP are a high-risk group.[15] Approximately 15% of young people with FEP have already attempted suicide before presentation at a clinic or hospital and another 5–10% will attempt suicide during the first 18 months of treatment. In the 18 months following the indexed psychotic episode, up to 15% of young people will continue to have high levels of suicidality.[35] In addition, clinicians need to be mindful that the risks for harm to self are present during both the acute and non-acute phases of illness, though the drivers of risk may differ. In the acute phase, suicidality may be a direct response to psychotic experiences, depression or feelings of shame, fear or guilt.[36] In the recovery phase, however, suicide may be related to poor functional recovery, realisation of losses and the development of insight.[36] In addition, it has been well documented that transition points in care, such as discharge from hospital, or transition from UHR to psychosis, present periods where suicide risk is more elevated.[36,37] Therefore, the risk factors for suicide in young people with early psychosis should be assessed regularly and form part of the ongoing assessment and management plan. The greater the number of risk factors the young person has, the higher the risk of suicide.[34]

Some risk factors for suicide in young people with early psychosis include gender, ethnicity, higher education, living alone, recent loss, family history of depression and suicide, substance use and hopelessness.[34] Previous attempts at suicide and recent suicidal ideation are serious risk factors for young people with early psychosis and clinicians should carefully consider during risk assessment.[34] Suicide risk assessment should be undertaken regularly as part of routine clinical care; however, the clinician should especially consider reassessment of risk following:[36]

- any act suggestive of suicide attempt
- change in mental state
- major stress or trauma
- service disengagement
- transitions in care (change in treating team, admission/discharge from hospital)
- commencement of leave during inpatient care
- change in contextual or personal factors that have been previously identified as contributing to risk (e.g. increased substance use)
- increase or changes in the family's concern for the young person.

Risk to others

Risk assessment should also include the assessment of risk to others, both specific persons (family, friends, neighbours, clinicians) and to the general community. Although the likelihood that this risk will occur is relatively small, the impact on the young person, the victim, their families, the community and others is significant.[38] Psychotic symptoms, personality disorders (particularly anti-social personality), substance abuse as well as demographic factors have all been shown to have a relationship with increased violence risk.[38-40] Risk factors such as diagnosis of a psychotic illness, male gender, alcohol abuse, drug misuse, unemployment, non-adherence to treatment, poor impulse control and poor insight were associated with higher risk of aggression in young people with first episode psychosis.[40,41] It may be helpful for clinicians to conceptualise risk of harm or violence towards others as either affective aggression or predatory aggression; where affective aggression occurs in response to perceived threat, and predatory aggression is planned, purposeful and goal directed.[42] Factors that may increase the likelihood of aggression and violence include:[42]

- past history of aggression or violence
- substance misuse
- diagnosis of a psychotic disorder
- diagnosis of a mood disorder
- cognitive impairment
- personality traits/disorder (conduct disorder and anti-social personality).

Risk to others remains difficult to accurately assess, and where there is high risk, the assessment, formulation and management plan should be discussed in the wider multi-disciplinary team and with the consultant psychiatrist. The team may also consider using standardised structured risk assessment tools such as the HCR-20[43]or the SAVRY[44] to inform clinical risk assessment.[45] These tools should be used to complement a comprehensive clinical risk assessment and not as a standalone assessment due to the inherent limitations of using these tools exclusively.[42] Clinicians and services need to be aware that these tools require specific training in order to be administered, and additionally some caution should be applied when communicating this kind of information with other agencies or providers. In addition, services should utilise specialist tertiary or consultative forensic services where there may be identified high risk to others. These services may assist in assessing complex high risk and developing comprehensive management plans.

Risk from others and non-adherence/disengagement

The clinical team also need to assess risks to the young person that may be perpetrated by others and the risk of non-adherence to treatment or disengagement from services. With regards to risks from others, clinicians should consider whether the young person is putting themselves in situations where they may be vulnerable (either intentionally or unintentionally) or whether they may be exposed to risk (especially violence or victimisation) due to the kinds of activities they engage in or environments that they might encounter. There is some evidence to support that the risk of victimisation is higher than the risk of violence perpetration in people with psychosis.[40] Young people may also be at risk of victimisation or exploitation, particularly if they are younger in age, have active psychotic symptoms, cognitive impairment or impaired judgement (for example due to substance use), with limited supports.

Disengagement and adherence should also be assessed routinely as part of risk assessment. Attitudes towards treatment and medication, insight, judgement and family support may have implications for assessing this kind of risk. In any case, this should occur in discussion with the multidisciplinary team.

Framework for risk assessment

As previously stated, clinical risk assessment should include:

- Risk to self:
  - includes risk of self-harm and suicide
  - includes intentional and non-intentional harm
  - includes physical and non-physical harm (risk to reputation, psychological risk e.g. due to disinhibition).

- Risk to others:
  - includes aggression, violence and homicide
  - includes threats of harm, verbal and physical aggression
  - includes general risk to others (e.g. driving while acutely unwell).
- Risk from others:
  - victimisation, neglect and vulnerability
  - environmental risks (includes homelessness, substance use, non-violent offending).
- Risk of non-adherence and disengagement:
  - risk of treatment non-adherence
  - risk of absconding and disengagement
  - risk of delayed recovery/treatment resistance/chronicity.

For each of these domains, the clinician might consider the assessment in terms of static factors and dynamic factors associated with risk. An assessment of risk factors is usually identified through a thorough interview, clinical notes and gathering collateral information.[46] **Static risk factors** are usually historical and by their nature not amenable to change, however are useful to identify due to their relationship with potential risk. This should also include the young person's point of view on any past incidents, and will aid in the clinician obtaining information about the client's awareness of the triggers and appraisal of the incident and attitude towards future risks.[46]

Risk factors that may be included under this heading might include:

- previous ideation (harm to self or others)
- previous attempts (harm to self or others)
- family history
- personality disorder
- past life experiences
- previous history of trauma
- cognitive impairment
- past experiences of services/help-seeking.

Dynamic risk factors are those which are contextual and potentially modifiable, and are usually the target of risk management plans. These include mental state and insight (particularly affective symptoms), substance use, impulsivity, recent loss, treatment adherence and stress, among others.[46] Dynamic risk factors are usually individualised, and are best integrated into a formulation of risk. Newly referred young people who are difficult to engage, should be regarded as high risk (especially for harm to self) until the clinician or team have gathered enough information to demonstrate otherwise. A team approach to risk assessment and management is advised in such cases.

Where the clinician needs to assess risk of harm to self or others specifically, the assessment should take into account:

- The presence of thoughts of harm to self or others (frequency, duration and associated distress).
- Intent: does the young person want to act on the thoughts, how do they feel about dying?
- Plans: what plans or preparation have they thought about or acted on?
- Choice of method and setting (lethality of method, effectiveness, reversibility).
- Protective factors (supports and resources, help-seeking).

Formulation and risk management

Ideally, a risk assessment and risk management plan should be developed collaboratively with the young person, their family and other agencies involved as part of the initial assessment.[34] This risk assessment and management plan should be documented in the young person's clinical file and communicated to relevant parties. Risk should be assessed and documented at each review, and the management plan updated and communicated to the treating team if risk changes.[34] The information gathered during a risk assessment can be written as a formulation, that explains the relationships between static and dynamic risk factors, mental health and level of risk.[38] This will enable the development of specific and targeted interventions to address modifiable risk factors. Effective risk management not only relies on good assessment and formulation, but also on clear and consistent documentation, that is easily accessible by all clinicians and teams in the service. Good documentation is important to articulate decisions made by the clinical team and should be incorporated into the broader risk management plan.

The young person, their family and the treating team should ideally agree on a plan to manage the risk, which would also include 'contingencies' if the young person's risk changes between reviews or the management plan is not working.[34] It is also important for the young person and family to be clear about what to do and who/how to contact should this occur. The treating team should also incorporate the views and suggestions of the young person and family about what has been helpful or worked in the past.[47] The risk management plan should clearly outline what to do to support the young person, the role of the family or significant others, and the role of the clinical team. Psychological and behavioural strategies may be used in addition to increased support from the treating team to mitigate risk; however, hospital admission may be necessary for short term containment of risk. For further information please see 'Suicide prevention in first-episode psychosis' in *The recognition and management of early psychosis: a preventive approach.*

CASE SCENARIO **MICHAEL**

Michael is a 21-year-old young man living at home with his mother, father and two younger siblings.

Michael presented with symptoms consistent with FEP and had already experienced two acute episodes with remission of symptoms and good recovery in between episodes and following the second episode. He attended the service for regular case management appointments where he and the clinician discussed goals and plans. Michael's mental state did not appear different to the clinician, however she noted that he was more passive in his interaction and his concentration was poorer. The clinician said to Michael what she had observed in the session by saying to him 'Today you look a little different Michael, is there is something on your mind or something is bothering you? Do you want to talk about it?' Michael replied that he had been having 'bad thoughts'. Upon further questioning, Michael disclosed that he had been experiencing intrusive, distressing thoughts about harming his parents by stabbing them with a kitchen knife. Michael described these thoughts as not belonging to him (ego-dystonic), however he was unsure about whether he could control himself not to act on the thoughts. He reported that the thoughts had occurred twice in the past two days and that each time he was at home alone and just waited for them to pass by watching TV. He said that he didn't contact his case manager because he was 'afraid of getting in trouble with the police'.

Michael and his case manager discussed strategies that he might be able to use if the intrusive thoughts continued to occur. Michael could not identify anything that he had done previously that was helpful. The case manager did remember that previously when Michael had experienced suicidal thoughts, doing an activity that required some concentration such as playing cards with his Dad was helped him by for distracting him and lessening the distress he experienced. The case manager arranged a short review with the treating doctor who suggested adding some as required medication that Michael could use to ease his distress if the thoughts reoccurred. The case manager also liaised with the after-hours support clinicians (Mobile Assessment and Treatment Team) who agreed to visit Michael later in the evening, to check-in about how the plan was going, to discuss the situation with his parents and to provide additional support required. Michael agreed to attend an appointment with his doctor and case manager the following day to discuss how the plan had gone and to review need for additional support.

Michael's parents had been involved in his treatment throughout his participation with the early psychosis service and with Michael's permission were invited to join the session. The case manager further explained the risks, what Michael had discussed and the plan that they had made together. The case manager continued with the plan that the early psychosis crisis outreach team had suggested the previous night that Michael and his parents might feel safer if they could remove any knives in the house and lock them away in a cupboard or drawer where Michael could not access them. Both Michael and his parents had been agreeable to this. Michael's parents agreed to bring him back to the office for another appointment the following day, and they were all reminded to call the crisis outreach team if they had any concerns or if they felt things weren't going well. The team would then be able to home visit to assess the risk again and develop strategies to assist Michael and his family.

Case scenario continues over page

CASE SCENARIO **MICHAEL** (CONTINUED)

Discussion

In this instance, Michael's risk was assessed on a background of his previous history of risk (nil previous history in terms of harm to others), the current risks (ideation, plans, intent, means and lethality), and the potential for future risks (acting on thoughts and awareness of consequences). The treating team were able to develop a management plan that reduced the risk by increasing level of support, removing potential weapons, increasing the level of monitoring and developing contingencies if the plan was not working. Furthermore, Michael and his family were engaged, supported and empowered in the process of developing a plan, modelling future treatment planning. In this case, Michael was admitted to hospital a day later when the risk increased, and he and his parents were no longer able to manage at home. Even though Michael was admitted to hospital, the process with the treating team was empowering for Michael and his family.

Key points

- Thorough risk assessment
- Safety plan and contingencies
- Hospital admission delayed
- Empowering even in failure (Michael and his family had given it a go)
- Michael and his family were engaged and empowered in the process
- Modelling future treatment planning (collaborative and young person centred with family sensitive)

Medical screening during assessment

Please note: unless otherwise stated, the following section is drawn largely from the *Australian Clinical Guidelines for Early Psychosis* (2010).[3] Another recommended reference is Lambert (2009) 'Initial assessment and initial pharmacological treatment in the acute phase.'[15]

A full medical evaluation of the young person that includes physical, laboratory and medical assessments should be performed. This could help identify other medical comorbidities, risk factors for treatment resistance or other medical disorders, and establish a baseline to measure pharmacological complications or adverse events. Psychosis may not be pathognomonic of schizophrenia and may in fact be a symptom of wide array of psychiatric, neurologic and general medical conditions. The most common secondary causes for psychoses include epilepsy; primary infectious, demyelinating, metabolic and degenerative conditions of the central nervous system; and autoimmune, endocrine and metabolic disorders that have a secondary impact on the central nervous system. Such conditions may present with psychiatric manifestations before frank neurological syndromes manifest. Hence, even if the index of suspicion is low, a thorough physical evaluation is necessary for all young people presenting with psychotic symptoms. A medical evaluation is also important to assess the relationship between psychosis, drugs and alcohol. Apart from a history of drug use, a physical

examination may reveal signs of recent drug use (such as pinpoint pupils associated with opiate use, piloerection or gooseflesh during opiate withdrawal). Blood or breath alcohol assessments may help indicate recent intoxication among young people who present with confusion, drowsiness or are unable to cooperate in emergency settings. An assessment of comorbid alcohol use may also guide future therapeutic interventions among young people. Stimulants and cannabis are particularly associated with psychosis and all evaluations for psychosis should include an assessment of recent use of these drugs. Urine tests for suspected drugs of abuse may be useful if there is a concern about minimising of drug use. It should be noted that drug use is often a source of conflict with parents or other family members and thus information about their use may not be easily divulged. Initial enquiry and disclosure of results may need to be conducted with respect for young people's privacy due to the potential impact of such information on their family relationships and the therapeutic alliance. However, clinicians must also not shy away from questions about drug use due to their prevalence, potential impact on mental and physical health as well as the relationship with psychosis.

In the era of atypical antipsychotics and associated metabolic complications, a baseline metabolic evaluation has become one of the most significant tasks during the medical assessment of young persons with psychosis. Antipsychotics such as clozapine, olanzapine, risperidone and quetiapine commonly cause significant weight gain, especially in the first few months of antipsychotic medication initiation. Hence, an examination of height, weight, waist circumference, body mass index and metabolic parameters at baseline is essential at the earliest point at which this examination becomes feasible and should occur before antipsychotic commencement in most instances. A history of diabetes, hypertension, obesity or heart disease among young persons or their family members will also be helpful in assessing the future risk for weight gain and its attendant complications. During the initial blood investigations, it is also useful to request liver functions, kidney functions and serum prolactin levels as these may be affected by prescribed medications. Serum prolactin levels are often raised with antipsychotics that have a higher degree of D2 blockade and are associated with sexual and menstrual side effects. Even with atypical antipsychotics, those with a higher risk of D2 blockade, there is also a risk of movement disorders such as tremors, rigidity, bradykinesia, tardive dyskinesia, dystonia and akathisia. Unfortunately some persons with schizophrenia may have 'spontaneous' dyskinesias even without the use of antipsychotics. A baseline medical evaluation can identify such neurological abnormalities and guide the use of antipsychotics among these young persons. For further information please see the ENSP manuals *Medical management in early psychosis: a guide for medical practitioners* and the *Medical interventions in early psychosis: a practical guide for early psychosis clinicians*.

It is important to remember that young people may be anxious and suspicious of physical examinations and investigations especially if this is their first experience of a medical procedure. Clinical staff members should carefully explain the procedures involved in physical or other assessments to the young people and their families.[24] Recommended biological assessments are presented in the table over the page.

TABLE 4. **RECOMMENDATIONS FOR PHYSICAL, LABORATORY AND MEDICAL ASSESSMENTS IN YOUNG PEOPLE WITH FIRST EPISODE PSYCHOSIS**

RECOMMENDED BEFORE STARTING ANTIPSYCHOTIC MEDICATION	
History	Medical history including allergies Family history including that of heart disease, obesity, diabetes Neurological signs and symptoms suggestive of head injury, epilepsy or other disorders suspected in specific situations
Physical examination	Blood pressure, pulse, temperature Height, weight, body mass index (BMI)
Laboratory tests	Full blood examination, ESR, fasting blood glucose, fasting lipids, urea, creatinine, electrolytes, liver function tests, thyroid function tests Urine drug screen, urine microscopy Urine pregnancy test (among women)
As early as possible:	Magnetic resonance imaging (MRI) or computerized tomography (CT) scan
If there is a suspicion of neurological or medical issues, consider	Electroencephalogram Urine porphyrins, serum ceruloplasmin HIV, hepatitis screen, syphilis screen Autoantibody screens, especially among women in the reproductive age Nutritional indices (Vitamin B12, folate, iron) Serum calcium phosphate

A CT scan of the brain is recommended but it is preferable to wait until the psychosis has settled and the young person is able to tolerate with the procedure. Urgent CT and MRI scans are recommended when there is a strong indication of an organic cause for the psychosis.[24]

Common markers of underlying organic causes may be:

1. Atypical symptoms such as florid visual hallucinations, delusional misidentification, delusional parasitosis.
2. Confusion, disorientation or delirium.
3. Fluctuating symptoms or brief recurrent symptoms in discrete episodes.
4. History of thyroid, nutritional, autoimmune conditions, head trauma, epilepsy.
5. History of seizures may sometimes be missed, especially if epilepsy is of adolescent onset. In these cases, episodes of fainting, staring, nocturnal bedwetting of recent onset or movements or abnormal behaviour at night may be indicative of possible seizure activity.
6. Hallucinations that occur at sleep onset or at awakening may be indicative of narcolepsy.

Only about 3% of young people with FEP have a demonstrable organic cause for their illness. Hence a thorough history and physical examination may point towards potential causes of secondary psychosis and can guide the use of certain investigations. It is important to remember that if these investigations are missed in the initial evaluation phase they may not be conducted in the course of the patient's illness course.

Alcohol and other drugs

The National Drug Strategy Household Survey, conducted in 2010 by the Australian Institute of Health and Welfare, reported that approximately 28% and 25% of 20–29 and 15–19 year olds, respectively, used illicit drugs in the previous 12 months. Furthermore, the National Survey of Health and Wellbeing, conducted by the Australian Bureau of Statistics, reported that substance-use disorders were ranked as the second most common mental health issue for young people in 2007 with approximately 30% of 12–24 year olds displaying high-risk drinking behaviour and 11% being daily tobacco smokers. The rates of alcohol and drug misuse tend increase from adolescence into early adulthood, therefore, targeted treatment and care that reduces the risk of substance misuse in young people should be provided.[1,48] It has been reported that young people who experience mental health issues are up to five times more likely to misuse substances compared to young people without mental illness.[49] Therefore, screening for alcohol and substance misuse is essential in young people regardless of their presentation. Substance misuse is common in young people with FEP and is several times higher in this population group than the rest of the population. Approximately 60–70% of young people with FEP report substance misuse at some stage in their life prior to presentation with alcohol and cannabis being the most frequently misused substances.[50] A study that examined the prevalence of cannabis use disorder among 169 people with a FEP and 59 people at risk of psychosis found that 45% and 27% had a cannabis use disorder.[51] Standardised tools such as Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and Alcohol Use Disorders Identification Test (AUDIT) are important for use in this population as the burden of disease from substance misuse is substantial. It is recommended that early psychosis clinicians ask questions about what substance the young person is using and gather information about frequency of use and how use impacts the life of the young person. Assessment of substance misuse facilitates interventions to improve clinical outcomes. It is important to provide feedback on use during assessment (e.g. indications of severity of use). A dialogue around the young person's pattern of use is imperative regardless of their desire to address alcohol and other drugs issues. Information about substances and mental health should be readily available for young people and their families. Substance misuse should be conceptualised as part of the mental health assessment and formulation.

Psychosocial assessment

Assessment of premorbid functioning should be carried out using three domains: academic functioning, ability to live independently (depending on age of the young person) and social contacts.[15] Assessment in this phase should logically include all of the domains mentioned previously in addition to the domains mentioned above. The treating team should allow symptoms of psychosis to settle prior to assessing current level of functioning because psychotic symptoms will have a significant impact on functioning.

Assessment of premorbid and current functioning can include information from the young person, family or partners, school, TAFE or workplaces. This is important because it allows the clinician to understand how the psychosis has affected the young person's ability to engage in day-to-day activities and provides a baseline (premorbid) level of functioning to aim for in terms of intervention.

Social assessment of the young person's living and family situation should also take place. This will assist the clinician to understand what supports the young person currently has access to, and what further supports they might need. For example, do they live with their family? Who are the important people in their life? Where are they located? Are they available to help the young person? Does the young person get Centrelink allowance? It will help the clinician to target the most appropriate practical support and assistance for the young person and their family. A vocational assessment of the young person's work and/or school situation should be conducted; this needs to be done so that treating team can support the young person to stay connected with school or work, and minimise potential disruption of illness. A strengths-based approach to psychosocial assessment should be used to support recovery and maintain hope and optimism. Additionally, an assessment of the young person's strengths/resources and available supports needs to be performed so that the treating team can support the young person to stay connected with school or work, and minimise potential disruption caused by illness.

Comorbidities and grey areas

Clinicians need to be aware that a psychotic episode is likely to co-occur with other disorders. It can take multiple longitudinal assessment sessions to tease symptoms out of the history. Even experienced clinicians can sometimes find it difficult to determine whether the young person's symptoms are better accounted for by early psychosis or another condition such as borderline personality disorder, obsessive-compulsive disorder, post-traumatic stress disorder, mood disorder, or 'at risk mental state'.[52] In such disorders, psychotic symptoms may be present but may not predict the development of a psychotic disorder in the longer term.[53] In addition, psychotic symptoms may or may not be an indicator of the illness severity. For instance, psychotic symptoms in depression may indicate a severe depressive episode, however in other cases (such as for borderline personality disorder) some research has shown that psychotic symptoms (hallucinations and delusions) can be transient or may persist over time, and may not be related to the severity of the condition.[53] The way that a young person describes their symptoms may be similar across disorders; however, there may be some qualitative differences in terms of how these symptoms are experienced. It is difficult to determine during early stages what is what, due to ambiguity of symptoms (especially if the condition is emerging), the complexities of developmental stage and underlying personality traits.

Another alternative may be that the young person is presenting with early psychosis in addition to a comorbid condition such as those named above. In any case, it is important to gather enough information about the quality and course, as well as the frequency and duration of the symptoms experienced to gain a thorough assessment and develop a comprehensive formulation. Understanding the phenomenology of the experience will help to determine whether the psychosis is occurring in the context of another disorder or not.

Where there is uncertainty about the young person's condition, it is useful to better understand the quality of the psychotic experience. In addition to asking the young person broadly about the nature, frequency and duration of the symptoms, you may consider asking the young person to describe:

- their emotional state when psychotic experiences occur – happy, sad, angry, frightened, elated, confused
- the circumstances when they were first experienced – what was happening around that time
- triggers – may be emotional, physical/environmental, stress-related
- the influence on behaviour – how does the experience influence the young person's behaviour? How does the young person react?
- their relationship with the experience – how does it make them feel, can they control the experience, can they ignore it?
- coping strategies – what do you do when you have the experience? How do you deal with the experience?

Adapted from Romme and Escher *Making sense of voices*.
London: Mind Publications 2000.

This can also be applied to other psychotic experiences such as paranoia, ideas of reference or passivity phenomena. The 'funnelling technique' described earlier in the section 'The interview process' may also be useful for teasing apart symptoms to work out whether they relate to psychosis or another disorder (e.g. paranoia from social anxiety symptoms).

Clinicians may also need to consider whether the symptoms reported serve a function for the young person. This can take two forms: the function as perceived by the young person, and as assessed by the clinician. The young person may perceive their symptoms to be protective or threatening for instance, (in the case of delusions or hallucinations) and may prevent or enable them to do things. The clinician on the other hand, may assess that the young person's symptoms might be an effective way of them eliciting care or help. For example, when reporting symptoms that are very distressing or risky, this may elicit a desirable caring response from the clinician or service. This may not necessarily mean that the young person's report is not truthful, however it will impact on the types of interventions that are most suitable.

The types of detailed questions that are needed to clarify grey areas are best undertaken over multiple sessions. Clinicians need to remember that they must prioritise the young person's engagement alongside assessment, so these questions need to be asked sensitively and carefully. Additionally, it is important not to dismiss or make assumptions about symptoms or rush into a diagnosis.

Recommendations

- Where there are psychotic symptoms present, the young person should be accepted to the early psychosis service for ongoing assessment and initial management.
- Clinicians should use the supports available to them through the multi-disciplinary team, particularly consultant psychiatrist, to discuss and review assessment outcomes and diagnosis.
- A review by the consultant psychiatrist should be prioritised.
- A primary 'working' diagnosis may be applied initially with an agreement within the team about what to prioritise during further assessment.
- Differential diagnoses should always be kept in mind (and documented) but are especially important when the initial picture is unclear.
- The CAARMS can be used to determine psychosis threshold even where there may be questions about the nature of symptoms.
- A formulation-based approach to treatment should always be used, regardless of diagnostic uncertainty.

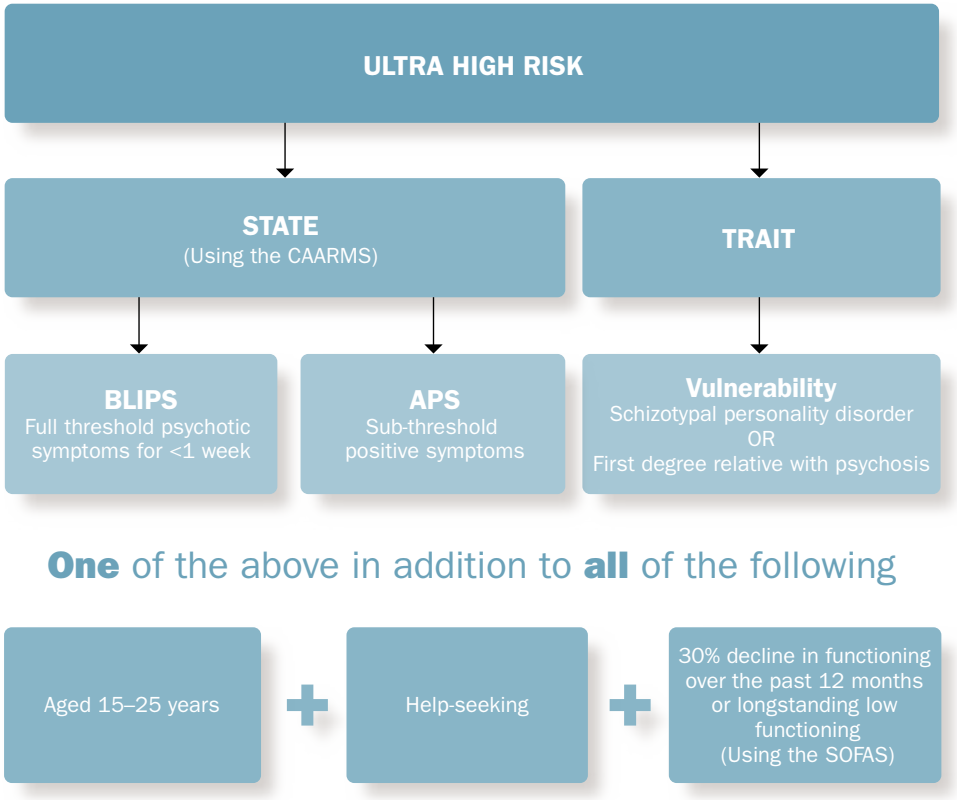
CASE SCENARIO **ANDREW**

A young man, named Andrew, was referred for assessment at the early psychosis service for 'possible psychosis'. He had a long history of being involved in gang-related activities, selling drugs and using substances himself. Over the few months, he noticed that he had been feeling 'not quite right'. He reported feeling that he was probably under police surveillance and was convinced that there may be undercover police trying to entrap him. He experienced a significant assault 6 months earlier where he was bashed by six members of an opposing gang in a nightclub that left him with serious injuries and resulted in hospital admission. He reported that he felt more 'on-edge' and had begun to feel as though people were watching him when he was out in the community. He had also been using amphetamines more frequently to keep himself alert and started carrying a knife to protect himself.

Discussion

In this example, the young man is presenting with a number of symptoms that might fit a diagnosis of post-traumatic stress disorder, psychosis or 'at risk mental state' and complicated by ongoing substance abuse. The clinician's task is to carefully ask questions about each aspect of the young man's report to understand the qualitative experience and the meaning of what the young man is saying. In this example, it would be wise for the clinician to ask the young person about police surveillance by asking questions about why he would be under watch, who is watching him, how this is being done, where it is happening etc? Furthermore, asking questions about his 'on-edge' feelings, the clinician should try to discern what this feeling is like, how long it has been occurring, when it happens, where it occurs, who might harm him (particular people or more general). In this case, it is also important to investigate whether the young person has reported is based in reality. It is important to note that even pursuing these lines of questioning may not give enough clarity around the clinical picture. In such cases, a Comprehensive Assessment of At Risk Mental States (CAARMS) can be used to assess whether the young person meets criteria for UHR or psychosis and to determine the need for further assessment or treatment. (See also The CAARMS: assessing young people at ultra high risk of psychosis.)

FIGURE 3. **ULTRA HIGH RISK CRITERIA**



Biopsychosocial assessment for formulation and treatment

Comprehensive overview

It is important at this stage to help the young person formulate their personal experience of symptoms. By helping young people develop an understanding of their illness in a way that is likely to engage to treatment and further assessment. This is also the first opportunity that treating clinicians have to inform the young person's explanatory model to facilitate hope and optimism for recovery.

Clinical or aetiological case formulation

An aetiological case formulation is a process of collating information that has been gathered during the assessment process. It is an attempt to synthesise information across the biological, psychological and social domains and provides a cohesive narrative about what may have led to symptoms and difficulties that the young person presents with. Generally, case formulation offers hypotheses about factors that may have led to, or which maintain, the presenting problems. Furthermore, it provides an opportunity to include a discussion of the young person's strengths and protective factors that may ameliorate the impact of mental health problems.[54,55]

Why use case formulation?

The use of a psychiatric diagnosis when working with young people who are experiencing psychotic symptoms is fraught with potential challenges. It is essential to remain tolerant of diagnostic uncertainty when working with young people who are either at risk of a first episode or psychosis, or who have already begun to experience frank psychotic symptoms. At this stage, applying a diagnosis is provisional, the diagnosis is revised a number of times through a process of ongoing assessment. It is important to have a clear idea of the provisional and differential diagnoses for young people from a clinical and medico-legal perspective. However, a diagnosis alone is often not clinically useful in determining what interventions are going to beneficial for the young person, and in what order. Additionally, there are likely to be co-morbidities such as anxiety, depression or substance use with this population that can lead to an overwhelming number of issues to prioritise.

The primary reason for using case formulation in conjunction with provisional diagnosis is to provide clarity around how best help a young person and to guide treatment interventions. The use of case formulation to conceptualise presenting difficulties using a stress–vulnerability framework provides a way of balancing these priorities. It emphasises the importance of understanding the young person's explanatory model about their presenting symptoms and allows us to consider a number of working hypotheses about the likely aetiology of symptoms.[56] Case formulation provides a rationale for treatment and specific targets for intervention, both for clinicians, the treating team and most importantly for the young person, their family or significant others. The benefits of using this model are that it can be applied in a flexible manner to the wide array of presentations and that it allows for an individualised treatment approach that is non-stigmatising and optimistic.[57]

Case formulation should be considered a collaborative process, where the young person and clinician come to a shared understanding or explanatory model about the presenting problem. This process allows the young person to be actively engaged with their treatment and is likely to lead to a more comprehensive understanding of relevant factors that may impact successful outcomes.[55]
The content of the case formulation may be revised regularly as new information becomes available. Therefore, the depth and content of the case formulation following the initial assessment will be different to that written once the young person has been seen for a long period of time.

Core elements of a case formulation

There are a number of different methods for clinical case formulation that vary according to the structure or theoretical background that is emphasised. The model below is consistent with an emphasis on the stress–vulnerability model. The core elements of this model are known as the '5Ps' and a description of each is outlined in table below.

TABLE 5. **THE '5PS' OF CASE FORMULATION**

THE '5PS' OF CASE FORMULATION		
Presenting	Initial signs, symptoms or other issues that are clinically important for the young person	For example, paranoia, low mood, homelessness
Predisposing	Factors that infer vulnerability or increase the risk for the presenting problems	For example, early childhood trauma, family history of psychotic disorder
Precipitating	Personal or circumstantial stressors or triggers that are associated with the onset of the presenting problems	For example, relationship break-up, began using cannabis, bullying
Perpetuating	Factors that maintain or exacerbate the severity of the presenting problems	For example, regular substance use, interpersonal problems, poor social support
Protective	Personal or circumstantial factors that buffer or ameliorate the impact of the presenting problems	For example, previous success at school, supportive family, good coping skills

One method of transforming the information collected about the young person's history into a diagrammatic form using the case example of Tim can be seen in Appendix 3. The grid format allows a clinician to quickly categorise information and to inform where information may be missing that requires further assessment.

It can also be a useful tool for discussing treatment goals and interventions with a young person, although there should be careful consideration about if, when and how this information is discussed. For more information about how to use case formulation please see the ENSP online module *Introduction to case formulation for early psychosis clinicians*.

Generally the case formulation is then summarised in a narrative or written synopsis for communication with members of the treating team about the young person at this point in time. An example of a written summary for the case example of Tim can be found in Appendix 4.

Assessment in the acute phase

Aims of assessment in the acute phase

The *Australian Clinical Guidelines for Early Psychosis 2nd Edition* describes the acute period as 'the presence of psychotic features such as delusions, hallucinations and formal thought disorder' that may occur 'with comorbid conditions of depression, obsessive-compulsive disorder, post-traumatic stress disorder, anxiety disorders or substance use difficulties.'[3]

Safely and effectively assessing young people in an acute psychotic state may be difficult or impossible until they are relaxed and calm. Ideally, an assessment would take place before any antipsychotic medication is administered. An antipsychotic-free period allows mental health professionals to make repeated assessment of the mental state, collect more clinical information and conduct routine medical examinations; this period is valuable when organic causes of psychosis are suspected and further investigation is required.[24]

Assessment in the non-acute phase

Aims of assessment in the non-acute phase

The non-acute/early recovery stage is defined as a period of 2 years where there is a remission of symptoms, the young person has returned to work or school, the young person is able to manage their own day-to-day needs and/or is participating in recreational activities and peer relationships.[58] Assessment in this phase will focus more on functional goals and tasks, and using assessment to support intervention for these areas. While late/incomplete recovery is defined by the persistence of positive symptoms and focuses on behaviour, function, suicidality and ability to work; other factors include ongoing negative symptoms, depression and anxiety, social and cognitive deficits.[3] These also require ongoing assessment and monitoring so that interventions can be targeted effectively.

Crisis assessment

'Crisis' refers to situations that are broader than simply risk to self or others. A crisis occurs when the systems that support a young person break down or the young person experiences stress or distress that profoundly impacts on their functioning and ability or exceeds their capacity to cope.

A 'crisis' can be experienced subjectively, in terms of the young person and their family, and/or identified objectively by the clinician. In subjective terms, the young person may not feel like they are coping with stress or able to continue coping in the current situation even though the clinician may objectively assess that the young person and family are doing well despite their circumstances. In these kinds of crises, it is important to pay attention to the young person's (and family's) experience of the crisis in order to be able to work effectively with them. The clinician may also see the crisis in objective terms, which the young person and their family may or may not necessarily agree with. For instance, a young man presents with acute psychotic symptoms and acute high risk to self (objectively) however his insight is impaired and he does not see any need to engage in treatment. Both the subjective experience and objective assessment of crisis are a valid reason for a response and intervention from the clinical team.

An assessment during a psychiatric crisis aims to return the person to as stable state as possible in terms of their mental state, functioning and ability to cope.

This may include containing them through physical or psychological means or removing high levels of stimulus (admission to hospital/talking to them/use of sedation). Threshold for crisis assessment should not be so high that it prevents the young person and their family from being able to access support from the early psychosis service. Often a 'crisis' needs to be substantial before young people are able to access help from traditional mental health services. Intervening earlier can prevent a crisis from worsening and ameliorate the crisis sooner which is consistent with the aims of an early psychosis service.

Initial assessment in crisis

It is important to be more cautious during initial presentation because very little is known about the young person. Clinicians should apply caution if assessing a young person for the first time in crisis. Often clinicians may need to err on the side of caution and work conservatively in high risk situations until sufficient information can be gathered.

Clinicians need to consider that a naive young person will not be acculturated to the assessment process and plan for this accordingly.

Aims and location

Aims

The first aim of an assessment during a crisis is to understand what is happening in terms of the young person's perspective on their situation, and the clinician's assessment of the situation. Additionally, clinicians should aim to make an assessment of;

- Risk and safety:
  - Comprehensive assessment of risk to determine acute and chronic risks to self, others, vulnerability or exploitation.
- Mental state:
  - Establish the nature and kinds of symptoms the young person is experiencing and whether there is an increase in symptoms; this will also inform the risk assessment.
- Available supports and resources:
  - Personal resources of the young person and their ability to cope, family and other supports and external resources.
  - Need for increased support from the service or hospital admission.

Other aims of a crisis assessment are to establish whether the young person is experiencing psychotic symptoms and to determine the context of the 'crisis' situation. The current risks to the physical and emotional safety of the young person and others should also be thoroughly assessed. Furthermore, the safety needs of the young person and the family should be established. Once this has occurred, the clinician or treating team can work with the young person and family to establish the kind of support or assistance that will help to ameliorate the crisis. The principle of 'least restrictive treatment' should be upheld during this assessment, and young people and their families should be encouraged and supported to use the supports and resources they have available to them.

Crisis assessment provides an opportunity to build engagement with the young person and their family. In some situations, clinicians may find themselves proving the value of the therapeutic or service relationship, and the relationship being tested by the young person. The clinician needs to balance risks with an opportunity for the young person to develop coping skills. Over time, it may be undermining for a young person to feel that they are unable to cope with a particularly stressful situation, and it is therapeutic for them to learn how to cope and feel empowered in crisis situations with support from the treating team. In these situations, it is especially important to have a thorough risk assessment, formulation and plan that all parties can agree and adhere to. However, where the level of risk is unclear or doubtful, clinicians need to err on the side of caution and make more conservative decisions about management.

Location

Ideally, crisis assessment should occur in a location that is both safe and comfortable for the young person, their families and the clinicians involved.

In a practical sense it is important to consider the accessibility to weapons or objects that can be used as weapons when conducting an assessment during a crisis. For example, don't interview people in the kitchen, where there is easy

access to knives. Other risks to accidental harm to self or others such as proximity to roads, train lines, falling from a balcony etc. also need to be carefully considered during this time. The safety of other people (family, friends, housemates, police or other professionals) needs to be considered when conducting the assessment. Additionally, the risks to family members who may be blamed for calling services need to be examined when assessing young people during a crisis. It is important to consider whether the young person has the ability to leave the location of the crisis assessment. It is also recommended that a course of action is determined if it is decided that it is safe/unsafe for a young person to leave the location of the assessment as early as is practical.

Feedback from assessment

It is important to provide feedback to young people and their families from assessments. Generally, this will include providing information to the young person and significant others about the type of assistance that is available for their problems/concerns, making another appointment for further assessment or to begin treatment, or linking the young person with other follow up options. The type and depth of information provided at the end of an initial assessment interview will depend upon the young person's mental state at the time, the severity of symptoms, level of insight and judgement the young person has and their capacity to understand the information that is being given. The clinician needs to assess these factors before providing feedback as this might impact on whether the young person continues to engage with the service. For example, if a young person is presenting with intense delusional beliefs and does not appear to have any insight into their symptoms then telling the young person that some of their beliefs may be related to a psychotic episode could be unhelpful for their future engagement with the service. It may be better to provide more general information to the young person about how the service can assist them with their particular concerns such as their level of stress, concentration or sleep difficulties, or school or work issues. These will be determined on a case by case basis but should have been uncovered during the assessment process.

Clinicians need to consider 'what is the purpose of providing information/feedback from the assessment?' It is important to consider who is appropriate to share information with (for instance other health providers), and considering how much or what information is relevant. To some extent this will be guided by relevant legislation, but also the question of what does the person 'need to know'? For example, other medical practitioners/specialists should be informed of medications that are prescribed (and updated if these are changed) so that they can prescribe accordingly. In addition, it is often good practice to provide information about assessment, diagnosis and treatment in a written report if possible. In addition, it is often sensible to send copies of any medical investigations that the young person has done through the early psychosis service (e.g. copies of bloods/CT) to a GP or paediatrician (or other specialists), especially if ongoing monitoring or follow up might be required. This will minimise the replication of testing. Young people should always be informed what information is being shared and why. Most young people will understand and agree if given the information.

In terms of what is shared with schools, workplaces or other supports this needs to be assessed on a case-by-case basis, and best practice suggests to include the young person (and their family if appropriate) in making these decisions. Often providing the school with some general information about psychosis can initiate a discussion as to how the school can support the young person to continue with their studies. Some agencies may require information on risk, how this is provided needs to be discussed with the young person, and assessed by the clinician as to the urgency and relevance.

For example, Child Protection may insist they need a full report on the young person's mental state, diagnosis, risk and treatment because they are already involved with the family and feel that there is a risk to the younger members of the household. A clinical team may decide only to provide brief information about the young person's risk to others, and agree to notify the agency if that risk changes.

Limitations of assessment

The initial stages of early psychosis can be vague and fluid. Although young people can present with acute symptoms of psychosis, it is also common for young people to be referred with vague and undifferentiated and evolving symptoms. Assessments are only a cross-sectional examination of a young person's mental state and circumstances. To understand a longitudinal picture, you need many assessments over time and it is part of the therapeutic process. It is important to recognise that assessments are just a snapshot at one point in time, that they are not set in stone and that things can change considerably for a young person over time. Clinicians should be prepared to be wrong, and to question what they know clinically. It is equally important to expect that change is the rule rather than the exception. In most circumstances, it is unlikely that the first assessment will be definitive or enough for a diagnosis.

Clinicians need to be comfortable with ambiguity and recognise the limitations of what they can gather in the first appointment.

They may need to prioritise what information they gather depending on illness, risk or engagement. For instance, clinicians may just need to assess safety and make a plan around that the first time they see a young person. Clinicians and treating teams should assume that there is always more information that needs to be gathered during assessments. It is also important to recognise what information is missing during or after an assessment. Good clinical good practice suggests that the assessing clinician needs to make notes/references for key bits of information that is missing in their assessment report. This will enable other clinicians in the team who may see the person to gather this information and is also a good way to prioritise what information needs to be gathered next. This approach fits in with the idea that an assessment is a 'work in progress' and almost never a static document. This approach is also useful when considering aetiological formulation.

Assessment and the service culture

Assessment and the service culture

There are four critical factors that contribute to successful establishment of any early psychosis service: service culture, leadership, governance and resources. These factors all impact on and improve direct clinical practice within the service, including assessment processes with young people and their families. This section will briefly describe the service culture factors that affect how assessment of a young person takes place within an early psychosis service.

Leaders of an early psychosis service influence the culture, philosophy and vision of an early psychosis service which in turn influences the nature of the attitudes and nature of the work. All staff are pivotal in promoting an empathetic and understanding approach to young people's recovery. This approach can begin at the first point of contact with a young person and their families and be embedded in the assessment process. Importantly, an early psychosis service must be easily accessible and offer a level of care, including practical assistance, to all young people who seek help for difficulties (see the box entitled 'Ease of access' on page 14).

Leaders of an early psychosis service need to be able to: see the opportunities available to them; support the early psychosis philosophy and to 'walk the walk'; be acknowledged as clinical experts; and inspire confidence and encourage others, while having a strong commitment to understanding the structures and tasks that need to be done within the resourcing framework. A clinical director needs to be a strong and caring leader and be able to inspire hope and confidence in the model to promote recovery for young people and their families.

It is important to have a multidisciplinary team of clinicians that have expert skills and knowledge in all areas of early psychosis and can conduct comprehensive biopsychosocial assessments as early and quickly as possible. Support and supervision for clinical staff are crucial. The clinical team should include some senior staff that can mentor and guide staff members that are less experienced in the area of early psychosis. Clinical staff should be able to engage and liaise with the young person and their families in a respectful manner while providing hope and optimism within a stage-based recovery framework. Please refer to the *EPPIC Model and Service Implementation*[2] for more details.

Staffing and resource considerations to support assessment

Staffing arrangements for assessment

There are a number of recommendations for staff configurations to support assessment in an early psychosis service.

Clinical experience has demonstrated that it is best to have two clinicians present during an initial assessment. These may be allied health professionals, nurses or doctors. When considering who will be involved in the assessment, it may be helpful to think about what the roles each clinician will be and to make sure this is clear prior to the assessment interview (e.g. whether one clinician needs to be a doctor so it is possible to assess suitability for particular medical treatment option). This enables both clinicians to work together to gain information. It may mean that one clinician speaks to the young person and the other speaks with family member(s) (this can be especially helpful during home visits), or one person may be responsible for attending to practical issues while the other is talking with the young person. In any case, the role of each clinician during the assessment should be made clear so they can work together effectively. For ongoing assessment, particularly in a service context (i.e. where the young person is being seen at the service) it is acceptable to have one treating clinician gathering information on their own.

Following initial assessment, further assessment should be conducted using a multidisciplinary team approach. Multidisciplinary assessment and team reviews can offer an excellent opportunity to discuss assessment utilising the specific skills and experience of doctors, nurses, occupational therapists, psychologists and social workers, as well as clinicians with varying levels of experience with particular areas of assessment. For example, one clinician in the team may hold particular expertise in substance use/dual diagnosis that would be useful when thinking about what information has been gained about a young person's substance use and what further information might be needed. This approach also enables clinicians to share their knowledge and expertise with the wider team, and encourages inter-disciplinary learning.

Given the complexity of presentation and uncertainty of diagnosis, which is often prevalent in early psychosis, developing a culture of acceptance and acknowledgement of each other's clinical uncertainty is a healthy concept. It encourages open clinical discussion to determine the most appropriate course of action that best meets the needs of the young person and their family.

Regular clinical review meetings where members of the multidisciplinary team have the opportunity to discuss clinical cases are important in the assessment process. This provides a good opportunity to review initial aetiological formulation and have input from other team members (including a consultant to provide clinical governance) with particular skills, experience and knowledge. Clinical review meetings offer a team-based approach that allows for discussion of assessment of mental state, risk and priorities for ongoing involvement.

Resources and practical considerations

The availability of material and other resources needs to be considered when conducting assessments. Clinicians should also have access to resources such as cars and phones to enable outreach appointments. Time is an important resource, as assessments can be lengthy, especially if it is an initial assessment and the clinician needs to focus on engaging the young person. There should not be a rush to 'complete' an assessment; however, at the same time a young person should not be made to wait for a 'complete' assessment before they receive access to a service.

Providing access to resources that support professional development related to assessment such as training and education, clinical supervision or research participation opportunities is important. This enhances the quality of care and fidelity to the model and also contributes to the retention of a sustainable workforce.

Having assessment, community treatment and crisis response operating within by one multidisciplinary team allows for an efficient and specialist response to manage acuity and risk that can help to prioritise workload. The team-based approach offers flexibility and responsiveness in terms of location and operating hours, and provides a mechanism for shared-clinical responsibility and duty of care.

Summary

The process of assessment with a young person and their family presents a unique challenge for clinicians working in early psychosis services. The influence of developmental stage combined with the ambiguity and fluidity of symptoms in early psychosis means that clinicians need to develop skills not only in assessing symptoms and mental state, but also in assessing risk, crisis and psychosocial functioning and recovery.

The initial assessment process also presents a unique opportunity: the opportunity to shape a young person's ongoing involvement with an early psychosis service, and through this, promote their recovery. Assessment is more than finding out about signs and symptoms; it can help clinicians understand the young person and family's experiences, influences the young person's engagement with a service, and allows an opportunity to intervene early with treatment to improve the longer-term symptomatic and functional recovery of young people with early psychosis.

This manual has described the principles, aims and key considerations of assessment in early psychosis. It is important for clinicians to develop their core skills in assessment, but also utilise training, supervision and support from senior clinicians and the service to continually build on their skills. Clinicians who perform assessments regularly will realise that each assessment is individual, requires individual techniques, skills and a degree of creativity when faced with specific challenges. Clinicians should also keep in mind the principles and overarching goals of the service, and work closely and collaboratively in partnership with local service providers to provide comprehensive and evidence based care to young people experiencing early psychosis.

Appendices

Appendix 1: Suggested risk questions to ask young people

Whenever asking questions about the past 'have you ever…' these should be followed up by asking about the present 'Do you feel like this now?' and if not identifying protective factors 'What keeps you from feeling this way at the moment?' When young people are being asked about risk for the first time, it can be helpful to preface these questions with a normalising statement, such as 'In the past when other young people have told me they feel down/depressed/angry/upset, they have also had thoughts about harming themselves/ending their life/dying. Is this something that has happened for you?'

Suicidality

Have you ever felt like hurting yourself?

Have you ever felt like taking your life?

What have you done in the past to hurt yourself? Or recently?

Have you ever considered suicide?

Do you feel like taking your life now?

Are you safe at the moment? What stops you from acting on these thoughts?

Do you need help to stay safe at the moment?

How do you feel about dying? (identifies ambivalence and passive suicidality)

Have you ever felt like life is not worth living?

Have you ever wished that you would go to sleep and not wake up?

Psychotic experiences

Voices or passivity (commands, or control, whether the person has agency or ability not to obey commands, what would happen if they did/didn't obey commands)

Paranoid delusions (believe that people are after them, they need to protect themselves, they need to escape)

Manic delusions (invincibility or special, superhuman powers)

Depressive delusions (guilt, nihilistic delusions or blame for events)

Risk to others

It is important to identify whether the person understands the outcome or consequences of their actions. Ego-dystonic and ego-syntonic concepts can be helpful here in understanding possible motivation for behaviour.

Do you ever feel angry at people?

Are you worried about your or someone else's safety?

Do you ever feel so angry you might hurt someone?

Are you worried about people enough to do something about it?

What would you do?

What would happen to you if you did hurt someone?

Again important to assess psychotic experiences for risk to others
(e.g. protecting others from harm, paranoia or invincibility)

Have you ever had any involvement with the police? If so, what was this for?

Vulnerability

Be aware of gender and cultural issues (same sex questioners may make some of these questions appropriate while opposing gender questioners may make these inappropriate and potentially traumatising). It is especially important to ask for collateral information as the young person's judgement and insight may be impaired or their symptoms may interfere with what they might normally consider to be uncomfortable (e.g. mania).

Has anyone approached you for money recently?

Have you ever felt that someone is taking advantage you your generosity?

Do people ever come to you when they need things?

What sort of things do they ask for?

Do you give them what they ask for?

Has anyone ever asked you to do something you weren't comfortable with?

Have you ever found yourself in a difficult position with someone asking for sex?

Have you done things recently that you wouldn't have done in the past?
(may not have understanding of the impact of action, judgement maybe impaired e.g. mood)*

Do you find yourself doing things without thinking about the consequences? (impulsivity)*

* It is imperative to ask for collateral information in these situations.

Risk of non-adherence/engagement to treatment

It is important to identify the young person's motivation to work with the treatment. It is important within the assessment process to help the young person develop a 'useful' explanatory model (useful in the sense that it allows treatment) For example,' I understand that you feel that what has been happening for you is due to... do you still think this is the case or have your views changed?'

What do you understand is happening for you at the moment?

When we talk about psychotic symptoms what do you understand this to mean?

When we talk about psychotic episode what do you understand this to be?

When we talk about a diagnosis what is your understanding about this diagnosis?

What do you think about the plan to help you?

Do you think the plan is helpful?

How do you think the plan could be improved for you?

Are you going to follow the plan?

If you changed your mind about following the plan what would you do?

Would you be able to let us know if you changed your mind?

Appendix 2: Example of an initial assessment

ASSESSMENT DETAILS	ATTACH LABEL OR RECORD PATIENT DETAILS
Who: _____ Date: _____ Time: _____ Place: _____ Program: _____	

Precipitants History of current Episode & treatment Change in behaviour Signs & symptoms • hallucinations • abnormal ideation • preoccupations • suicidal ideation • aggressive • homicidal thoughts • anxiety states • mood disturbance • sleep • appetite • substance abuse Other disability IDS/Physical Demographics	**PRESENTING PROBLEMS** (Clients perception of problem) Tim is a 22 year old young man of caucasian Australian background, living with his girlfriend in a rented flat in St Kilda. Tim was referred to the EPS by his justice worker. Over the two months, his worker had noted a change in his mood; he appeared low in his mood and more socially withdrawn. Tim was seen together with his girlfriend of four years. Tim stated that he was worried that there was 'a price on my head' and that people were after him. He had been released from prison two months earlier after serving a 12 month sentence for assault. Tim reported a history of anxiety and depression over the past 6 months, which he stated had worsened as his release date approached. He reported poor sleep and appetite and had lost approx 5kg's in the past month. Tim also reported paranoid ideation, ideas of reference and auditory hallucinations, changes in sleep and appetite and increased in substance (cannabis) use. Tim recently began experiencing suicidal ideation, which prompted him to seek help through his justice worker.
Major illnesses Surgical interventions Current medical Conditions	**MEDICAL HISTORY** Tim reported nil current medical issues. He had history of asthma as a child, however not currently on treatment for same. He reported on mild head injury (with short LOC), however did not receive treatment for same. No other illness or allergies reported.
Previous Illness Bruises/injuries Marks/deformities Development Build Nutrition Skin/hair Eyes Mouth Lymph nodes Thyroid Thorax/lungs Abdomen/pelvis Extremities Nervous system • Fundi • Cranial nerves Reflexes Tone Power Coordination Sensation Gait Speech Other findings Temperature Respiratory Rate BP Pulse rate / rhythm	**PHYSICAL EXAMINATION** Date of Last Physical Examination: Physically well built, healthy looking young man. Tattoos on both forearms and calves. Nil other physical marks. Apparently normal physical development. Physical exam NAD.

Name	Signature	Designation	Date

PSYCHIATRIC HISTORY

Reported a history of conduct problems as a child, nil treatment received. Often got into trouble at school and police involvement from age of 13. Reported that he started stealing and taking substances around this age.

Reported history of anxiety and depression "for as long as I can remember" – though no treatment.

FAMILY HISTORY

(Includes family history of mental illness, quality of relationships, current family issues, carer's perspective of presenting problem)

Father reportedly has history of schizophrenia and alcohol/substance abuse issues. Witnessed and experienced family violence up until age of 12 when his father left the family. Nil contact with his dad growing up, but recently had contact with his Dad via Facebook. He also reported that his mother has a history of depression and alcohol and heroin abuse. Nil contact with mother since prior to his most recent incarceration.

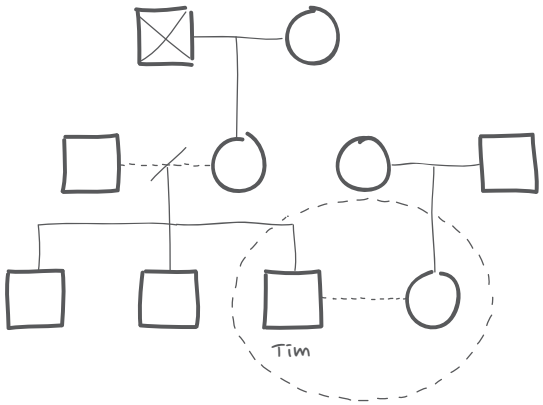
Two older brothers, both have history of substance abuse issues.

Tim has intermittent contact with his maternal grandmother, who has been his main support in recent times.

Genogram Key

- male
- female
- unknown
- married
- defacto
- separated
- divorce
- adoption
- or death

GENOGRAM



COMMENTS

Need further information about family relationships.

Name	Signature	Designation	Date

Early development
- Milestones
- Significant events
- Losses
- Difficulties

School

Academic performance

Social development

Friends at school

Local neighbourhood

Childhood interests

Hobbies

Current support network

Psychosexual development

Significant intimate relationships

Cultural issues
- Reason for migration
- Connection with community

Recreational interests

Capacity for independent living

Religious issues

PERSONAL HISTORY

Youngest of a sibship of three. Older brothers aged 29 and 31. Tim reported that his mother had said to him that he was an 'accident' – unplanned pregnancy. Tim reported that his mother came off all substances during pregnancy. Grew up in Shepparton.

Family violence until age 12. Tim regularly witnessed violence perpetrated by his father towards his mother and brothers. Also became the victim of violence around age 10, at which time both of his older brothers had left home. From age 12 onwards he was raised by his mother and maternal grandmother. Mother had problems with substance use and depression throughout his childhood and adolescence. Child protection were involved around age 14, when Tim went to live with his grandmother full-time for a year.

Early physical development unremarkable, though needs further exploration.

Tim reported that he was initially very shy in early primary years and found it difficult to make friends with others. Tim reported that in year two he began 'mucking up', often getting in trouble with teachers for being disruptive, and reported difficulties with reading and attention. In years five and six began getting into physical fights with other students, was suspended a couple of times in year six.

Commenced high school at Shepparton High School. Academic difficulties continued and Tim reported getting into more fights at school. Also commenced using cannabis around this time. Left school at end of year eight. Spent about a year working at a local mechanic until age 16, when the workshop closed down. Has not worked since. Reported that after the workshop closed his substance use increased (boredom) and he began stealing to support his drug use. convicted of multiple charges of theft and one charge of assault at age 17. Spent six months in juvenile detention.

Met his current girlfriend at 18 years. Moved to Melbourne and settled in St Kilda together a year later, where they have been living since. Describes her as 'the love of my life' and they plan to have children and get married. At age 20 Tim was convicted of a serious assault (with a history of other assault and drug related charges) and spent 12 months in jail. Tim's girlfriend remained supportive throughout this period.

Tim's girlfriend is aware of his current difficulties and is supportive. Her parents are also very supportive and she and Time spend time with them on the weekends. Tim reports that his girlfriend works part-time as a beauty therapist. She does the majority of household tasks (cooking and cleaning) and manages the household finances.

Tim has a interest in watching motorsports on Tv and bodybuilding. He previously worked out at the gym 7 days a week, however has not been able to do this lately. Also reported previous interest in 'clubbing'.

Name	Signature	Designation	Date

Appearance
- Physical
- Dress
- Grooming

Personal hygiene

Behaviour
- Guarded, Suspicious
- Distracted
- Psychomotor retardation
- Compulsions
- Panic attacks
- Catatonic behaviour
- Eye contact
- Mannerisms
- Degree co-operation
- Rapport
- Gait

Speech
- Rate, volume, tone
- Coherence
- Spontaneity
- Repetition

Thought Form
- Flight of ideas
- Loosening of association
- Circumstantiality
- Confabulation
- Incoherence
- Poverty of thought
- Neologisms
- Perseverations
- Echolalia
- Clanging

Thought Content
- Overvalued ideas
- Illogical thinking
- Obsessions
* Phobias
- Magical Thinking
- Ideas of reference
- Paranoid ideation
- Thought withdrawal
- Thought insertion
- Delusions
- Anhedonia
- Homicidal/ suicidal

Disorders of perception
- Illusions
- Hallucinations
- Sensory impairment

Emotional state
- Mood (Subjective feelings – client)
- Affect (Observable behaviours)

Cognitive function
- Orientation, memory
- Attention
- Concentration
- Intelligence (estimate)

Biological
- Sleep, Appetite, Energy

Judgement
- Control over behaviour
- Awareness of social norms
- Consequences of actions
- Planning for the future

Level of insight
- Degree of self awareness
- Attribution
- Understanding of illness
- Denial, blame
- Stated willingness to comply with medications/ treatment
- Ability to relabel symptoms as due to illness

MENTAL STATE EXAMINATION (Use continuation sheets if required)

Well built, muscular young man of average height. Caucasian appearance with a shaved head. Colourful tattoos on both forearms and calves. Wearing a sweatshirt and shorts and a woollen beanie which he removed upon entering the interview room. Moderately well groomed with apparently reasonable hygiene.

Appeared suspicious during interview, looking around the room, particularly at smoke detector. Difficult to establish rapport, however this improved gradually. Distracted at times but easily redirected back to conversation. Poor eye contact. When not looking around the room, sat hunched over looking at his hands. Some PMA evident – wringing hands and jaw clenching. Guarded in response to particular questions –what he had been doing in the past weeks, stating 'that's none of your business'.

Affect flat, blunted. Appears depressed. Mood subjectively reported as 'depressed' and 'anxious'. Rated mood as 2/10 over past month.

Decreased spontaneity in speech. Poverty of speech evident, monotonous, normal volume. Nil repetition.

Poverty of thought evident. Complained that concentration is poorer more recently. Mild tangentiality noted, but able to be redirected back to questions.

Paranoid ideation – reported that since leaving prison has been monitored and followed by others. Unsure exactly who they are but feels that they might be members of a bikie gang. Reports that there is 'a price on my head' however unable to explain what the 'price' is for, stating 'they just want me gone'. Reported that he saw a news telecast about the tsunami which gave him clues as to why he is being monitored, however stated that he 'still needs to work it out'. Also relates this to recent contact with his father on Facebook, however declined to give further information about the nature of this contact. Does not leave the house during the day, only after dark and only in the company of his girlfriend. Has begun sleeping with a knife next to his bed in the past month. Girlfriend reported that he has taken down the smoke detector in their apartment and dismantled the sensor light at their front door step. When asked why he had done this, Tim stated 'there's one less thing they can use against me'. Declined to elaborate further.

Auditory hallucinations – reported hearing things outside his window at night, though found it difficult to describe. Stated that he thought it sounded like people talking, mumbling however he couldn't be sure. Gets up to check but there is no one there. Reported this mostly happens when he is about to fall asleep around 2am – 3am. Currently occurring every night. Finds this experience distressing and worrying. Also reports 'seeing things' – described images of his mother being assaulted. Unsure whether these images are triggered, however reports this happens about once a month.

Sleep poor. Initial insomnia, usually gets to sleep around 2am. Wakes frequently. Experiences nightmares of being assaulted, raped and murdered. Appetite poor, usually eats one meal per day (dinner with his girlfriend). Energy low.

Judgement impaired. Feels that he needs to protect himself and may need to 'do what it takes' however vague about what this means. Little concern for consequences of actions.

Insight impaired. Agrees that there is 'something not right' however attributes this solely to recent incarceration. Able to acknowledge deterioration, however hesitant to accept medication.

DIAGNOSTIC STATEMENT AND FORMULATION

Provisional Diagnosis (Including Substance Use)

Refer to Appendix 4

FURTHER INVESTIGATIONS REQUIRED

- Full metabolic and initial medical screen
- Substance use screen and assessment

Name	Signature	Designation	Date

Appendix 3: Case formulation example

BIOPSYCHOSOCIAL CASE FORMULATION GRID FOR CASE EXAMPLE 'TIM'

	BIOLOGICAL	PSYCHOLOGICAL	SOCIAL
Presenting	Weight loss (5kgs) Cannabis use Sleep disturbance Poor appetite Psychotic symptoms Depressive symptoms	Low mood Paranoid ideation Ideas of reference Auditory hallucinations Suicidal ideation	Social withdrawal Forensic problems (previous 12-month sentence for assault)
Predisposing	Mild head injury (short LOC) First degree relative with psychotic disorder (Sz) Cannabis use since early high school Untreated psychiatric issues (depression, anxiety) Family history of substance use and alcohol dependence	Conduct problems Longstanding depression and anxiety Early trauma in family environment (violence and mental health issues) Shy temperament Possible learning disorder and attention difficulties	Early behavioural problems at school Poor academic performance Early criminal history: contact with police since age 13 Limited friendships and social problems since primary school Witnessed and experienced family violence until age 12 years Child protection involvement from age 14 with move to grandmother for 1 year Likely poor relationship with mother and father result of 'unplanned' pregnancy Family environment with regular use of substances (parents and siblings)

	BIOLOGICAL	PSYCHOLOGICAL	SOCIAL
Precipitating	Increased cannabis use	Suicidal ideation Low mood	Release from prison Recent contact with dad via Facebook Social withdrawal
Perpetuating	Psychotic symptoms Initial insomnia and frequent waking Poor appetite Low energy Ongoing cannabis use?	Depressed and anxious mood Concentration difficulties Paranoid ideation Auditory and visual hallucinations distressing and related to prior trauma PTSD symptoms – nightmares Impaired judgement and insight	Hesitant to accept medication Social withdrawal and dependence on girlfriend Risk to others? (impaired judgement and sleeping with weapon) Difficulties with engagement
Protective	Nil current medical issues Normal physical development	Good relationship with supportive girlfriend and grandmother	Support from youth justice worker Supportive maternal grandmother Supportive girlfriend and family Stable accommodation Financial security through girlfriend? Interests in motorsports and bodybuilding History of employment

Appendix 4: Example of a case formulation – Tim

Tim is a 22-year-old young man of Caucasian Australian background, living with his girlfriend in a rented flat in St Kilda. Tim was referred to the early psychosis service by his justice worker for assessment of depressed mood and social withdrawal. Tim presented with paranoid ideation, ideas of reference, auditory hallucinations, sleep disturbance, loss of appetite and associated weight loss, depressed mood, trauma symptoms, increased substance use and suicidal ideation.

Tim is likely predisposed to a range of mental health problems through cumulative pathways of vulnerability. His early childhood was characterised by a combination of physical abuse and emotional neglect, circumstances that are likely linked to his longstanding difficulties with depression, anxiety, trauma and conduct problems. Tim may also have a biological vulnerability to psychosis, mood and substance use disorders. His father has a diagnosis of Schizophrenia, his mother has a diagnosis of Major Depression, and numerous members of his immediate family have a history of problematic substance and/or alcohol use. Additionally, Tim's head injury at an early age may have contributed to cognitive, emotional and behavioural problems and the extent of possible brain injury warrants further investigation. Tim's social difficulties, possible learning disorder, attention and conduct problems were never formally addressed, which led to poor academic performance and premature departure from schooling. In the absence of alternative coping strategies Tim began using cannabis to manage emotional distress. His disrupted home environment and limited employment or educational involvement led to increased boredom, substance use and forensic issues such as theft and assaults against others.

The onset of Tim's psychotic symptoms was preceded by his release from prison following a 12-month period spent in jail. He indicated that in the lead up to his release his anxiety and depression symptoms had worsened with associated loss of appetite and sleep disturbance. Coinciding with Tim's release was his contact with his father via Facebook for the first time since he was 12-years-old. Precipitating Tim's referral to the EPS was his increased cannabis use and worsening suicidal ideation that led to him seeking help from his juvenile justice worker.

Perpetuating factors for Tim include his ongoing depression, trauma and psychotic symptoms, and associated distress. Tim and his girlfriend have indicated that his sense the others are watching and monitoring him is maintaining his social withdrawal and poor occupational functioning. His paranoid ideation is compounded by long-standing mistrust of others and belief that he will be hurt or abused if he shows vulnerability to others, including clinicians. Tim's untreated trauma symptoms and forensic history have led to hyper-vigilance to threat and potentially risky means of protecting himself, such as sleeping with a weapon in his room. Potential risk to others is increased further by Tim's poor judgement and drive to protect himself, irrespective of consequences. In addition, Tim's low energy, poor appetite and sleep disturbance are likely impacting on his general functioning and leading to lowered distress tolerance in the context of persistent psychotic symptoms. Tim's lack of insight into his illness means that he is reluctant to use medication and he has continued to use cannabis as an alternative means of managing distress.

Protectively, Tim is living in stable accommodation with his long-term girlfriend who has ongoing employment as a beautician. Tim's girlfriend and her parents have been long-standing emotional and practical supports for him over the past four years. In addition, Tim has a good relationship with his maternal grandmother who has been his main source of family support since he was young. Although Tim has not been gainfully employed for some time, he has a history of working at a mechanic workshop for one year and is interested in finding a job where he can work with cars. Tim's youth justice worker is another source of support and has assisted him to seek help for his mental health problems.

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NOTES

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