What to Do?

A Guide to Crisis Intervention and Risk Management in Early Psychosis

Orygen
The National Centre of Excellence in Youth Mental Health

EPPIC
Early Psychosis Prevention and Intervention Centre

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

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

ISBN 978-1-920718-57-2

Suggested citation

Coulson L, Crlenjak C and Simpson R. *What to do? A guide to crisis intervention and risk management in early psychosis.* Orygen, The National Centre of Excellence in Youth Mental Health, 2015.

Acknowledgments

This manual was written by Lucas Coulson, Caroline Crlenjak and Raelene Simpson with contributions from Frank Hughes, Heather Stavely, Rob Oldani, Simon Blaikie and Felicity Cockshott. The authors would like to thank the PLATFORM team at Orygen Youth Health Clinical Program for their invaluable contribution to this manual.

Disclaimer

This information is provided for general education and information purposes only. It is current as at the date of publication and is intended to be relevant for Victoria, Australia and may not be applicable in other jurisdictions. Any diagnosis and/or treatment decisions in respect of an individual patient should be made based on your professional investigations and opinions in the context of the clinical circumstances of the patient. To the extent permitted by law, Orygen will not be liable for any loss or damage arising from your use of or reliance on this information. You rely on your own professional skill and judgement in conducting your own health care practice. Orygen, does not endorse or recommend any products, treatments or services referred to in this information.

Orygen, The National Centre of Excellence in Youth Mental Health

Locked Bag 10
Parkville Vic 3052
Australia

www.orygen.org.au

What to do?

A Guide to Crisis Intervention and Risk Management in Early Psychosis

Contents

‘Crisis is a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms’.

R. K. James[1]

Introduction

A first episode of psychosis frequently presents as a crisis for a young person and their family, as it is a period often accompanied by emotional distress and impaired functioning. Crises by their very nature can be overwhelming experiences for young people and their families and can often leave individuals feeling vulnerable, isolated and misunderstood. As crises can often be the initial contact with, or entry to, a service they provide a pivotal opportunity to engage young people and their families. How clinicians respond during an initial crisis will have a significant impact on future engagement.

Responding effectively during a crisis is crucial, as this can help to reduce immediate and potential harm to young people, their families and the wider community. Quickly and effectively intervening during a crisis may prevent the delay of necessary interventions, reduce hospitalisation, trauma, severity and duration of signs and symptoms, and promote rapid recovery while preserving social supports. Providing effective interventions during a crisis can help prevent the biological, psychological and social deterioration that occurs during a long duration of untreated psychosis.

About this manual

What to do? A guide to crisis intervention and risk management in early psychosis is aimed at individuals responsible for service development within early psychosis services and mental health professionals working with young people with early psychosis. This manual is relevant to all clinicians within early psychosis services. While crisis intervention teams are at the forefront of responding during a crisis, all clinicians should be familiar with crisis intervention models and how to respond. This ensures safer and better outcomes for young people, their families and the service.

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. 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 at Orygen Youth Health Clinical Program 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. It is based on current evidence, the experience of other early psychosis programs internationally and shaped by real world considerations.[2] 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:[3]

- 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.

How to use this manual

This manual has three sections. Section 1, 'Crisis response and clinical risk in early psychosis', introduces and provides a basic understanding of key concepts of crisis and clinical risk. Section 2, 'Key considerations in crisis and clinical risk', highlights the important issues clinicians need to consider in preparing their service for crisis response, while section 3, 'Crisis and clinical risk in practice' is a practical framework clinicians can use when intervening during a crisis.

A clinical case scenario is used throughout to outline what to do in a real-life clinical setting for a young person who presents to an early psychosis service during a crisis.

It is recommended that clinicians read this manual in conjunction with the ENSP manuals '*Let me understand …' assessment in early psychosis, Get on board: engaging young people and their families in early psychosis* and *There's no place like home: home-based care in early psychosis*.

Crisis intervention and clinical risk in early psychosis

Crisis intervention and clinical risk in early psychosis

This section introduces the key concepts of crisis intervention and risk management. It provides definitions of the major terms and explains why it is important to assess clinical risk during a crisis. This section will help clinicians understand the different aspects of crisis and risk management, and guide effective decision-making during a crisis in an early psychosis service.

What is a 'crisis'?

There are many definitions of 'crisis' in the literature, and what constitutes a crisis is personal and unique to each young person. Additionally, the threshold for what is considered a crisis can differ significantly between clinicians, young people and their families. Therefore, it is important to intervene and provide support to young people experiencing a crisis even if the clinician does not perceive the young person to be in a crisis. Any crisis situation should be taken seriously by everyone responsible for providing assistance to that individual.

Crisis is defined by Roberts as 'a disruption in the psychological homeostasis when an individual fails to cope using their existing coping strategies'. A crisis is often associated with distress and functional impairment.[4] Frequently, the main cause is a stressful, traumatic or hazardous event. This, combined with the individual's perception of the event, can disrupt a person's day-to-day life and result in them being unable to resolve the disruption using their usual coping mechanisms, leaving them feeling vulnerable, anxious and powerless. Simply, crisis is an imbalance between the demands of a particular situation and the personal resources available to the individual to deal with them.[5]

Many psychiatric disorders are associated with crisis presentation during the acute phase, which can rapidly become a psychiatric emergency if timely intervention is not provided. Not all crises become psychiatric emergencies, but they are potentially life-threatening and require rapid response and intervention.

Crisis and clinical risk are often associated with each other; however, this does not mean that a young person with 'high' clinical risk will always present in a crisis, nor does it mean that a young person who presents in crisis will be assessed as high clinical risk. It is also important to understand that not all young people who are considered high risk will present to a service or will help-seek in a crisis situation.

Help-seeking in a crisis

Crises can happen for anyone, at any time and place, for a variety of reasons. It is important to remember that not all crises are the direct result of mental health problems. A crisis for a young person may or may not be related to mental health problems, but services need to respond to what the young person is seeking help for to help facilitate engagement. A crisis requires an appropriate response by clinicians and services to help young people work towards a resolution. Young people may commonly seek help during a crisis because they are experiencing:

- distressing symptoms of mental health problems
- relationship issues (peers or an intimate relationship)
- family issues
- legal issues
- schooling or vocational issues
- financial issues
- housing issues
- issues they perceive as being a crisis for them.

Some young people may not directly seek help themselves and often it is their family members, friends or supports that seek help on their behalf. At times this may be done without informing the young person because they are concerned by the change in the individual's behaviour. Early psychosis services should have a low threshold for assessment for their service, and young people and their families should receive assistance and guidance with any issues they may have.

Why do we intervene during a crisis?

A first episode of psychosis is most likely to occur during adolescence or young adulthood,[6] as this is a period often associated with significant psychological, cognitive, neurological, social and physical changes. A disruption during this time can have negative long-term effects if not addressed adequately.

Intervening during a crisis can reduce:

- immediate risk and danger
- symptomatic distress
- trauma
- the need for hospital admission[7-9] and readmission[10]
- further biological, psychological and social deterioration
- duration of untreated psychosis.

Providing effective help to young people experiencing an episode of psychosis is very important, as this may be the first time they are in contact with mental health services. How clinicians respond to young people and their families in this first interaction can significantly influence engagement and subsequent interactions with the service.

Crisis intervention can be provided over the phone or face-to-face, in either a regular clinical setting or while visiting young people in their home or in any other community setting. The published literature clearly indicates that providing crisis intervention to individuals in their home is associated with many benefits. One study reported that providing crisis intervention to young people with early psychosis in their homes decreased inpatient admission by 16% compared with standard care.[11] Another study found that community-based crisis intervention immediately reduced hospital admission by 8% and by 51% at the 30-day follow-up.[7] Jethwa and colleagues reported that crisis resolution and home treatment teams reduced hospital admission rates by 30% following their introduction to a service.[8]

Providing crisis intervention to young people in the home can:

- prevent mental health deteriorating
- allow young people to remain in the home and receive care in an environment they are comfortable with
- enable engagement with the service
- provide support to young people and their families
- prevent relapse.

For more information about home-based care, please see the ENSP manual *There's no place like home: home-based care in early psychosis.*

Assessing risk in early psychosis

While a crisis does not necessarily involve risk, risk should always be assessed as part of a crisis. Risk in mental health can be defined as 'the likelihood of an event happening with potentially harmful outcomes for self and others'.[12] Furthermore, risk should also be thought of as how likely will an event (or harm) occur and how soon will it occur.

Risk frequently arises in day-to-day clinical practice; therefore, assessing risk and intervening to minimise risk are important skills for clinicians to learn. When risk is assessed within mental health

services, it includes an assessment of how risk might impact the health, wellbeing and safety of the person being treated, their families and the wider community.

Why do we assess risk?

When a young person is presenting in a crisis at an early psychosis service for the first time, their risks are relatively unknown. Initial information can be provided by the referrer or the family of the young person; however, often this information is insufficient to complete a thorough risk assessment. Clinicians need enough information to identify the needs of the young person and their family.

A thorough and comprehensive risk assessment can help a clinician understand the risks a young person is presenting with to develop and implement a clear risk management plan. The main aims of a risk assessment are to:

- gather relevant information
- develop an overall understanding of the young person's presentation
- identify the presenting risks and protective factors
- develop a treatment and risk management plan
- implement a plan that will mitigate risk to the young person, their family and general community.

Assessing and managing risk should start as early as possible in the young person's treatment and care with the service,[13] and should focus on achieving the best possible outcome for the young person, their family and the wider community.[14]

To be accurate, effective and safe, a risk assessment should:

- take into account the individual situation
- occur within a mental state examination and a comprehensive biopsychosocial assessment of the young person
- pay equal attention to the young person's strengths and protective factors
- take into account historical factors and current dynamic factors
- support recovery
- be documented in terms of strengths and protective factors
- be carried out regularly and documented at every review.

A framework for assessing risk

Risk assessment is a complex task and unique to each crisis presentation. The crisis situation is usually preceded by a variety of factors that may influence the severity and nature of risk. Combined with an emotionally vulnerable state often associated with crisis situations, this can make risk assessments challenging and complicated for clinicians.

Using a framework during clinical practice is important, and will help clinicians during risk assessments. It may prompt questions that explore risk in more detail and provide a clear structure to capture and analyse the information acquired during an assessment. The framework can help clinicians develop a risk formulation and plan interventions to mitigate the risks. Table 1, on page 15, provides a template for clinicians or services to use to help guide the development of their own risk assessment framework.

Domains of risk

There are many different types of risk in day-to-day clinical practice. Risk in mental health settings is involved in every decision and action that relates to a young person's treatment and care within the service.[14] Clinicians focus on three domains of risk:

- risks of harm to self
- risk of harm to other people
- risk from others.

Risk of harm to self

Risk of harm to self consists of risk of suicide or deliberate (or intentional) self-harm, accidental self-harm, misadventure or neglect. Assessing risk of deliberate or intentional self-harm and risk of suicide requires direct questioning of the young person's intent (to die or harm), their level of hopelessness, the frequency and intensity of thoughts, their plan (including assessing level of lethality), their access to means, previous attempts and any protective factors.[15] Self-neglect, absconding, quality of life, conditions of general life, and social and financial status should also be considered when assessing risk to self. Box 1 presents the components when assessing risk of harm to self during a crisis.

BOX 1 ASSESSING RISK OF HARM TO SELF DURING A CRISIS

Important things to consider when assessing risk of harm during a crisis situation include:

- Physical health (brief assessment)
  - Is immediate medical attention required?
  - Has the young person self-injured? If so, it is serious self-injury? Provide basic first aid (if possible) until emergency assistance arrives.
  - Has the young person ingested a poisonous substance? If so, find out what has been taken, when it was taken and how much was taken – this information can be provided to emergency services when they arrive.
- Social, motivating and psychological factors associated with the self-harm behaviour
- Hopelessness
- Mental state

Deliberate or intentional self-harm

Deliberate or intentional self-harm is when an individual engages in behaviours that are intended to cause deliberate physical harm to themselves. In many instances, these acts are not intended to be fatal.[16]

Common behaviours might be:

- poisoning
- cutting
- burning
- self-hitting
- picking at wounds or scars
- pulling out hair.

Other behaviours include:

- starvation
- binge-drinking
- drug-taking
- dangerous driving.

Risk of suicide

Risk of suicide is when an individual engages in behaviours that are intended to cause fatal harm and death. Risk of suicide is increased during a young person's initial assessment and entry to a service, when there are changes in their treatment and care, following admission and discharge from hospital, and after changes in mental state.[17,18] It is vital that risk assessment and management plans be reviewed at these points.

Asking young people about suicide is a crucial part of assessing risk during a crisis, as young people experiencing an episode of psychosis have been identified as a high-risk group for suicide.[19] It has been reported that approximately 6–14% of young people with first episode psychosis will attempt suicide before their initial assessment and entry to the service. During the first 18–24 months following their first suicide attempt, around 5–12% of young people will make another attempt at suicide, while 15% will continue to experience high levels of suicidality over the subsequent 18 months. A quarter of these young people will continue to make repeated attempts at suicide, with a completion rate of 1–3%.[20-22]

Risk of harm to others

Risk of harm to others refers to general and specific risk of the young person causing harm to others. Assessing risk of harm to others should include details of a history of or current behaviour involving the following:

- offending
- homicide
- violence (including emotional, sexual and physical)
- aggression
- intimidation or threats towards others
- public nuisance
- reckless behaviour that endangers others
- property damage
- stalking
- neglect of dependents.

General risk

General risk of harm to others may include threats to harm others or acts that have the potential to harm others, such as driving a car while acutely intoxicated, general aggression towards others because of paranoia, or carrying a weapon for protection. It is often challenging to assess general risk of harm to others because young people may not intend to harm others, but harm may occur inadvertently because of psychotic, disorganised or manic symptoms, lack of insight, or poor judgement due to cognitive impairments or drug use.

Specific risk

Specific risk is harm directed towards a specific person or people. There are many factors that need to be considered when assessing specific risk of harm to others such as:

- Who is the person who is at risk?
- Is it someone that the young person has contact with on a regular basis or is likely to see, or are they someone who is not easily accessible (i.e. they live overseas)?
- Why is the person at risk?
- Is the risk driven by anger, jealousy, paranoia or delusional ideation?
- Is the risk impulsive or premeditated?
- Does the young person know where that person lives or works, or do they have access to finding out this information?
- How likely is it that the young person will act on their thoughts to harm the specific person?
- Does the young person possess means of harming this person?
- What is the degree of severity and reversibility of the act? For instance, does the individual plan to punch the person or stab them with a knife?
- Are any of the factors mentioned above escalating over time?
- Should this risk be communicated to the person who is at risk? (For more information about confidentiality and communicating about risk, see section ‘Communicating and providing information about risk’ on page 36.)

Two tools that can be used to conduct a structured assessment of risk to others are the Historical Clinical Risk Management (HCR-20)[23] and the Structured Assessment of Violence Risk in Youth (SAVRY)[24] for people under the age of 18; these tools are not necessary for everyone, but they may be useful to guide structured risk assessment in individuals with a history of offending or violent behaviour.

These tools are a useful addition to clinical assessment skills, but they are not intended to replace clinical judgement. They are standardised clinical tools that can be used to help clinicians calculate the risk based on identifiable and quantifiable factors. They are considered to be more accurate than clinical observation and are usually applied in forensic settings with individuals considered at high risk for offending and general violence.[25] The HCR-20 assesses the young person’s history of violence, including previous violence and the age of the first violent incident, relationship instability and employment issues, substance use issues, major mental illness, early maladjustment and personality disorder. Clinical items such as lack of insight, negative attitudes, active symptoms of mental illness, impulsivity and unresponsiveness to treatment are also measured in the HCR-20. It is important to note that these assessment tools are not conducive to emergency settings or changeable home environments.[25]

Risk due to vulnerability or harm from others

Risk due to vulnerability is when young people's behaviour or activities put them in situations where they are vulnerable to harm or exploitation from others. These behaviours or activities are often associated with a deterioration in mental state, such as mania or acute psychotic symptoms, and are related to maturity level, personality traits, social circumstances, cognitive abilities, insight and judgement.

Risk due to vulnerability is often under-recognised when assessing and managing risk. When assessing risk due to vulnerability, the following should be considered:

- homelessness
- sexual abuse or exploitation
- harm through misadventure
- financial harm
- non-violent offending
- substance abuse
- neglect, exhaustion or illness
- damage to reputation
- physical health.

The case scenario below demonstrates the importance of assessing risk due to vulnerability.

TINA

CASE SCENARIO

Tina had been diagnosed with psychosis not otherwise specified (NOS) and borderline personality disorder. She previously used heroin daily, but was incarcerated for 6 months for theft and assault charges. While incarcerated, Tina was prescribed maintenance therapy for her opioid addiction and her dose was gradually titrated down.

During a session with her case manager, she indicates that she will use heroin again when she is released back into the community.

Tina's risk of overdose is significantly higher, as she intends to use at the same level as she had previously used, but her physiological tolerance has reduced. In the past, Tina also shared injecting equipment and used with people who were known to her as perpetrators of violence towards women. This puts her at increased risk of vulnerability due to: death or serious harm through accidental overdose, risk of physical harm, risk of illness and risk of financial and sexual exploitation.

Risk factors

There are two types of risk factors that need to be considered in a risk assessment: static and dynamic. Each young person will present with their own set of static and dynamic risk factors. Examining static and dynamic risk factors and taking into account the young person's context, situation, strengths and resources will allow clinicians to meaningfully assess and plan for risk.

Static risk factors

Static risk factors, also known as historic, enduring or stable risk factors, are factors that increase an individual's risk but do not change over time. Examples of static risk factors include:

- past attempts at suicide
- family history of suicide
- history of trauma
- history of violence and aggression.

When assessing suicide during a crisis, clinicians should be aware of the static risk factors for suicide, as they are an indicator of a young person's long-term risk for suicide, and are cumulative. Static risk factors for suicide are presented in Box 2 below.

A history of a suicide attempt is the most significant static risk factor for suicide. It is important for clinicians to get information regarding past suicide attempts and behaviour around attempts, as this provides information about how many times the young person has tried to harm themselves, their preferred methods and whether if they were planned or impulsive.

Questions clinicians should ask include:

- 'What were you hoping the outcome would be after you took the overdose?'
- 'How do you feel now after your suicide attempt? Are you relieved to be alive, don't care or disappointed that you did not die?'

BOX 2 STATIC RISK FACTORS FOR SUICIDE

- Past or current mental illness (mood disorders, anxiety disorders, schizophrenia, borderline personality disorder, substance abuse, comorbidity)
- Previous suicide attempts, recent attempt, previous attempt, with serious intent
- Attempts where young person did not seek help
- Numerous serious attempts within the past 12 months
- Male gender
- History of deliberate self-harm and recent deliberate self-harm
- Recent discharge from hospital or the early early stages of treatment
- Comorbidity or substance use issues
- Recent negative life events
- History of hostility or aggression
- History of impulsivity
- Family history of suicide or close friends that have died due to suicide
- Physical illness or chronic illness

Dynamic risk factors

Dynamic risk factors, also known as variable or current risk factors, are factors that change over time and can respond to specific interventions. Dynamic risk factors are either internal or external to young person:

- Internal factors are related to the young person, such as mental state or personality traits.[14]
- External factors are related to the young person's situation or environment.[14]

Some examples of dynamic risk factors include psychotic signs and symptoms, mood and anxiety. Dynamic factors can have a ripple effect on other risk factors, and can develop into 'clinical flags', where the risk factor is known to dramatically increase the likelihood of a particular behaviour and subsequent outcome because it has been associated with that behaviour in the past.[14] These clinical flags may be used as warning signs or as an indicator that a particular response or plan needs to be implemented straight away by the treating team. Dynamic risk factors for suicide are presented in Box 3.

BOX 3 DYNAMIC RISK FACTORS FOR SUICIDE

- Current mental illness (mood disorders, anxiety disorders, schizophrenia, borderline personality disorder, substance abuse, comorbidity) and severity of symptoms
- Hopelessness
- Affect that is depressed, flat or blunted
- Dramatic and inexplicable change in affect
- Psychosocial stressors
- Interpersonal conflict or loss
- Parent–child discord or discipline crisis (fight with parents, limit setting)
- Periods of extreme stress/agitation/anxiety
- Rejection, fear of abandonment (peers, relationship), humiliation (cyber bullying/ harassment/social media)
- Feeling isolated/disconnected
- High conviction that suicide will solve a problem and minimal perceived negative impact

Protective factors and strengths

Assessing the protective factors and strengths of young people is important during a crisis. It is equally important as assessing clinical risk factors and mental state, yet often overlooked by clinicians. Protective factors are family supports, connections and experiences that reduce the risk for suicide for young people. These factors can be anything a young person feels that prevents them from attempting suicide, such as being responsible for others and the impact the suicide would have on others. Clinicians need to assess the young person's reason to live, as they may be able to use this as motivation during a crisis. For more information, see 'Assessing protective factors and strengths' on page 45.

Potential protective factors include:

- cohesive family, family warmth, support and acceptance
- community support and strong cultural identity
- pregnancy or having young children
- strong perceived social supports/peer group affiliation
- strong sense of belonging and connection
- support from existing therapeutic relationship (counsellor, case manager, general practitioner, school counsellor)
- adequate coping skills, problem solving, ability to resolve conflicts and non-violent ways of managing disputes
- cultural and religious beliefs
- experiences of success and feeling effective
- interpersonal confidence
- ability to seek and access help
- sense of responsibility to look after others or pets.

TABLE 1. **A TEMPLATE FRAMEWORK FOR RISK ASSESSMENT**

	SELF	OTHERS	VULNERABILITY
Static			
Dynamic Internal External			
Protective			

This matrix table is a template for clinicians or services to use to help guide the development of their own risk assessment framework.

Acute and chronic risk

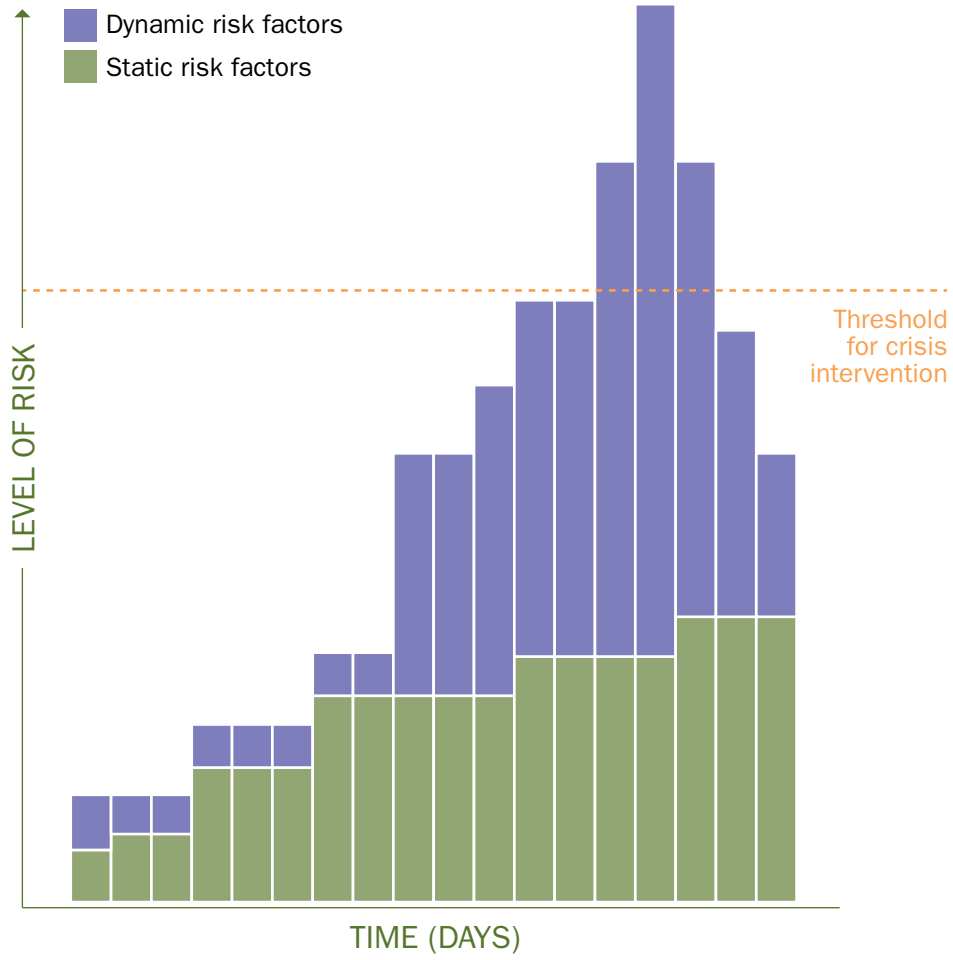
Assessing risk should clearly distinguish between acute and chronic risk, as this helps clinicians and the multidisciplinary team develop and implement effective risk management interventions. Exploring previous patterns of behaviour associated with risk can help clinicians identify when these behaviours are more likely to occur in the future. Patterns of behaviour can also help clinicians determine whether the risk is acute or chronic (see figures 1 and 2).

Acute risk

Acute risk is the sudden increase in prominent symptoms or behaviour that influences short-term risk severity and indicates that an adverse outcome is imminent.[14,27] Acute risk implies that urgent interventions to mitigate serious consequences or adverse events such as suicide, homicide, serious harm or misadventure is required.

Individuals with acute risk have an increased number of co-occurring dynamic risk factors that influence the risk status of the individual and are associated with a serious adverse outcome. Acute risk may occur with the onset of a first episode of psychosis when severe symptoms and distress or behaviour has the potential to increase the risk of harm to self or others.

FIGURE 1. **ACUTE RISK**



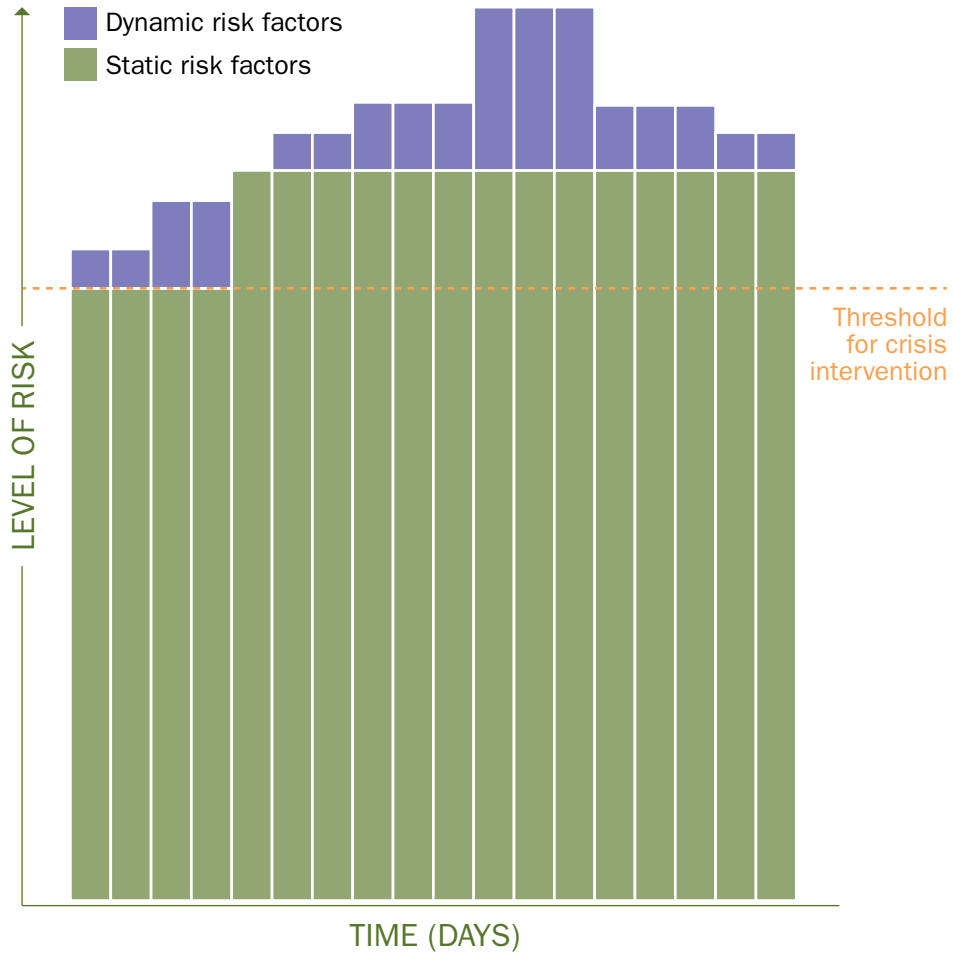
In this diagram, the static risk factors alone do not increase the level of risk enough to warrant intervention. However, additional dynamic risk factors increase the level of risk that it then becomes an acute risk situation that may warrant crisis intervention. It is important to remember that the threshold for crisis intervention will vary for each young person and should be considered on a case-by-case basis.

Chronic risk

Chronic risk is the presence of ongoing multiple patterns of risk, such as regular self-harm behaviours.[14,27] Chronic risk with an acute exacerbation in stress or symptoms can also occur;[14,27] for example, a young person can have high chronic risk of self-harm based on a range of static and dynamic factors, but an acute change in dynamic factors may induce an exacerbation in risk (please see case scenario 'Jarrod').

Young people may not always disclose when they are experiencing an exacerbation in stress or symptoms. Moreover, they may not be help-seeking, so it is important to consider previous patterns of risk and the potential outcomes of this behaviour and assess for an increase in stress or change in mental state.

FIGURE 2. **CHRONIC RISK**



In this diagram, there is a high level of static risk factors that continually exists and is considered chronic risk that requires ongoing risk management. Dynamic risk factors may increase the level of risk which in this case may warrant crisis intervention. It is important to remember that the threshold for crisis intervention will vary for each young person and should be considered on a case-by-case basis.

JARROD

CASE SCENARIO

Jarrod is 18 years old and presents with ongoing psychotic symptoms and uses cannabis and methamphetamines. Jarrod has an intellectual disability and ADHD that was diagnosed when he was at primary school. He has a number of antisocial personality traits, a forensic history of assault and drug-related charges. He is itinerant and often steals or deals drugs to support himself. He is also known to associate with criminals and bikies. Jarrod's drug use is mostly opportunistic, but he usually smokes cannabis daily. He presents as high chronic risk of harm to others due to his static and dynamic factors.

Static factors associated with increased risk in Jarrod's presentation include:

- Intellectual disability (increased impulsivity and reduced capacity for abstract reasoning)
- ADHD (pathway to antisocial personality disorder)
- Forensic history
- History of significant substance use

Dynamic factors associated with increased risk in Jarrod's presentation include:

- Current substance use, especially methamphetamines use
- Antisocial personality traits
- Itinerancy and homelessness
- Current involvement with criminals and recent criminal offending

When he uses methamphetamines, Jarrod's acute risk increases dramatically due to the paranoia and aggression that accompany his use.

Chronic risk needs to be carefully evaluated and managed by the multidisciplinary team with support from senior clinicians and service processes. Young people with chronic risk should be presented and reviewed in clinical review meetings and a service-wide decision be made regarding their level of risk. Regular ongoing review of chronic risk is necessary.

Chronic risk should be thought of as falling into different risk quadrants as 'low chronic', 'high chronic', 'low acute' and 'high acute 'with possible outcomes. The model used to describe managing risk in a person with borderline personality disorder can be used.

Managing chronic risk (adapted from the National Health and Medical Research Council's Clinical practice guideline for the management of borderline personality disorder)[28]

- **Low chronic risk** is a combination of chronic pattern and less serious consequence. This might be a person with a chronic pattern that has less serious potential outcomes, such as self-harm involving superficial cutting. The treating team would consider community treatment and risk management as the best option.
- **High chronic risk** is a chronic pattern and serious consequence. This may be a person with a chronic pattern involving more serious consequences, such as ongoing serious substances abuse or serious deliberate self-harm. In this instance, the treating team may consider a more conservative approach to risk management and a more careful approach to review.
- **Low acute risk** is a new pattern and less serious consequence. This may be a person with a change in method of self-harm (or a change in pattern from using substances to superficial cutting) that should prompt a review by the treating team to assess why there has been a change in the pattern.
- **High acute risk** is a person that presents with a new pattern with serious consequences, such as threats or attempts to self-harm using high lethality methods. The treating team would need to consider whether the person requires inpatient care in these circumstances.

Please see the National Health and Medical Research Council's *Clinical practice guideline for the management of borderline personality disorder* for more information.[28]

RAMON

CASE SCENARIO

Ramon, a 21-year-old nursing student has been diagnosed with schizophrenia. He is well engaged in a range of interventions and is adherent to medication.

In the past, Ramon has experienced homicidal ideation towards his parents, with whom he lives. He had delusional ideas that the end of the world was imminent and the only way to save his parents' souls was to kill them both. At the time, Ramon had become more isolative than usual and spent increasing amounts of time in his bedroom reading the Bible. Ramon had experienced increased stress at university during exam time, had broken up with his girlfriend and had stopped taking care with personal hygiene and having dinner with his parents.

Although the major risk factor for violence is the delusional beliefs about the end of the world, Ramon was always forthcoming with this information. For his treating team, more useful indicators of risk were the patterns of behaviour surrounding the risk: reading the Bible, isolating himself from his family and increased psychosocial stress.

Ramon would be considered chronic medium risk of harm to self, given his range of static and dynamic factors (diagnosed mental illness, young age and male, insightful, engaged and adherent with treatment). His acute risk to others is high in the context described above.

Key considerations in crisis situations

Key considerations in crisis situations

Working with young people and families during crises is challenging for both clinicians and early psychosis services. Successfully managing crisis situations involves a number of approaches and strategies to be implemented both before and while delivering crisis interventions. This section describes the key considerations in crisis situations that can enhance the effective management of crisis interventions.

Service-level considerations for managing risk

A team-based approach

The responsibility for clinical risk should be shared across treating teams in early psychosis services, using a service-wide approach. It does not sit solely with individual clinicians, for a variety of reasons. Crises are often complex and challenging situations that require a team approach to ensure quality interventions and outcomes are achieved for young people, their families and clinicians. The burden of responsibility can be enormous for individual clinicians if they are not provided with adequate support and assistance when managing and dealing with the aftermath of crisis situations. Even with this support, crises may result in high levels of stress for individual clinicians.

It is essential that all staff members have immediate access to senior clinicians. Medical registrars and a consultant psychiatrist should be involved in the decision-making when clinicians are managing medium-to-high risk situations.

A shared team approach provides a supportive environment for managing crisis and risk, and should be embedded in the culture of the service. Services that have clear risk management systems and processes in place encourage clinical staff members to ask for assistance, provide opportunities to consult with experts and allow discussion and decisions around risk management.

Service elements that help embed a team-based culture for crisis and risk management include:

- regular clinical reviews where heightened levels of risk, risk assessment and management is discussed
- access to consultation with senior-level team members (including on-call consultant psychiatrists) when risk needs to be discussed outside of meeting times
- access to specialised consultation, for example, forensic consultation or complex case conferences
- risk monitoring processes and procedures such as alert systems on clinical records (paper or electronic)
- service-wide, easily accessible clinical and crisis management plans
- follow-up on post-crisis interventions, especially if a critical incident occurs, for example, a serious incident committee to review critical incidents using a ‘no-blame’, root-cause analysis framework.

Intensive case management model

Early psychosis services may come across young people who have a chronic risk profile, complex presentations or who are at risk of incomplete recovery. These young people may benefit from an intensive case management model, and some larger early psychosis services might consider establishing a separate intensive case management team. A model of intensive case management has been previously described by Brewer et al. in 2015. This model includes a small multidisciplinary team with capped case loads of 10 per case manager and a more intensive, outreach level of care provided to young people who meet certain inclusion criteria.[29] This model of intensive case management:[29]

- improves engagement
- reduces hospital admission
- improves compliance
- improves functional outcomes
- reduces risk and the frequency and number of crisis contact.

If early psychosis services choose not to establish a separate intensive case management model, then it is recommended that team leaders within the service establish a caseload monitoring system. This can identify those young people who require an intensive case management approach and ensure that the case manager is able to respond effectively. High caseloads or additional allocations may have an impact on delivering quality care.

Clinical governance

Effective governance is one for the four critical factors for effectively implementing the EPPIC Model. Early psychosis services should have clear clinical governance processes and procedures about how risks and crises are managed by their clinical staff members. Clear policies and procedures should be in place around the roles and responsibilities of members of the multidisciplinary team during crisis situations and how risk is managed at all levels. This reduces the risk of ambiguity in organisational processes, including clinical processes, and reduces the risk of gaps in the service system.[30]

When responsibilities around risk are shared, lines of accountability and a hierarchy of responsibility should be clearly acknowledged.[30] It is important for less experienced clinicians to inform senior clinicians about clinical risk and crisis situations, particularly when the level of risk is medium-to-high. It these circumstances, a consultant psychiatrist should be informed.[3] Services should ensure that senior clinicians are available to provide support to less experienced clinicians in crisis situations. This way, risk management can be shared with the multidisciplinary team and shared team decision-making is supported within the service.

The importance of less experienced staff members knowing and understanding when to ask for help should be emphasised through staff education, clinical supervision and training. Developing a culture of open discussion and shared decision-making about risk within the multidisciplinary team should be modelled and encouraged by service leaders including managers, consultant psychiatrists and senior clinical staff members.

Clinical governance has a role in proactively and reactively minimising clinical risk. Strategies should be implemented that ensure the following:[30]

- there are identified protocols for identifying and reporting clinical risk
- critical incidents are reported and investigated to identify underlying systems issues and root cause analysis
- organisational culture supports open communication about risk
- clinical processes are designed to minimise error and ensure clear communication
- policies and protocols are reviewed and updated regularly
- risk information is considered when setting goals, priorities and developing strategic plans for the service
- compliance with relevant legislation.

Crisis intervention teams

Early psychosis services may be structured in a number of different ways depending on the population demographics or service model preference. Established early psychosis services such as the Lambert Early Onset (LEO)[31] and Orygen Youth Health Clinical Program[32] have crisis intervention teams that are separate from their continuing case management teams. Whereas the OPUS program in Denmark[33] has an integrated system using an assertive community treatment model.

The separation of crisis and continuing care teams is a common configuration; whether to do this or not is a complicated decision and mainly depends on the size of the overall service, the size of the catchment area and financial resources.

Crisis intervention teams are called many different names depending on the service within which they operate and how the teams are structured. These teams have produced positive results in managing people during a crisis in the community.[26,34] Crisis teams can play an important part in providing care within the least restrictive environment and minimise the iatrogenic trauma commonly associated with inpatient admission. The common characteristics of crisis teams are:

- rapid 24/7 clinical response
- mobile
- flexible in terms of outreach.

For more information on crisis intervention teams in the EPPIC Model see section 1.3.4 in the *EPPIC Model and Service Implementation guide.*[3]

Clinically informed risk-taking

'Clinically informed risk-taking' refers to a risk management approach where the treating team (led by the consultant psychiatrist) tolerates a level of potential risk if they believe it may help to promote recovery.

For example, the treating team may decide not to arrange hospital admission for a young person with early psychosis who has ceased taking medication and is showing signs of relapse, instead continuing with a community-based treatment approach involving intensive home-based care. This approach may actually promote engagement and development of a trusting relationship between the young person and the treating team, and therefore lead to better outcomes than what might have been achieved by a hospital admission.

Likewise, clinicians responding to an initial crisis of a young person who is experiencing a first episode of psychosis and is reluctant to seek help, may decide they will benefit from home-based care. Assessing and engaging the young person in their home, or an environment they are comfortable with, has significant benefits, as it allows the service to increase their contextual understanding of the young person, build engagement, initiate medication (if necessary) and gradually provide psychoeducation. These benefits significantly outweigh the potential traumas associated with an involuntary hospital admission.

> 'It is not a process of reducing risks but a process of deciding which risks to take in the context of trying to help the patient get better.'
>
> Flewett, 2010[14]

Clearly, such an approach must be a team decision, with a comprehensive risk assessment underpinning the decision-making. The level of risk a clinician or service is willing to manage this way will depend on a number of different factors, and each young person should be considered on a case-by-case basis.

This approach may be appropriate for young people with chronic risk, where short-term clinically informed risk-taking may mitigate longer-term risks. However, this approach should not be applied as a blanket rule to all young people presenting with chronic risks. It requires comprehensive knowledge of the young person's:

- risk factors
- patterns of behaviour
- early warning signs
- known triggers
- identified coping strategies, and
- supports

and should be used in conjunction with increased clinical contact, psychiatric and risk reviews, specific risk mitigation strategies and home-based care or assertive outreach. Frequent review is also essential.

Making decisions in a crisis

Personal factors such as clinical workload, tiredness and past stressful clinical interactions can influence a clinician's ability to make decisions during crisis situations. It may also be affected by their overall level of clinical experience and confidence of managing young people in crisis situations.

New or less-experienced clinicians may tend to be risk-averse and cautious in their decision-making. These 'risk-averse' decisions may be associated with premature use of the Mental Health Act and unnecessary hospital admissions, which can be traumatising, distressing and damaging for engagement of the young person and their families. On the other hand, more experienced crisis clinicians may not respond with enough empathy to a young person's distress or help-seeking due to their seasoned attitude. This can lead to a young person being reluctant to seek help in the future.

The demands of a busy shift or of a hectic day can have an effect on how clinicians undertake assessments and make decisions. Recent or past stressful clinical interactions can influence a clinician's ability to make effective decisions. A recent suicide or homicide can also influence a clinician's decision-making.

If clinicians feel unsure or anxious about a situation, they should discuss their decision-making and plans for clinical interventions during a crisis with members of their treating team, senior clinicians or other medical staff for clarification or a second opinion.

Clinicians should also use a risk–benefit analysis to practically inform their clinical decisions during a crisis. Risk–benefit analysis is a method that compares identified risks with the potential benefits of a particular clinical decision to inform a treatment option.[14] This analysis also considers protective factors and prioritises the young person's wellbeing and preferences.

A risk–benefit analysis may assist with decision-making when clinicians or treating teams are undecided or divided in their approach. Further discussion helps generate transparent and objective exploration and discussions that clarify risks and how they should be managed individually in the context of the young person's presentation. For example, Table 2 shows a risk–benefit analysis for a young person of inpatient care versus home-based care.

TABLE 2. **RISK–BENEFIT ANALYSIS OF INPATIENT VERSUS HOME-BASED CARE**

TREATMENT OPTIONS	RISKS OR DISADVANTAGES	BENEFITS
Inpatient admission	• Impact on engagement • Potential for trauma • Not in own environment • Reluctance of friends to visit, away from supports which leads to increased sense of isolation • May be vulnerable to other inpatients • Stigma associated with admission • Feel controlled • No access to personal items or pets • Can't guarantee a bed in a youth-friendly environment where staff members are familiar with young people with early psychosis	• Closer monitoring and supervision, but does not guarantee reduced risk • Manage distress and sleep assertively (usually with medication) • Medication and prescribers are more accessible • Staff feel less anxious – managing young person's secondary risks • Easier decision-making process for staff • Reduced options to act on risk-taking behaviour or thoughts • Families and supports feel less stressed and feel reassured regarding a service managing the risk
Acute home-based care	• Less supervision • Less structured environment • No immediate access to expert care • Families, partners or friends are more likely to be part of the care plan and may need to monitor the young person and manage clinical visits. • Increase stress for everyone in the home environment	• Young person likely to experience less stigma • Treated in least restrictive and familiar environment • Access to personal items (e.g. musical items, pest, clothes, video games) • More normal experience than inpatient admission • Less likely to experience frustrations processes and services than at home • No vulnerability or not prone to exposure to trauma on the inpatient unit • May be able to continue to engage in meaningful activities

Managing new versus existing young people using the service

A key consideration when providing crisis intervention and managing risk is whether a young person is known to the service or whether this is their first contact with the service.

More quantitative and qualitative information (including a comprehensive history and case formulation) is known about young people who are known to the service, usually because they are currently receiving treatment and care, or have previously received care from the service. Having access to this information, including a history of previous crises and risk management plans, allows clinicians to plan more effectively for the current crisis and manage risk more effectively. More importantly, if a young person is known to the service, there may be clinicians who have previously engaged and worked more closely with the young person and the family who can be called upon to help manage the situation. These clinicians may have also provided support to this young person and their family through a previous crisis situation, meaning the young person may already feel they can trust them.

When a young person is unknown to the service, which is usual with new referrals, the amount of information about the young person is limited. Clinicians need to get to know the young person very quickly and ensure that everyone is safe while trying to manage a particularly distressing situation.

Table 3 presents some initial steps clinicians should take when managing a crisis, depending on whether the young person is new or already known to the service.

TABLE 3. **INITIAL STEPS FOR MANAGING A CRISIS**

IF YOUNG PERSON IS NEW TO SERVICE	IF YOUNG PERSON IS KNOWN TO SERVICE
Collate all information available from referrers. There should be a strong emphasis on engagement with the young person, referrers and supports. Gain as much new information as possible from collateral sources such as the family, general practitioner or school. Try to arrange to see the young person with someone who knows them well. Screen for risk over the phone before going out to see them in the community. Ask basic questions about their environment and who they are before going out. Provide information about the service and psychoeducation about mental health issues.	Collate all available information such as crisis management plans, case formulation, history, previous risk assessments and the current precipitant for the crisis. Determine who is the best person to respond to the crisis e.g. which clinician is the young person best engaged? Are they available? If not, who next? Contact the usual treating team if possible to discuss what the best approach might be and what follow-up arrangements could be offered.

Prioritising safety

Safety is equally as important as establishing rapport with the young person. Clinical risk and safety are primary concerns for clinicians throughout their interaction with a young person during a crisis situation. Assessing safety should become a natural part of assessing young people in crisis, and clinicians may need to focus on attaining enough information from both the young person and their family to ascertain whether the situation can be de-escalated or not.

When assessing a young person in their home, the safety of the clinicians visiting the young person is paramount. An initial assessment should be undertaken during the initial intake call focusing on potential risks posed by:

- the young person
- family members, partners, housemates or other individuals in the house
- the home environment, such as pets, drug-dealing, isolated location, presence of unknown individuals, health risks, unsafe area.

Identified risk and any other obvious risks should be documented clearly in the paperwork and reassessed during the initial assessment.

Safety when visiting the home

Whenever visiting the home of a young person who is unknown to the service during a crisis, ensure that two clinicians attend the assessment. There are many benefits associated with assessing young people and their families in pairs:

- It is safer to assess young people during a crisis with two clinicians. There are two sets of eyes and ears and two minds working simultaneously to assess the situation and associated risks.
- Clinicians have different interpersonal styles and interviewing techniques; assessing in pairs provides more options to find a style that fits with the young person.
- One clinician can focus on engaging the young person, paying attention to the behavioural and emotional cues and their questioning during the assessment, while the other clinician can write, paying attention to non-verbal aspects of the assessment
- The second clinician may be able to ask questions the interviewing clinician has overlooked.
- The second clinician may also able to interview family members or primary supports for collateral information.

Clinicians who visit young people in their home during a crisis need to be prepared. Box 4 describes what clinicians need to consider taking with them when visiting a young person in their home and ‘working on the road’.

BOX 4 WORKING ON THE ROAD: PRACTICAL CONSIDERATIONS FOR CLINICIANS

It is useful for crisis clinicians to be prepared to respond to a young person in a crisis situation outside of the usual clinical setting. Having a work bag ready with all the equipment and information necessary for a clinician to respond, communicate key messages and coordinate treatment and care is important. This work bag should contain:

- current assessment paperwork
- legal paperwork
- business cards
- pens and paper
- phone and charger
- easy reference service directory
- map or navigation device in car
- for medical staff – medical equipment, prescription pads, pathology slips etc.

Involving and supporting families in a crisis

A young person's 'family' encompasses their key supports and may include a range of relationships, from immediate and extended family to friends, partners and other people who may have legal responsibility for the young person, such as residential care workers.

Involving and supporting families is essential when working with young people in crisis situations. It is often a family member who first contacts the early psychosis service during a crisis, and this will likely be a time of increased distress for families. Families can often play a vital role as a 'treatment ally' in managing a crisis situation and minimising risk, both at the time of crisis and afterwards.

Families will usually have expectations of mental health services, which may be based on a variety of factors, such as their own previous experiences with services, or from what they have seen in the media. Clinicians should be aware of the perceptions of family members about mental health services as these may provide a barrier to family engagement, especially when there are stigma-related issues.

Providing families with information and psychoeducation during the initial intake/triage and assessment of a crisis is essential. Engaging the family during the initial crisis is important to obtain the necessary collateral history, help monitor the young person and help provide continuing care.

Young people and their families are often highly motivated to participate during a crisis. It is important to remember that the first contact young people and their families have with a mental health service is a crucial time, as it influences future interactions. This is often a time where families are experiencing a high degree of stress and may need to tell their story and be provided with support.

Please see the ENSP manual *In this together: family work in early psychosis* for more information about working with families of young people with early psychosis.

Communicating and providing information about risk

Communication is an essential consideration when working with young people and their families during a crisis situation. Information about the crisis situation and risk should be clearly communicated to all members of the multidisciplinary team. This information should also be communicated to other agencies involved in the young person's care. Communication ensures that everyone is on the same page in terms of how the crisis will be managed within the early psychosis service.

Communication about risk should clear, succinct and clinically relevant. The level of clinical detail needs to convey the necessary information about the young person's presentation, their risks and management plan.

Communication about the crisis and risk should be made in writing, never just verbally. Although verbal communication is necessary when making referrals, highlighting risks during handover, consulting with senior clinicians and medical staff or transferring care from one part of the service to another, it must be followed up with written documentation that can be accessed by other clinicians or services.

When communicating with other health care providers and agencies it is important to consider the language and level of detail involved in the communication to ensure that it is effective.

Documenting risk during a crisis

Safe and consistent risk management during a crisis depends on up-to-date, accurate and good quality documentation of risk, as this is the primary means by which clinicians and treating teams communicate with each other between shifts, teams and other agencies. Access to quality and up-to-date clinical documentation is crucial for clinicians to make vital, clinically-informed decisions about young people presenting in crisis. The following minimal information about a young person should be documented during a crisis:

- current presentation – including presenting problem
- mental state examination
- risk assessment of dynamic, static and protective factors
- initial treatment plan
- risk management plan.

After-hours clinicians working in state crisis teams are required to use standardised triage scales to assign a triage score to a young person's risk. These standardised scales aim to improve communication between different service programs or clinical teams and facilitate consistent responses by providing clear parameters for urgency and response. Early psychosis services may consider using this type of scale, especially if admission to a state-based inpatient unit is being considered as a treatment option.

Documentation of risk should follow a risk framework and should be written as a narrative formulation describing the relationship between static and dynamic risk factors across the relevant domains of risk while taking into account protective factors and resources available to the young person. Clinicians should also attempt to document their clinical judgment in a structured format. How they attempt to manage the identified risks (using a clear risk management plan), their decisions to mitigate risks and their rationale for making these decisions should all be clearly documented; follow-up and review also need to be documented. Additional information should be provided if the young person's risk changes, if there is an increase in dynamic risks or if a change in protective factors occurs.

Confidentiality

Services need to have clear guidelines about what information about a young person clinicians may discuss with third parties, such as family members or other services, and under what circumstances. Usually the information a young person discloses is confidential, unless there are extreme circumstances when this confidence needs to be broken. This will include situations where the young person or others are at high risk of harm.

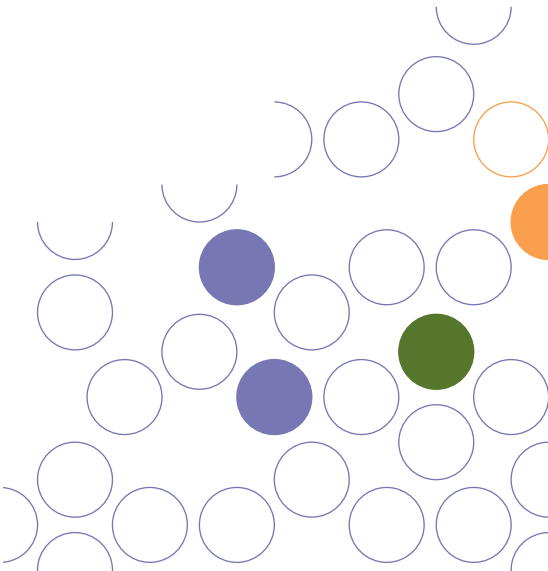
If a young person has made specific threats to individuals or groups, generally, the laws and acts that govern the sharing of health information permit the sharing of information to prevent serious and imminent danger to individuals' health, safety and welfare; however, they vary from state to state. Clinicians and treating teams should consider disclosing information to the police or the person targeted if:

- there is a clearly articulated threat of potential serious harm (life-threatening or serious injury)
- the risk of harm is imminent and requires quick action.

Clinicians may be reluctant to breach confidentiality, for reasons such as the effect this may have on engagement. However, breaching confidentiality and disclosing information is acceptable if it will reduce or stop the harm or alert individuals or agencies about the potential harm. Clinicians should inform young people that they will need to breach confidentiality and provide a clear explanation of how they have to do so. When deciding to disclose information, clinicians should ask themselves:

- What is the purpose of sharing the information?
- Are there good reasons to believe that the threat is real?
- Will disclosing the information prevent or lessen the threat?
- What are the alternatives? Is the information available from another source?
- Do you have a duty of care to inform the person being threatened, regardless of the potential outcome?

In situations where clinicians decided to disclose information, they should contact the necessary agencies and discuss the potential actions. Clinicians should also talk to the young person about the potential actions if this is permitted and document the disclosure and other relevant information in the clinical file. This documentation should be guided by the Privacy and Freedom of Information Act.



Crisis response and risk management in practice

Crisis response and risk management in practice

Overview

This section of the manual is a practical 'how to' for crisis response and risk management. It includes a framework for clinicians to use when working with young people during a crisis. This framework is intended for use by any clinician in an early psychosis service, as a crisis can occur at any point across an episode of care. Many skills required during crisis intervention will already be used in everyday clinical care, but for slightly different purposes. For example, a mental state examination in crisis intervention is used to make a clear plan in the 'here and now', rather than an assessment over time that usually occurs in clinical care.

The interventions used during a crisis need to be flexible and broad in their approach and address the biological, psychological and social components of the crisis. Additionally, interventions need to be person-centred, developmentally appropriate, specific to the phase of illness and adapted to factor in diagnostic uncertainty.

A framework for crisis intervention

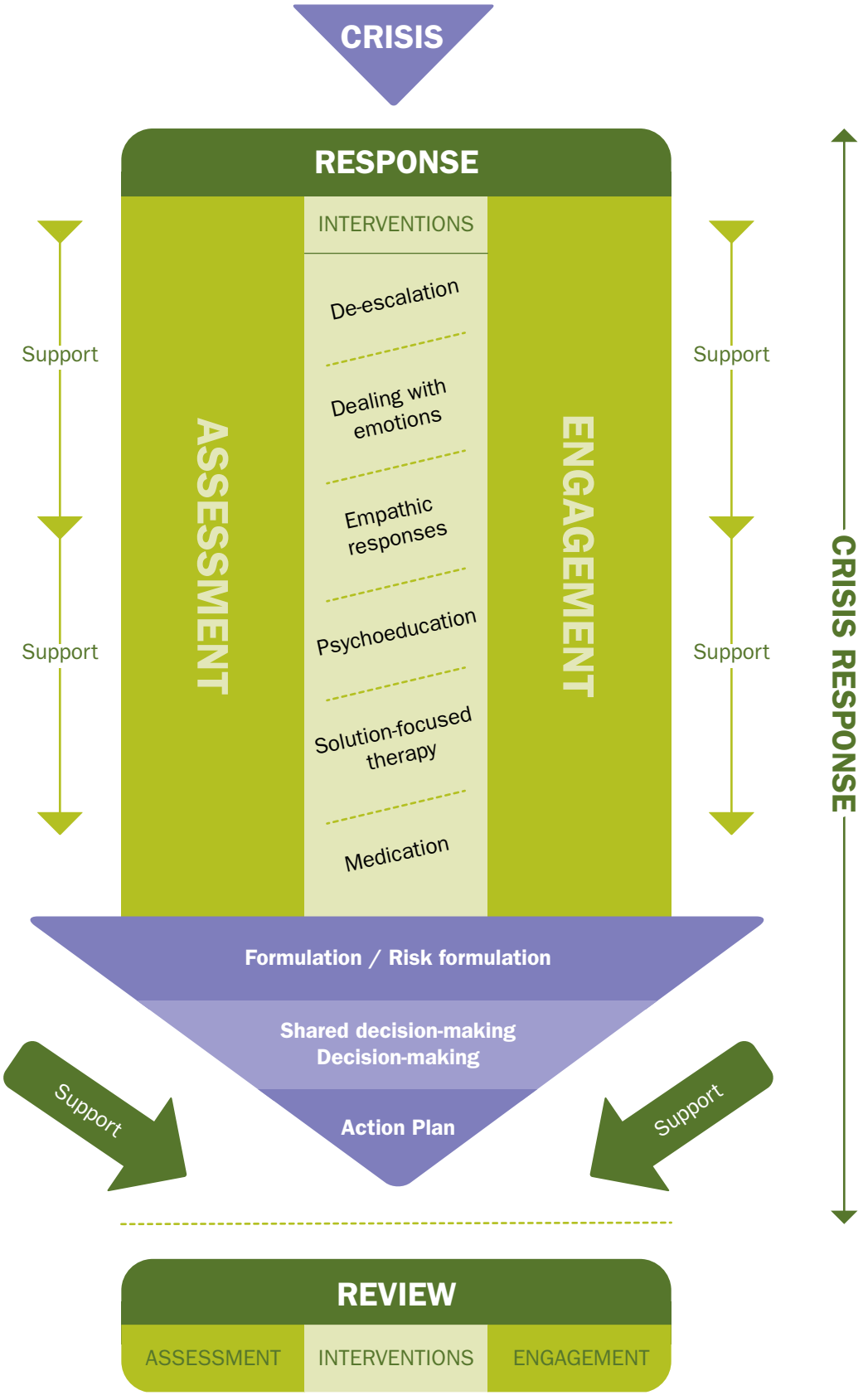
The framework for crisis intervention described within this manual is based on available literature, with a strong influence from the seven-step crisis intervention framework described by Roberts[35] and the six-step crisis intervention framework by Gilliland and James.[1] Importantly, this crisis intervention framework remains congruent with the key principles of the EPPIC Model. The framework consists of the following stages:

- rapid engagement
- assessment
- formulation
- planning
- implementing strategies
- follow-up.

Although this may appear to be a linear process, it is important to note that the stages may follow a different order depending on the young person's presenting circumstances, risks and clinical needs at the time of assessment. Clinicians should use this framework flexibly to guide their approach and clinical decision-making when providing interventions to young people during a crisis. The framework is represented in Figure 3 on page 32.

A case scenario, 'Trung' will be used throughout this section to demonstrate how to use this framework in a real-life clinical setting. The scenario presents sample dialogue between a clinician and a young person in a crisis situation, and demonstrates a key interview technique and risk formulation grids.

FIGURE 3. **A FRAMEWORK FOR CRISIS INTERVENTION**



TRUNG

CASE SCENARIO

Trung is a 16-year-old student who lives at home with his mother, stepfather, older sister and younger half-brother. He is of Vietnamese background and is in year 10. His mother contacted the police via emergency services after Trung destroyed his room, burned his forehead with a cigarette and appeared to be talking to himself. The police attended the house and were informed that over the past 3 weeks his family had noticed the following changes in his behaviour:

- staying up late most night and keeping unusual hours
- spending most of his time alone in his room
- his self-care and hygiene decreased
- speaking or mumbling to himself
- weight loss and refusing to eat with his family.

The police believed that Trung was experiencing mental health difficulties, and suggested he get some support to help him and his family. He agreed to speak with an intake worker from an early psychosis service over the phone. The police contacted the early psychosis service and requested a crisis assessment.

Below is the initial conversation between Trung and the early psychosis service intake clinician.

CONVERSATION	INTERVIEW TECHNIQUE
Clinician: 'Hi Trung, my name is Gary and I work for a youth health service. Part of my job is to speak with young people who may be feeling stressed or having a difficult time. The police have asked me to speak with you about what's going on to see if I can help you and your family. Do you think we could talk about what's been going on for you lately?'	• Clinician introduces themselves, their role and provides a rationale for them being involved • Offering assistance • Asking permission to speak with the young person
Trung: 'Arggggh, yeah, okay …'	
Clinician: 'Great, thanks. It sounds like your mum is pretty worried about you and your behaviour and that's why she called the police. That must have been a surprise when the police rocked up?'	• Being genuine • Using youth-friendly language
Trung: 'Yeah it is but I haven't done anything wrong.'	

TRUNG

CASE SCENARIO (CONTINUED)

CONVERSATION	INTERVIEW TECHNIQUE
Clinician: 'No Trung, you haven't done anything wrong. The police are sometimes involved and together we try and see young people to offer help and see if they're okay. Have they treated you okay?'	• Acknowledging his concern • Providing reassurance as to why the police are there • Explaining the role of police as allies • Genuinely enquiring about the young person's wellbeing
Trung: 'Yeah, they've been fine. I'm okay now.'	
Clinician: 'Good, good. Do you mind if I ask you a few questions to try and understand why your mum's worried and what's been going on for you lately?'	• Beginning the enquiry
Trung: 'Yeah, that's okay.'	

The intake worker from the early psychosis service was calm, non-judgmental and warm when talking to Trung about the circumstances that led to him destroying his room and burning his forehead. Gary provided genuine empathic responses and sounded interested when Trung told his story.

Trung explained that he destroyed his room and burned his forehead to 'scare them off'. Further enquiry by the intake worker allowed Trung to explain that he was experiencing derogatory and command auditory hallucinations telling him to kill himself. Trung said: 'They tell me to jump off the freeway bridge over and over again.'

Clinician: 'A lot of young people I speak with also have these experiences … and to be honest, it sounds really scary and confusing. I was wondering would you be able to tell me more about …'

The intake worker tried to normalise those experiences for Trung and continued to ask about other symptoms and his immediate safety.

Trung described paranoid themes about the mafia and bikie gangs and he thought that they were trying to get him. He said he had difficulty with getting to sleep, problems with concentrating and had been 'feeling on edge'.

Trung told the intake worker about his longstanding mood problems and previous suicidal ideation. He also said he had been feeling more 'down' since a recent assault and robbery and indicated that his mood might be getting worse because of the hallucinations and persecutory beliefs. Trung said 'I feel like giving up', but denied any clear plan or intent to currently take his own life. The intake worker reassured him that they would be able to help with him with his sleep and be able to reduce some of his distress and help him make sense of his experience.

During the phone call, a particular emphasis was placed on:

- determining his history of previous risks
- identifying his current risks (to self and others)

TRUNG

CASE SCENARIO (CONTINUED)

- establishing whether he had the ability to resist acting on his auditory hallucinations and paranoid delusions in the short-term
- identifying potential safety issues in the home environment.

The intake worker then asked to speak to Trung's mother to gather collateral and corroborative information.

The information focused on: understanding the circumstances that led to the crisis presentation, recent behaviour, and understanding the onset of Trung's presentation from her perspective. The phone call with the intake worker allowed Trung's mother to voice her concerns and was an opportunity for brief psychoeducation about the early psychosis service and the referral process. She was also informed that Trung might be experiencing mental health issues and that an urgent assessment with a specialised youth mental health team would be advisable.

A home-based assessment was arranged with the service and the family within the next few hours. The intake worker spoke with Trung and recommended that a home visit would help them clarify what was happening. Trung agreed to the service visiting his home.

'Not having a thousand people with you [when you are being seen] would be great … so would having a choice of having a different gendered person in the room.'

Young person,
EPPIC, Orygen Youth Health Clinical Program

Rapid engagement

'Engagement' is often used as a broad term that includes engagement with treatment (medical, psychosocial or other interventions), with the early psychosis service and with individual members of the treating teams. Additionally, engagement equally applies to young people and their families or other supports (please see the ENSP manual *Get on board: engaging young people and their families in early psychosis*).

Engagement has long been considered a crucial element in establishing and maintaining a successful therapeutic relationship with a young person, and should occur simultaneously when assessing young people.

Engagement during a crisis can help:

- contain and de-escalate situations
- reduce immediate fear and anxiety
- make young people feel at ease
- make young people feel more relaxed
- facilitate assessment
- make help-seeking a positive experience
- reduce isolation
- improve the quality of the clinical and personal information obtained.

Engagement during a crisis needs to be rapid and begins as soon as the clinician and the young person meet each other or speak over the phone. Clinicians therefore need to quickly establish rapport with the young person. This requires a calm, reassuring, professional and friendly manner, with a flexible commitment to negotiating the best outcome for the young person. Time invested in listening and establishing rapport can go a long way towards developing engagement and help with collaborative, shared decision-making treatment options and adherence to planned interventions.

There are a number of factors that can affect the engagement of a young person during a crisis, including:

- the young person's willingness to engage
- their level of distress or other emotions
- severe psychotic symptoms (paranoia, persecutory beliefs, hallucinations)
- the environment
- organisational issues
- the clinician's attitude
- stigma
- embarrassment.

The following are some techniques for facilitating engagement with a young person during a crisis.

Use existing relationship or links to engage young people

If the young person has already established a positive therapeutic relationship with a clinician of the service, it is important to use that relationship to help engage the young person during the crisis situation, as their existing knowledge will help guide your assessment of risks and help with planning interventions.

Explain why you are there

For young people who are new to the service it may be useful to explain how the service became involved. Referrers or family members may have told the young person that they sought help on their behalf; however, it is not unusual for family members to put the young person on the phone without having told them. In these situations, it is important to clearly explain who you are and what the service does. It is equally important that the explanation is pitched at an appropriate level. For existing young people of the service, it may be helpful to check whether they understand the clinician's role if it is not the usual treating clinician, especially if the young person is experiencing increased symptoms and distress.

Offer young people a safe, neutral and private setting

Young people should be assessed in a setting they feel comfortable with. The setting should be private and safe for both the clinician and the young person. A neutral setting helps the young person feel more at ease and focus on telling their story without outside influences. Giving young people the opportunity to choose where an assessment takes place helps build a trusting relationship with the clinician and allows young people to gain some control of an often distressing situation.

For more information on the importance of setting when assessing and engaging young people, please see the ENSP manual *'There's no place like home': home-based care in early psychosis.*

> ‘It’s good having that option, like having someone with you, like a friend or whoever.’
>
> Young person,
> EPPIC, Orygen Youth Health Clinical Program

Allow young people to be seen with or without family or supports

It is important to offer the young person the opportunity to be seen alone or with their family, friends or other supports whenever possible. Providing young people with the choice will promote trust and build rapport with the early psychosis clinician.

Use familiar language

Clinicians should use plain English and youth-friendly language, ensuring it is pitched at the young person and their families’ level of understanding. For example, instead of asking, ‘When you feel down or overwhelmed do you self-harm?’ ask, ‘When you feel down or overwhelmed, have you ever cut or burnt yourself, punched a wall or hit yourself in the head?’ Similarly when asking family or friends questions, instead of asking, ‘Has your son has been experiencing any psychotic symptoms?’ clinicians should ask ‘Have you noticed if Johnny has been behaving strangely lately? ‘Has he been talking to himself or saying that people are watching him or thinking that things have a special meaning?’ Please see also the ‘Avoid psychiatric or medical language’ section of the ENSP manual *Get on board: engaging young people and their families in early psychosis.*

Ensure that your body language is appropriate

Body language is equally important during a crisis situation. Clinicians should try to sit alongside the young person and position themselves so that both parties can exit the room if necessary. They should be mindful that their posture indicates that they are being attentive and responsive to the needs of the young person. When assessing young people during a crisis it is important for body language to be:

- calm
- respectful
- warm and friendly
- reassuring.

Be genuine

Clinicians should be genuine in their interactions with young people and their families during a crisis. Being responsive, honest and transparent when assessing young people may well encourage young people to model that behaviour. Using humour and self-disclosing in a genuine manner can also help facilitate engagement.

Show empathy

During a crisis, young people and their families should feel that they are understood by clinicians. Showing empathy through facial expressions, body language, tone of voice and using empathic responses will help young people and their families feel understood and subsequently facilitate engagement. Clinicians should sound interested, have a caring attitude, be encouraging and use reflective comments when summarising what the young person has said.

Empathic statements should start with basic statements such as, ‘I know that must be difficult’ and develop as the rapport between the young person and the clinicians develops. The statements can then become more complex and reflect the clinician’s understanding of the young person’s perspective. Be aware that the continued use of basic empathic statements by the clinician may be interpreted as a lack of understanding or a lack of interest by the young person.

Be kind

Clinicians need to convey the message that they care about the young person and their families. Offering the young person and their families a glass of water or cup of tea is an act of kindness that should never be underestimated, especially when people are distressed. Reassuring the young person about their belongings, getting them something to eat or clean clothes, or finding out if they are allowed outside for a cigarette, if the young person is at a police station or an emergency department, can help be important acts of kindness during a crisis.

> ‘Having someone who isn’t intimidated by your sexuality or by your gender preference … who isn’t awkward about it is really important. I called a suicide line the other day and talked about my relationships and I felt like they were really non-judgmental and really accepting.’
>
> Young person,
> EPPIC, Orygen Youth Health Clinical Program

Ask young people to tell their story

Clinicians should encourage young people to tell them what has happened and describe their symptoms in their own words, as many of them will not know or understand what is happening to them. Allowing young people to explain what has happened at their own pace and without judgement can be reassuring for the young person.

Guide young people through the assessment process

Providing the young person and their family with information about the assessment process is an important part of effective engagement. Helping the young person and their family understand the steps in the assessment process, or liaising with emergency services and other organisations on their behalf, can help establish trust and foster engagement between the clinician and the young person.[36]

Prepare the young person for assessment questions

Prepare the young person for the types of questions that may be asked during the assessment by introducing the types of questions and explaining why these questions are asked. For example, ‘Some of the questions may be quite personal but it really help us understand what’s going on for you. I’m going to ask you some questions, some may be relevant and others may not be. There are certain questions that we need to ask when we see all young people, so if they are not relevant to you, please let me know.’

Normalise the situation

Clinicians should try to normalise the situation or symptoms for the young person. Using example statements implies that their behaviour is understandable, and not uncommon. For example:

- ‘I see a lot of young people in similar stressful situations and they often worry that they may say something silly when talking about their experiences. Just so you know, I’ve heard all sorts, so it takes a bit to freak me out’.
- ‘A lot of young people I see tell me that they hurt themselves when they feel overwhelmed or distressed.’
- ‘Other young people have told me that sometimes when they can’t sleep at night because they are worried about school or work and other things going on in their life. They try to read a book or get up to watch a movie instead of lying there tossing and turning. This helps them worry less.’

> ‘Using words like “It sounds like what you’re saying” or reflecting on what someone is saying is a huge thing about validating person’s experience.’
>
> Young person,
> EPPIC, Orygen Youth Health Clinical Program

Use ‘safe’ topics

Exploring safe topics of conversation can help a clinician to quickly engage a young person and build a ‘picture’ of the young person. Asking about a young person’s interests, hobbies or what they did on the weekend can help them feel like the clinician is interested in them as a person and not just their symptoms or the crisis situation.

> ‘It’s nice when they get to know you, when they get to know your interests and hobbies’.
>
> Young person,
> EPPIC, Orygen Youth Health Clinical Program

Provide practical support to young people and their families

Offering the young person and their family practical assistance may reduce their immediate distress, assist in meeting their primary needs, reduce their sense of burden and help develop rapport.[3] Practical assistance in a crisis can be provided in many forms:

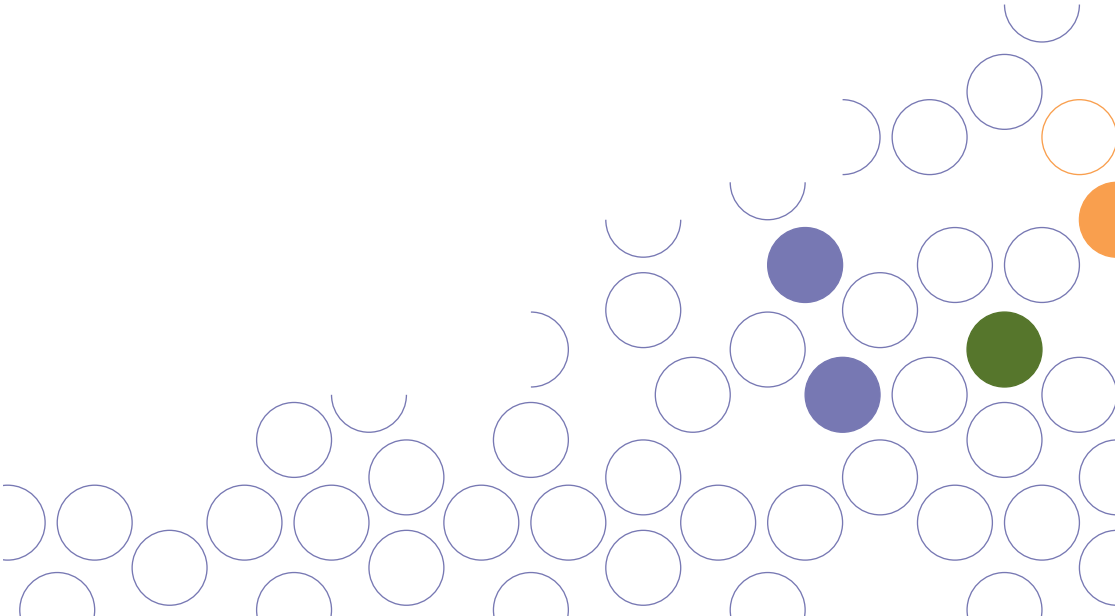
- organising accommodation for young people
- helping young people access other social services such as Centrelink
- helping young people with vocational, legal or financial issues
- organising medication to help manage symptoms.

Don’t try to measure engagement

Clinicians should not try to measure engagement using tools during a crisis situation. Instead, engagement can be gauged by how forthcoming young people are with information, how short their responses, if they are angry or how frequently they interject and correct you. The rapport between the clinician and the young person and how much information they share with you should gradually improve as the interview progresses. The nature of acute psychotic symptoms and their impact on how much spoken information can be provided also needs to be taken into account.

Explain confidentiality

Clinicians should have a brief conversation with young people about the professional and legal requirements of confidentiality, including the types of clinical situations in which confidentiality may be breached and information disclosed, especially if they haven’t had contact with services before. Young people often see lack of confidentiality as an obstacle to accessing services and it can be a ‘game changer’ in terms of developing immediate rapport, or damaging an existing therapeutic relationship. Mentioning confidentiality early on in a crisis situation is always good practice, but at the same time, clinicians need to be sensible about when to do this. If clinicians need to engage and focus on the young person’s safety first, information about confidentiality can be provided at another point during the interaction.



TRUNG

CASE SCENARIO (CONTINUED FROM PAGE 35)

The clinicians arrived at Trung's house and introduced themselves to him, his mother and the police. Everyone was provided with a brief explanation of the clinician's role, the assessment process and the type of questions they would be asking. The clinicians reassured Trung by telling him that the interaction would be 'pretty informal', that there were no right or wrong answers and that he could stop at any point if he needed.

Trung was given the option to be seen with his mother or by himself, and the clinicians explained to him that the police would remain on site. Trung was initially seen alone by the clinicians and a police officer. He was settled and developed some level of rapport with the attending officer by talking about video games and his family pets. This allowed the clinicians to begin the interview with a 'safe' topic and they briefly discussed his pets.

The workers informed Trung that, even though they received information from their colleague, they were more interested in hearing his version of the story to gain further understanding. They tried to normalise his distress about his presenting symptoms early in the interview.

Clinician: 'It sounds like you've been going through something that sounds a bit different and pretty scary … can you tell me in your own words what has been happening?'

The clinicians remained attentive, relaxed and encouraging. One clinician scribed while the other led the assessment

By showing genuine interest in aspects of Trung's life by using reflective comments and summarising key information, the clinicians were able to clarify symptoms and details relating to the presentation with a caring attitude. This helped establish rapport and the gathering of clinical information.

Assessment of crisis and risk

Crisis assessments are often unplanned assessments that are characterised by significant psychological distress for the young person, as well as impaired functioning, acute symptoms and high levels of risk to self and others due to impaired judgment or risk-taking behaviour.

Assessing the clinical risks or the mental state of young people during a crisis is different to regular non-urgent assessments, clinic-based assessments or ongoing home-based care, as clinicians will be presented with a diverse range of clinical presentations in challenging, emotionally charged circumstances.

During a crisis, clinicians are often required to promptly conduct a comprehensive biopsychosocial assessment to understand the young person and the context of their crisis while trying to engage them in treatment and manage their risks. Assessing young people under these circumstances is a delicate interplay between engagement, information gathering, quick decision-making and minimising physical and psychological injury and distress.

Crisis assessment involves talking to the young person, their family and supports, and other agencies to source information and develop a both aetiological and risk formulation based on their identified risks that informs treatment and risk management plans and guides interventions. It is important for clinicians to quickly develop rapport and a connection with the young person to try to understand the circumstances resulting in them presenting in a crisis. Clinicians involved during the initial assessment of a crisis are required to carry out the following tasks:

- engage the young person and their family and supports
- attempt to defuse the crisis
- assess mental state
- undertake a comprehensive risk assessment
- provide emotional and practical support
- initiate early treatment
- facilitate referrals and pathways to appropriate care.

Assessing young people in crisis should be grounded in a biopsychosocial framework and incorporate a comprehensive mental state examination and risk assessment, explore collateral information, include considered clinical judgement informed by empirical evidence, evidence-based practice and sound clinical knowledge.[5,37] A detailed biopsychosocial assessment and collateral history informs and supports decision-making, risk management and determines whether a young person will need to be admitted to the inpatient unit or if they can receive care in the community. The main aim of the assessment is to focus on what the clinician can to do ‘right now’ to ensure that the young person, their family and the community is safe.

Information gathering

It’s not always possible to complete a comprehensive biopsychosocial assessment and be able to identify all long-term static factors to predict the young person’s future risk during a crisis situation. Factors that may impact information gathering include:

- severity of symptoms (i.e. thought disorder, depressive symptoms, distractibility)
- level of distress
- willingness to engage
- type of referral (i.e. self-referral or brought in by the police)
- stigma
- language
- level of risk.

The more information clinicians are able to gain, the better; however, this is challenging if the young person being assessed is new to the early psychosis service and has no history of involvement with mental health services. Clinicians need be patient, flexible and use their engagement skills when assessing young people during a crisis.

Using a funnelling approach

Clinicians should use a funnelling approach when attempting to identify crisis precipitants, undertaking a mental status examination (MSE) or undertaking a comprehensive assessment.[38] This involves initially asking broad open-ended questions to identify relevant symptoms or risk then selectively choosing content to focus on to gather further information.[39] Examples of open-ended questions include:

- 'Can you tell me something about what's been happening lately?'
- 'What happened that you called our service this evening?'
- 'Can you tell me, in your own words, what's happening to make you feel this way?'

Once the relevant symptoms or stressors have been identified, clinicians can then focus on the details on symptoms, such as duration, frequency and intensity, presenting risks and the relationship between psychotic symptoms and risks. Example statements include:

- 'Thanks for telling me what's been happening for you. That helps me understand a lot. You mentioned before that you have been experiencing a number of coincidences lately – can you tell me more about these experiences … what have you noticed?'
- 'I can see why you might feel confused, getting messages from the TV must really confusing and scary at times … when did you first notice these?'

Guided discovery

Guided discovery, a form of questioning used to elicit additional information from young people,[40] should be used in combination with the funnelling approach. Guided discovery questions include relevant information that is not the young person's main focus that help the clinician conduct the interview and transition from a previous topic to a new topic and learn more about the young person. Examples of guided discovery questions include:

- 'It certainly sounds like things have been difficult for you. When you've had difficult times in the past, what sort of things helped you get by?'
- 'When you've been really stressed out in the past, how you felt?'

Collateral information

Obtaining collateral information is an important aspect of assessment during a crisis. The families, friends and supports are an essential source of information that needs to be explored as quickly as possible during a crisis, especially if the young person is distressed or is unwilling to provide information. Clinicians should try to speak with each family member individually and then together as a family. Speaking with family members separately from the young person allows the family members to express their concerns openly without fear of what the young person will say or think. It is recommended that one clinician speak with the family and supports while another clinician assesses the young person in these situations.

Clarifying if young people are medically compromised

Young people may seek help or contact services following a suicide attempt. Recent data suggests that a large proportion of young people with experiencing a psychotic episode may take an overdose of prescription medication or ingest poisons with another 12% inflicting lacerations to themselves.[20] Clinicians should immediately check the young person's safety during a crisis to determine whether there are any ongoing medical dangers such as access to large quantities of prescription medication, open wounds or losing blood. It is difficult to know whether an overdose or an ingestion could be lethal as it depends on a number of different factors:

- what substance the young person has taken
- when the young person has ingested the substance
- how much the young person has ingested
- the interaction this substance will have with current prescribed medication etc.

Clinicians can contact the poisons hotlines for further information. If the clinician is unsure about possible medical risks due to insufficient information or poor collateral information they should ensure that the young person receives immediate medical attention by either calling an ambulance or getting a medical practitioner to see the young person if in the service setting.

Mental state examination

A mental state examination (MSE) is a structured clinical assessment that involves observing and appraising the behavioural and cognitive functioning of an individual. It is a comprehensive cross-sectional understanding of an individual's current mental state. It is also a clinically-informed 'snapshot' in time of the young person's current wellbeing. For more information please see the ENSP manual *'Let me understand …' assessment in early psychosis.*

When assessing the mental state of a young person presenting in a crisis, clinicians need to consider particular aspects of the MSE that would result in behaviour that increases risks for the young person or others. Acting on delusions and command hallucinations is a common clinical concern and can increase the risk of harm to self and others. Young people may respond to command hallucinations and delusions in a variety of behaviours such as harmless avoidant actions, behaviour to reduce and mitigate risks such as deliberate self-harm or more serious behaviours of aggression or suicide.

Clinicians should assess about the following:

- positive symptoms (auditory hallucinations, delusions, thought insertion, grandiosity)
- paranoia or sense of self-impending doom
- mood, hopelessness, psychological intent
- impulsivity
- capacity and judgement
- insight or awareness
- substance intoxication and withdrawal.

Identifying potential for aggression and violence

When assessing risk during a crisis, an assessment of the young person's potential for aggression and violence should also be conducted. Clinicians are required to accurately and rapidly assess young people for potential of violence to try and prevent incidences of violence, and the negative outcomes associated with violence that is sometimes directed towards clinical staff and members of the community.[41]

Clinicians need to be aware of the potential risk factors for aggression and violence when assessing young people during a crisis. Risk factors associated with impending violence include:

- Appearance:
  - angry facial expression, poor self-care
- Behaviour:
  - hostility and anger, impulsivity, agitation, uncommunicative, irritability
  - verbal threats or gestures, heightened responses to stimuli
- Thinking:
  - positive symptoms of psychosis, feeling persecuted, suspiciousness
  - thought disturbance

'I've learned over time that I'm okay to be suicidal, I'm not necessarily going to act on it but they don't know that. I explain to them that I'm feeling so bad that I want to die …but that really I just need someone to sit with me and talk to me until I feel like the urge to do that has passed.'

Young person,
EPPIC, Orygen Youth Health Clinical Program

Identifying the potential for suicide

Risk factors associated with suicide can help clinicians identify young people with an increased risk of suicide; however, assessing risk for suicide in young people involves subjective clinical judgment, a comprehensive review of static, dynamic and protective factors, the plan or intent for suicide, past history and current mental state.[37]

Clinicians should view all suicide intent as valid and the presence of ideation as a sign of suffering. If a young person indicates that they have a plan for suicide it is important that clinicians ask directly about their plan. A well thought out, detailed plan can be a good indicator that a young person is at increased risk of suicide. The lethality of a suicide plan needs to be assessed by clinicians. How a young person plans on attempting suicide relates to the lethality of the plan and it is extremely important for clinicians to investigate this. For example, jumping in front of a train or hanging versus cutting or ingesting toxic substances. How knowledgeable a young person is about the lethality of their chosen means of attempting suicide needs to be assessed by clinicians. Young people are considered at increased risk if:[4,20,22]

- they have researched a specific method in detail
- they have identified a location
- they have made recent attempts, including several high lethality attempts in the last 12 months.

How to ask young people about suicide

Clinicians need to enquire directly about suicide with young people in a crisis. Suicide is a difficult topic to discuss with young people. Many young people presenting in crisis will be naïve to mental health services, some young people may be embarrassed to talk about it and for others it is an expression of their suffering. When asking about suicide, the approach and line of enquiry should be gentle, direct and free of judgment. Some examples of questions clinicians can use to ask young people about suicide are presented in Box 5 below.

BOX 5 EXAMPLE QUESTIONS ABOUT SUICIDE

- Have you ever felt like life is not worth living?
- When things have been difficult or overwhelming have you ever thought about taking your life?
- If so, what were you thinking of doing to take your life?
- Where would you do this?
- Have you ever got prepared and ready to take your life before?
- Was there anything that prevented you from taking your life?
- What else was going on around this time in your life?
- At the moment or recently have you had any thoughts about wanting to take your life?
- How much of the day do you spend thinking about it?
- Have thought about how you might take your life? Overdose, cut wrists, hanging …?
- Do you feel like taking your life at this moment?
- What would taking your life accomplish?
- Is there anything that you can foresee in the imminent future that may increase the likelihood of you trying to take your life (e.g. like an argument with your boyfriend, bad news, running out of money)?
- What could we change in your life right now that might reduce the likelihood of you taking your life?
- Are you safe right now? What stops you from acting on these thoughts?
- Do you need help to stay safe right now?
- Do you think you would tell someone if you felt increasingly at risk of taking your life?
- How do you feel about dying? (Identifies ambivalence and passive suicidality)

'I don't like it when they do the tick boxes of risks … "So is there anyone else in the house with you? Are you safe? Do you have means of suicide near you?" I know they have to do that for safety but there is a way that you can do that so it's more casual and personal … It's more important to listen to the person first, build that rapport and then ask those questions'

Young person,
EPPIC, Orygen Youth Health Clinical Program

Assessing protective factors and strengths

Assessing protective factors and strengths of young people during a crisis is as important as assessing clinical risk factors as this can help reduce the risk for suicide. Discussing protective factors and strengths with young people and their families provides hope and shifts the focus away from potential risky behaviour. Clinicians should reinforce reasons for living and positive thoughts whenever they can during a crisis. Using statements such as 'It seems like things have been really difficult for you. I'm aware you've been having ideas of wanting to take your life … I'm curious, what's stopping you from taking your life? What keeps you going? For more information please see 'Protective factors and strengths' on page 15.

TRUNG

CASE SCENARIO (CONTINUED FROM PAGE 40)

The intake worker identified a number of risks factors and protective factors during the 'intake' process.

- Static risk factors
  - Family history of suicide (father)
  - Previous aggression and physical violence to siblings
  - History of cannabis use
  - Previous mood problems and suicidal ideation
  - History of carrying weapons
  - Recent deliberate self-harm (burning forehead) in response to psychotic symptoms
- Dynamic risk factors
  - Recent significant deterioration in mental state
  - Paranoid ideation towards former peers at school
  - Command hallucinations to jump off a bridge
  - Hostile, irritable and low mood
  - Suicide ideation, vague plan, no immediate intent
  - Some themes of hopelessness
  - Evidence of impulsive behaviour and impaired judgement
  - Arming self with weapons at night for self defence
  - Recent substance use (cannabis and ice) and potential withdrawal
- Protective factors
  - Supportive family
  - Good rapport with intake worker
  - Agreeable to further assessment
  - Motivated to get help for symptoms
  - Currently feels able to control behaviour
  - Weapons removed
- Police on site

Please see Trung's risk formulation grid on page 58 for more information.

TRUNG

CASE SCENARIO (CONTINUED)

During the initial home visit, Trung was asked a series of broad open-ended questions to identify symptoms and information about risks. A funnelling approach was used to further explore the information provided. The techniques Socratic questioning and guided discovery were used while conducting a loosely-structured comprehensive MSE and risk assessment. Clinicians gathered information about duration, frequency and intensity of Trung's symptoms and gained a better understanding of his symptoms, risk and behaviour.

The clinician focused on the symptoms that are most likely to influence his behaviour and risk that was his paranoid and persecutory delusions and whether they were powerful enough for him to act on them.

Trung's paranoid and persecutory ideation was further explored to clarify:

- the extent and characteristics of beliefs
- if specific targets been identified
- if he intended to harm others and how
- the feasibility of plan and extent of planning
- access to means to harm others
- proximity to identified targets, if he knows there whereabouts.

Below is a dialogue of a clinician trying to clarify information regarding Trung's intention and capacity to harm others.

INTERVIEW/ CONVERSATION	INTERVIEW TECHNIQUES/ INFORMATION TARGETED
Clinician: 'Trung you told my colleague early that you thought people may want to harm you. What exactly do you think they want to do to you?'	• Clarifying what harm young person thinks will occur
Trung: 'I think they want to kill me or get me to kill myself and make it look like an accident'	
Clinician: 'Okay that sounds pretty scary. Why do you think they would want to do that?'	• Validating concerns • Sounding interested, encouraging further disclosure • Attempting to understand young person's rationale as to why they think they will be harmed (reality based or delusional)
Trung: 'Because I can see what they're up to and I know what they're doing … so I guess they want me out of the way'.	

TRUNG

CASE SCENARIO (CONTINUED)

INTERVIEW/ CONVERSATION	INTERVIEW TECHNIQUES/ INFORMATION TARGETED
Clinician: 'How do you think they might try and harm you? Do you have any idea?'	• Gain further understanding of the young person's perceived danger. This may be useful to gauge what they might identify/misidentify as threatening circumstances and further understand delusional content
Trung: 'Poison my food, get me while I'm asleep, taunt me and do my head in until I kill myself'.	
Clinician: 'If you are worrying about all that I can see why you'd be feeling stressed then. Do you know when they might want to harm you? Might it be today, tomorrow, in the next few weeks?'	• Attempts to establish how close the young person perceives potential harm – may establish when they may act on delusional beliefs
Trung: 'I don't know exactly … soon. Not today. I can't say exactly, maybe in the future I guess'.	
Clinician: 'Who do you thinks responsible for these threats? Is it anyone you know?'	• Attempts to identify potential targets that maybe at danger and substantiate level of preoccupation and specificity of delusional content
Trung: 'I think it's those idiots from school … and now they've got organised crime involved and thug bikies to do their dirty work'.	
Clinician: 'So you think people from your old school might be behind it. How did you know it was them?'	• Trying to understand how paranoid and persecutory delusional content has been attributed to identified targets and how future delusional precepts maybe attributed to others
Trung: 'Well it's a few things. They have always picked on me at school. Then I noticed the numbers on the money. They were trying to track me. I can also tell by peoples hand gestures, the way they look at me and when I was watching "Underbelly" the other night they tried to scare me by showing me their plan on TV'.	
Clinician: 'I'm interested … if you think it's these people from school, have you tried to contact or approach them about it at all?'	• Tries to establish if young person has previously attempted to, or intends to, contact or approach identified targets

TRUNG

CASE SCENARIO (CONTINUED)

INTERVIEW/ CONVERSATION	INTERVIEW TECHNIQUES/ INFORMATION TARGETED
Trung: 'No. I haven't seen or tried to speak to them. But I know they've been monitoring me'.	
Clinician: 'Do you know where they live? Have you tried to find out?'	• Attempts to establish how close the potential targets are or if the young person knows their whereabouts. If young person knows their address or has attempted to locate them then this increases risks to others
Trung: 'I know that they're local because they went to my school but I don't know where they live … I suppose I could find out if I really wanted, but I haven't. I just want them to stop it and leave me alone!'	
Clinician: 'Do you think you might try and contact them or find out where they live in the future?'	• Attempts to clarify if young person currently has intent to locate identified targets
Trung: 'I don't want to speak with them, but they keep talking to me. I've been telling them to leave me alone. I don't really want to have anything to do with them. I've had enough. Maybe the police can tell them to leave me alone?'	• Clarifies that currently has no intent to locate them
Clinician: 'Thanks for telling me about what's been going on for you Trung. Listen … sometimes when people are worried about their safety they often think about protecting themselves, for example, with weapons … like a knife or something. Your mum and the police say that you've been keeping knives under your bed. Why?'	• Normalises behaviour. Attempts to clarify intention behind accessing weapon and keeping it in close proximity
Trung: 'It's for my protection. I sleep better knowing it's there'.	
Clinician: 'You must be pretty worried about your safety to have a weapon close then. Do you ever think about hurting your mum, stepdad or brothers and sisters?'	• Clarifying ideation and intent to harm close family members in the home (people living with or known to young person more likely to be at risks)
Trung: 'No, never. It's also kinda to protect them too'.	

TRUNG

CASE SCENARIO (CONTINUED)

INTERVIEW/ CONVERSATION	INTERVIEW TECHNIQUES/ INFORMATION TARGETED
Clinician: 'Can you foresee any circumstances in which you may use the knife on someone?'	• Attempts to establish specific scenarios where the young person may use weapon
Trung: 'Only if someone tried to hurt me or my family … then I'd probably use it?'	
Clinician: 'Exactly what sort situation might cause you to use it … what would have to happen?'	
Trung: 'If someone got into my house and physical hurt me or my family. I'd defend myself and my family'.	
Clinician: 'Would you just defend yourself or try and take their life?'	• Explores if young person has homicidal intent
Trung: 'Just hurt them enough to make them stop … I guess'	
Clinician: 'What do you think would happen to you if you did stab someone … I mean legally?'	• Checking to see if judgement is currently impaired in regards to risk to others
Trung: 'Well if it was self-defence then I think that would be okay … I'm not just going to attack someone'	
Clinician: 'What would happen if you did stab someone being provoked, threaten or attacked?'	• Further clarification to see if judgement currently impaired in regards to risk to others
Trung: 'Well I'd probably go to jail or something and I don't want that'.	• Signifies that he currently has capacity regarding 'right' or 'wrong'

TRUNG

CASE SCENARIO (CONTINUED)

Below is a dialogue that tries to determine the omnipotence of Trung's command hallucinations and delusions.

INTERVIEW/ CONVERSATION	INTERVIEW TECHNIQUES/ INFORMATION TARGETED
Clinician: 'Trung, you told the clinician on the phone that you can hear people talking to you even when they are not in the room. I was wondering if you could tell me a little bit more about that?'	
Trung: 'Well it started off as just whispers now and again. Then I started to hear people talking to each other about me … "look at what he's wearing" … "turn on the TV"… things like that. It was about nothing really, just comments. Then the comments started to make fun of me, and say bad things. Recently they have been saying nasty things and telling me to do things like kill myself or they are going to get me. They just won't shut up'.	
Clinician: 'That sounds like it would be hard to put up with and really upsetting. When they tell you to do things, do you ever follow through with it?'	• Checking if he has been compliant or acted on command hallucinations
Trung: 'Yeah in the past I have, just to see if will shut them up … make them go away'.	
Clinician: 'What about when you burned yourself today and smashed up your room. I wonder if that was related to the voices?'	• Attempt to clarify content or reason for deliberate self-harm
Trung: 'Yeah I guess so … not that they told me to do it, I was just trying to scare them off so they'd go away or leave me alone'.	
Clinician: 'What sort of things have you done?'	• Gathering information about types of actions undertaken
Trung: 'Things like go out the back and have cigarette, have a shower, change my hat. I drove over the freeway once'.	
Clinician: 'Okay. What did you do that for?'	
Trung: 'They had been telling me to go jump off the bridge, so I went to see the bridge and to see if it would shut them up'.	

TRUNG

CASE SCENARIO (CONTINUED)

INTERVIEW/ CONVERSATION	INTERVIEW TECHNIQUES/ INFORMATION TARGETED
Clinician: 'Did you think about jumping off at the time?'	• Enquiring about past intent associated with command hallucination and subsequent behaviours
Trung: 'Yeah, I couldn't stop thinking about it … they wouldn't stop urging me to do it'.	
Clinician: 'Well I'm glad you're still here. Do you mind if I ask what stopped you from jumping off?'	
Trung: 'I guess I don't want to die … it would hurt my family and I'd leave my pets behind'.	• Clarifying protective factors
Clinician: 'I'm glad you don't want to die and I'm sure you'd be missed by those around you. Looking back when you've done what the voices have told you, what's the reason you've followed through?'	• Establishing reasons behind compliance with command hallucinations (e.g. fear, distress, passivity phenomenon associated with hallucinations)
Trung: 'Mostly it's because they get me worked up … stressed out. It's like I've got to get it out of me for a bit, reduce the feeling it gives me'.	
Clinician: 'What happens if you don't follow through with what they're saying? Do you ever feel like something bad is going to happen? Can you disobey them?'	• Can the young person disobey the voices? Enquiring about the omnipotence, power and fear associated with command hallucinations
Trung: 'Yeah I try ignore them all the time, sometimes the voices keep going … sometimes they say worse things about me, threaten my family, threaten to kill me … it's really starting to get to me'.	
Clinician: 'Do you think that the voices or people behind it can actually harm you?'	• Enquiring the extent and conviction that perceived persecutors can harm him or others
Trung: 'I dunno … maybe. It's getting hard to tell. It seems real. I think about it more and more'.	
Clinician: 'As we're sitting here now what do you think the chances are, in the next 24–48hrs that you will take your own life?'	• Specifically asking about perceived intent in the short-term

TRUNG

CASE SCENARIO (CONTINUED)

INTERVIEW/ CONVERSATION	INTERVIEW TECHNIQUES/ INFORMATION TARGETED
Trung: 'Nah man, I'm not going to do that? I'm not going to let them do that to me'. **Clinician:** 'That's great Trung, because I think we might be able to help reduce the stress you've been having with the voices and possibly help them go away all together … would you be interested in that?'	

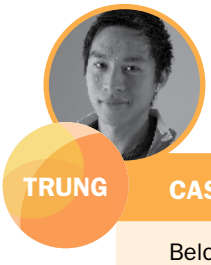
The dialogue above demonstrates how clinicians touched on a number of areas but were primarily focussed on understanding the potential for Trung to resist or act on his psychotic symptoms.

Formulation

The reasons young people present in a crisis are varied, and they must be understood to inform how clinicians and early psychosis services respond to the needs of the young person and their family. To do this, clinicians need to use a formulation-based approach towards the crisis itself and a formulation-based approach towards the identified risks, even if this is a rapid process.

Clinicians need to examine the different dimensions of the problem to understand it so they can provide effective and appropriate interventions to young people.[42] Forming an aetiological formulation of the 5 Ps (presenting, predisposing, precipitating, perpetuating, and protecting factors) helps summarise the young person's clinical presentation and helps clinicians develop a working hypotheses on how the young person has become unwell. This formulation establishes a helpful framework that guides decision-making about treatment and interventions.[43]

Ideally, formulation is done with the young person and their family over time; however, during a crisis situation, it needs to be done rapidly to implement key interventions and begin treatment quickly. During a crisis, there may be more emphasis on identifying and attempting to understand precipitating, perpetuating, protective factors rather than on predisposing factors. Clinicians need to also consider destabilising dynamic risk factors, as these are more likely to influence the young person's behaviour and mental state due to their changeable nature.



TRUNG

CASE SCENARIO (CONTINUED)

Below is Trung's case formulation based on his crisis assessment and categorised as either presenting, predisposing, precipitating or protective factors.

TRUNG'S AETIOLOGICAL CASE FORMULATION

	BIOLOGICAL	PSYCHOLOGICAL	SOCIAL
PRESENTING	Cannabis use Recent amphetamine (ice) use	Presenting with signs and symptoms associated with early psychosis: auditory hallucinations, ideas of reference, paranoid and persecutory ideation, low mood, suicidal ideation, deliberate self-harm, acting on distress associated with delusional beliefs	Isolated Angry outbursts towards family, especially sister
PREDISPOSING	Family history of suicide (father) Father undiagnosed mental health issues Male History of aggression	Learning difficulties impacting ability to focus at school, frustrated, outbursts Possible untreated mood disorder since late childhood Limited coping strategies often responds in anger, introverted, internalising negative events and impact on self-esteem Unresolved issues regarding his father and suicide	Some difficulties establishing and maintaining friendships History of being bullied in primary and secondary school

TRUNG

CASE SCENARIO (CONTINUED)

	BIOLOGICAL	PSYCHOLOGICAL	SOCIAL
PRECIPITATING	Cannabis use Recent amphetamine (ice) use	Longstanding low mood Trauma associated with being assaulted	Threatened and assaulted by group of youth for money and his phone Feeling betrayed and used by friendship network Peers involved in anti-social activities, substance use and crime Desperate to impress others, easily led astray and taken advantage of financial Limited social support other than family
PERPETUATING	Ongoing substance use and withdrawal	Ongoing paranoid/persecutory ideation Level of awareness/insight into signs and symptoms Flat affect Anxiety associated with signs and symptoms Suicidal ideation Hopelessness Sense of rejection from school and humiliation	Ongoing harassment over social media Currently suspended/ expelled/not attending school Damage caused by previous behaviour when unwell at school with staff/peers Isolated
PROTECTIVE		Agreeable to ongoing input Willing to adhere with suggested treatments Motivated to get rid of signs and symptoms No previous suicide attempts No clear psychological intent Future focused Currently feels able to control behaviour Agreed to given weapons to family and sharps put away	Supportive family, limited family conflict Good rapport with clinicians attending Pets

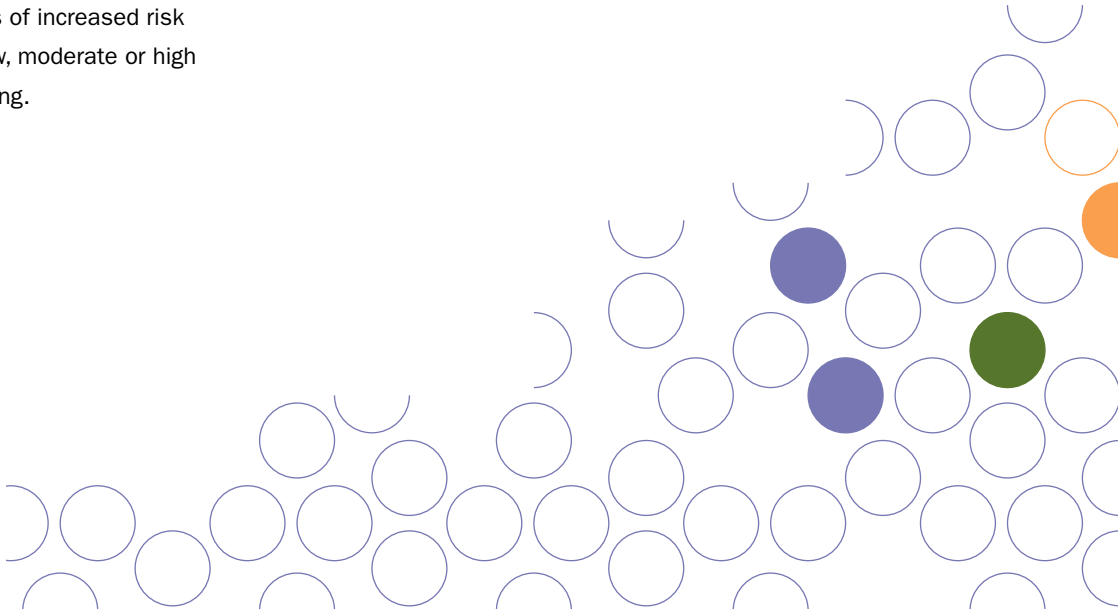
Formulation of risks

Risk formulation helps clinicians identify information quickly, facilitates understanding and provides a consistent approach to managing an individual's risk. Moreover, it forms a vital and informative link between risk assessment and management. It attempts to summarise the identified risks during an assessment while considering the dynamic and contextual factors that may increase or decrease the likelihood of potential harmful outcomes. Clinical hypotheses derived from risk formulations should be used to prioritise risks, inform clinical judgment and decision-making and guide subsequent treatment and safety planning.

Risk formulation should be written as an evolving clinical narrative and describe the static, dynamic and protective factors identified using the risk assessment framework. Another approach may be to develop a formulation using the risk assessment framework but frame these using a 5 Ps approach where static and dynamic factors can be translated to predisposing, precipitating and perpetuating factors. The content should help clinicians understand and predict clinical scenarios and circumstances that involve the potential for increased risks. Specific detail about clinical markers, triggers and early warning signs for that individual for particular risks should be included in the risk formulation narrative. Risk formulations should provide details about the best way to interact with the young person and the types of interventions that should be used to mitigate particular risks.

Risk formulations should discuss in detail each risk separately, covering the following:

- type of risk (e.g. acute or chronic, suicide or relapse)
- static, dynamic and protective factors
- likelihood of risk occurring in the near future
- potential triggers of increased risk
- level of risk – low, moderate or high
- treatment planning.



TRUNG

CASE SCENARIO (CONTINUED FROM PAGE 54)

RISK FRAMEWORK GRID FOR TRUNG

RISK FACTORS	TO SELF	TO OTHERS	FROM OTHERS
Static risk factors:	• Family history of suicide (father) • Previously fire setting • History of cannabis and ICE use • Previous mood problems and associated suicidal ideation • Got asked to leave school	• Previously set fires • History of physical aggression to siblings • Threatening behaviour at school to peers and teachers • Paranoid ideation focused on peers at school • Weapons in family home	• History of bullying at school and online • Financial exploitation from peers • Assaulted by group of youths for money and iPhone
Dynamic risk factors:	**Internal dynamic** • Deteriorating mental state • Paranoid ideation towards former peers at school • Command hallucinations to kill self • Increasingly hostile behaviour • Recent deliberate self-harm • Acting on psychotic signs and symptoms • Evidence of increasing impulsive behaviour and impaired judgment • Cannabis use/withdrawal • Low mood, irritable mood	**Internal dynamic** • Paranoid ideation focussed on peers at school • Attribution of persecutory beliefs to school peers	• Ongoing online bullying

	• Anxiety • Hopelessness • Suicidal ideation, vague plan, no psychological intent • Sense of rejection from school and humiliation • Ambivalent conviction that suicide would solve current problems **Situational dynamic** • Isolated • Recent substance use and withdrawal (cannabis) • Access to weapons under bed, recently sleeping with knife for protection		
Protective factors:	• Supportive family • Good rapport with attending clinicians • Agreeable to ongoing input • Willing to adhere with suggested treatments • Motivated to get rid of signs and symptoms • No previous suicide attempts • No clear intent • Currently feels able to control behaviour • Family protective re: suicidal ideation • Pets • Weapons agreed to be removed	• No attempts to locate or confront those suspected of harassment • Does not know whereabouts or address of perceived persecutors	• Currently not leaving the family home due to fear; therefore, decreasing vulnerability of physical assault and financial exploitation

TRUNG

CASE SCENARIO (CONTINUED)

TRUNG'S RISK FORMULATION

Harm to others:

Trung has a previous history of physically aggressive behaviour towards his sister and angry outbursts at school. Recently, there have been an increased number of verbal threats and intimidating behaviour both at school and in the family home due to bullying, criticism and taunts from his sister and fellow students. Previous physical aggression towards his sister have usually been punches in the arm or kicking out at her. In the past week, while play fighting with his sister, Trung vigorously throttled her and his family considered this to be excessive. In this instance his behaviour was not directly driven by psychotic phenomenology but rather out of frustration and distress associated with ongoing positive symptoms, persistent low mood and increased irritability. Without treatment, Trung is likely to remain irritable and have low mood, be intolerant of others that could result in negative outcomes. If Trung does not receive treatment for his positive psychotic symptoms, it is highly likely that he may harm others in response to paranoid and persecutory themes. His sister has been told not to provoke her brother and the family are willing to monitor their interaction closely. There have been no other significant incidences of physical or verbal aggression towards his sister in the past week. Trung is currently agreeable to commence anxiolytic medications to help manage his distress and irritability, which may help mitigate aggression towards others.

Trung has a history of carrying weapons when involved with gangs. Recently, he has been sleeping with a hunting knife under his mattress for protection. This weapon is kept because of ongoing fear and concerns associated with his recent persecutory beliefs and auditory hallucinations. Currently he denies any intention of harming his family. Harm to others is more likely to be a result of misidentification as a potential assailant or attacker inside the family home. He has agreed to surrender the knife to his family and has allowed his stepfather and mother to sleep in his room temporarily to reassure him. To further ensure safety in the family home, his family have agreed to temporarily remove sharps and other possible weapons and lock them in the boot of the family car.

Trung has attributed his recent assault and robbery, his ongoing threats and derogatory and command auditory hallucinations to former peers at school. While there is congruency between Trung's paranoid and persecutory delusional beliefs and his auditory hallucinations, he denies any recent attempts, current action plans or intention to locate, contact or harm his perceived attackers (former school peers). Immediate contact with perceived persecutors is limited as Trung does not know their addresses and has no ongoing face-to-face contact with them as he is suspended from school. There is, however, a history of online bullying on social media, which could potentially be a destabilising factor and provoke Trung in the future.

Harm to self:

Deliberate self-harm

Trung has no history of deliberate self-harm. The burning of his forehead was an impulsive attempt at reducing ongoing auditory hallucinations and associated distress, not a direct consequences of the command hallucinations.

TRUNG

CASE SCENARIO (CONTINUED)

Suicide

Trung has a family history of suicide (biological father), and a history of depressed mood and suicidal ideation. He is likely to have had a period of untreated depression and continues to have a number of depressive illness symptoms. These symptoms have increased since a recent assault and onset of derogatory hallucinations and persecutory themes. Trung is currently experiencing command hallucinations to 'kill himself by jumping off the freeway bridge, which he finds very distressing (egodystonic). Trung has no history of suicidal behaviour. He recently cycled to the freeway in an attempt to mitigate voices but denied clear intent to harm himself at this time. Trung is likely to be at increased risk of suicide in the short-term if he does not receive treatment for his depression, psychotic symptoms and distress. He currently denies any immediate plan or intent to act on command hallucinations, however, in the past week he has been more ambivalent about suicide. He currently lives 10 km from the freeway, so access is limited. His family agree to provide him with close supervision. He does not endorse other suicidal plans and he identifies his supportive family relationships and pets as protective factors against suicide.

Insight, judgement and motivation for treatment

Trung is current experiencing depressive and psychotic symptoms. His awareness regarding signs and symptoms and the attribution of these as part of psychosis is limited. His capacity to identify unusual or delusional thought is poor. He believes that some of his difficulties could be a result of stress and depression. His judgement shows evidence of moderate impairment with recent impulsive behaviour and compliance with command hallucinations. Note that in recent weeks Trung has been amenable with command hallucinations – most serious was riding his bike to the freeway. Most other actions which Trung has agreed with have been low risk and acted on either out of frustration or an active attempt to reduce the intensity of voices. Trung's irritability and depressed mood, positive symptoms, substance withdrawal, impaired judgement and distress are likely to be changeable factors in the short-term that may increase risk towards himself and others, therefore will require frequent and close monitoring. Trung is currently agreeable to receive further input from services, especially around symptom and distress management and has tentatively agreed to commence suggested medications and participate in safety planning.

His stepfather will be taking personal leave from work to remain at home with Trung to help monitor him, provide reassurance, structure, distraction and administer medication if necessary.

Treatment plan

- Daily by 2 per day home visits by the home-based care team to monitor his mental state, behaviour and risks (suicide, acting on signs and symptoms, harm to others)
- Family to monitor behaviour and risks overnight and to contact after hours service if increasing concerns around risks (self or others)
- Medication to be administered for psychotic symptoms and his sleep:
  - Diazepam 5 mg three times daily and as required
  - Zopiclone 7.5 mg to be taken at night
- Trung to check with family for reality testing and support
- Family to monitor food and fluid intake and encourage intake

TRUNG

CASE SCENARIO (CONTINUED)

- Trung to use distraction techniques and encourage activity scheduling
- Home-based care team to arrange for further investigations
- Medical certificate provided for stepfather for work
- Continue to provide psychoeducation to Trung and his family
- Trung to agree to currently abstain from substance use
- Present at clinical review with consultant psychiatrist and treating team
- Consultant psychiatrist appointment scheduled for …

Planning

How clinicians respond to young people and their families during a crisis is very important. Deciding what to do during and after a crisis has to be done very quickly and in collaboration with the young person and their family and other services that are involved. Planning what to do next during a crisis is informed by a clinician's clinical judgement, and is based on an assessment of the mental state, collateral history, and the subsequent formulation of the crisis and risk. It is recommended that clinicians consult with a senior staff member and a consultant psychiatrist. For more information please see 'Clinically informed risk-taking' section on page 23.

More importantly, planning interventions should be done in a collaborative manner wherever possible and should be considered best practice. Identifying the immediate goals of the young person and their family is vital and the overall aim of planned interventions be based on these goals. Building rapport through collaborative planning can establish 'a common purpose' and help the young person and their family to 'buy in' to any planned interventions.

Shared-decision making

Clinicians need to try and include young people and their families in all decisions regarding their treatment and care. Common decisions that need to be made during a crisis include:

- where treatment should be provided (inpatient unit versus home-based care)
- whether to seek medical treatment
- whether to start medication
- whether to manage substance use or substance use withdrawal.

Shared-decision making actively engages the young person in decisions about their health and treatment options.[44] Shared-decision making should be incorporated into interactions with young people and their families in the beginning as it often facilitates engagement and is an opportunity to provide psychoeducation.

Box 6 is an example of a process of shared-decision making.

BOX 6 EXAMPLE OF SHARED-DECISION MAKING

STEP 1. The clinician providing the young person with relevant information about the nature of the problem and potential outcomes if no intervention is implemented.

Clinician: 'Thanks for telling me about what's been going on for you lately, it sounds like it's been quite worrying and unusual for you. In my experience, sometimes voices can slowly go away on their own accord. However, for some people they can continue and can, at times, become intense and difficult to manage. At that stage, we usually suggest for people to start a low dose of medication that will help them remain calm and feel less anxious while we wait and see what happens, or see if we need to consider other options.'

STEP 2. The clinician asks more questions that facilitate further discussions about possible treatment options that are usually prescribed or applied.

Clinician: 'We could wait and see if the voices go away by themselves or we could start a low dose of what they call benzodiazepines, you know that medication I spoke about. This might provide you with some relief and help you manage the voices in the meantime. Would you like me to tell you more about this as an option?'

This is a relatively straightforward example, however if this was applied to the process of starting antipsychotic medication or discussing the need for an inpatient admission then the clinician may need to provide more detailed information.

STEP 3. The clinician and young person have a discussion about the potential benefits and harms involved with the options available.

Clinician: 'If you decide to wait and see if the voices go away by themselves and are you're not keen to take any medication there is a chance that you may continue to worry about what they are saying and this may have a further impact on your mood and sleep. Whereas if you were prescribed some benzodiazepines you might not feel as distressed or worried about what you're hearing them say and are more likely to be able to get on with things in your day-to-day life. There are some common side effects associated with taking benzodiazepines. Some people can feel tired, drowsy, have slurred speech or memory problems. We usually start at very low dose to avoid these side effects. During longer-term use there is a chance that people can develop a tolerance or dependence on these types of medications, however, we tend to use them for short periods of time. We would also advise you not to drive if you were taking these medications as it can affect your reaction time.'

STEP 4. The clinician attempts to understand the young person's preferences, values and circumstances with regards to the options available. This may include finding out more about their immediate needs and short-term goals. Clinicians should attempt to gauge how much the young person has understood the information to see if they need additional information or clarification of benefits and harms associated with a particular choice of treatment.

Clinician: 'Now that I've told you a little bit about the options, what do think? Is there one that you prefer?'

STEP 5. The clinician asks questions to see if the young person requires additional information, time or input from others to make decisions regarding treatment options.

Clinician: 'Do you have any more questions that you would like to ask about possibly commencing? Do you think you can make a decision or do you need to chat with mum and dad about it first?'

'Even if you're not doing well or really confused or you know you're having trouble making decisions … I'm not 100% gone, there's still a part of me there and I can still make some decisions … it's important people know that.'

Young person,
EPPIC, Orygen Youth Health Clinical Program

TRUNG

CASE SCENARIO (CONTINUED FROM PAGE 60)

When the clinicians felt they had enough information to establish Trung's overall risks status they briefly excused themselves to discuss Trung's presentation and collateral information. After promptly analysing the available information, they developed a provisional aetiological and a risk formulation. Their clinical judgement and choice of interventions were guided by both formulations and their clinical experience. The clinicians undertook a brief 'risk versus benefit analysis' comparing the risk and benefits associated with an inpatient admission versus home-based care in this case.

Please see Trung's risk–benefit grid below that outline the advantages and disadvantages of inpatient treatment versus home based care.

RISK–BENEFIT ANALYSIS FOR TRUNG

TREATMENT OPTIONS	RISK/DISADVANTAGES	BENEFIT
Inpatient admission	• Young person • Impact on engagement • Potential for further trauma • Not in own environment • Maybe vulnerable to other inpatients • Stigma associated with admission • Feel controlled • May reinforce paranoid/ persecutory themes • No access to personal items/pets • No guarantee early psychosis bed	• Access to phase specific appropriate care on early psychosis unit • Closer monitoring and supervision but not guaranteed to reduce risk • Medication and prescribers are more readily accessible • Emotional distress and sleep can be treated more assertively • Less chance of negative outcomes (suicide, further deterioration in MSE, substance use)

TRUNG

CASE SCENARIO (CONTINUED)

TREATMENT OPTIONS	RISK/DISADVANTAGES	BENEFIT
Acute home-based care	• Less professional supervision • No immediate access to acute expert care • More burden on family • Environment potential prone to more dynamic external stressors	• Treated in least restrictive and familiar environment • Less traumatic • Young person likely to experience less stigma • Have access to personal items • More normal experience than inpatient admission • Less likely to experience frustrations re: service processes (waiting for doctors, telling story to different staff) • Not prone to vulnerability or exposure to additional iatrogenic trauma on the inpatient unit • May be able to continue to engage in meaningful activities • Feels supported by family • More consistent monitoring by family (who are more familiar) than on ward

The clinicians decided that acute home-based care would be the best approach to managing Trung's crisis. The acute home-based care would require a brief medical review with the intention of starting benzodiazepines, followed-up with daily home visits (up to 2 times a day), close monitoring of risks and regular medical reviews. Trung's identified risks and risk factors were discussed with the consultant psychiatrist and the suggested plan was ratified by the consultant psychiatrist. Assessment feedback was provided to Trung and his family along with written information about the early psychosis service and the 24 hour contact number.

Trung remained settled and the police were no longer required. Trung and his family were transferred from the crisis outreach team to the after-hours service for medical review to facilitate the prescription for benzodiazepines and hypnotic medications.

A detail handover was provided to the medical registrar. The medical registrar provided Trung and his family was information on the benefits and side effects of benzodiazepines. Trung agreed to take the medication and was administered diazepam 5 mg.

Implementing strategies in a crisis

A range of strategies can be used in crisis situations that aim to minimise risks of the situation and alleviate the crisis itself. Examples of strategies and techniques that can be used during a crisis are described below.

De-escalation techniques

During a crisis, clinicians need to rapidly assess and de-escalate the situation. De-escalation uses psychosocial techniques to calm people who are agitated or being aggressive.[45] It is not meant to be a prescriptive or structured technique but should be viewed as a flexible set of useful options that clinicians can use to try and help the young person control their behaviour.[45] De-escalation interventions are thought to help facilitate engagement with services, build rapport and trust with clinicians, are likely to prevent the need for restraints or unnecessary hospital admission and subsequent iatrogenic harm.[45]

A commonly-used model of de-escalation developed by the American Association for Emergency Psychiatry is a three-step approach: 1) verbally engage the individual 2) establish a collaborative relationship 3) verbally de-escalate the situation. Verbal and non-verbal forms of communication are equally important in effective de-escalation. Clinicians should focus on trying to engage the young person as an active partner in the intervention. Tips for de-escalation are described in Box 7 and 8.

BOX 7 **TIPS FOR DE-ESCALATION**[46]

- Respect young person's space, about 2 arm lengths, allows them space and you room if you need to move.
- Hands should be visible, no clenched fists and stand on an angle as less confronting than front on.
- Posture should be open, hands out of pockets, no crossed arms as this is defensive and can be perceived as lack of interest.
- Body language needs to be congruent with what you are saying.
- Calm demeanour and facial expression. Use slow and deliberate movements – quick actions may surprise or scare the other person.
- Avoid excessive direct eye contact.
- One clinician to establish verbal contact, other clinicians can alert duress team and remove bystanders
- Be polite and introduce yourself. Reassure why you are there – to help and make sure everyone is safe.
- Provide some information re process and what to expect.
- Ask their name and what they would prefer to be called.
- Be concise – keep it simple, use short sentences and plain languages. Speak slowly as this interpreted as soothing.
- Repetition is essential when setting limits, proposing alternatives, offering choices.
- Identify what the young person wants – to vent and feel heard, medication, for assistance.

BOX 8 EXAMPLE STATEMENTS AND STRATEGIES THAT CAN BE USED TO DE-ESCALATE A CRISIS

By saying statements such as 'For me to be able to help you, I need to understand what you expected when you came here'. 'I'm not sure if I'm the right person, but I'm happy to try and help you with this'.

You can ask the young person what they think will resolve the problem and look for alternatives *with* the young person. Clinicians should try to have two or more options. Empower the young person to choose. If one approach doesn't work, then try a different one.

If the young person is shouting, drop the volume in your voice, they may mirror you. 'Brandon I'm having a hard time concentrating and understanding what you're saying because of how loud your voice is'.

Clinicians should use past information and previous interactions to build rapport and problem solve with the young person.

Clinicians and treating teams should try to listen attentively and seek clarification – use paraphrasing, summarising, reflecting, open-ended questions. This conveys a sense that young person is being listened to and understood. Using statements such as 'Jason tell me if I understand correctly …' 'When you say … do you mean?' 'Okay … yep, that makes sense.' 'What I hear you saying is … ' Or 'Okay, let me make sure I understand you … you've told me that people are bothering you and that your case manager is not helping you. That your meds are making you feel sick. Did I understand you correctly?'

Sometimes, clinicians may need to move from empathic statement to action statements if clinicians need to be more directive. By saying 'I understand that you are upset and that you feel like no one is listening to you or doing enough to help you. But you and I need to let these people get back to work here. I'd like you to walk with me to an empty room so you and I can talk.'

Give choices as it helps the young person save face, have options and not feel controlled.

Dealing with the emotions of the young person and their families

Clinicians should allow the young person and their family to express their feelings and emotions in an accepting, supportive and non-judgemental environment. It is equally important for clinicians to acknowledge that the family may be seeking help on the young person's behalf and the young person may not want help. This situation can be very challenging as there could be mixed and conflicting messages from both the family and the young person. Dealing with the feelings and emotions is done through active listening and listening in an empathic and supportive manner.

Allowing young people and their families to express their feelings and emotions from the beginning will:

- facilitate engagement
- help with the assessment process
- be a therapeutic intervention itself that alleviates distress during the crisis.

Use solution-focussed therapeutic strategies

Many young people attempt to manage challenging situations by using their usual coping techniques but sometimes they may not have sufficient life experience or adequate problem-solving strategies to do this without help. There are a number of factors that can have an impact on a young person's ability to cope during a crisis, including:

- cognitive ability
- problem-solving skills
- coping styles
- interpersonal deficits
- environmental stressors
- level of social supports.

Solution-focussed strategies (such as solution-focussed brief therapy) should be used to help young people explore other options during a crisis.[47] Clinicians should use these strategies to

help young people develop and focus on positive goals, in other words, focus on what they would do instead of what they wouldn't do. A clinician may ask a young person the question 'What will you do instead when someone calls you names?' Or 'What did you do that was different?' By asking these questions, the clinician is encouraging the young person to identify what worked for them when dealing with a problematic situation.

Coping questions can also be used to help young people identify their own resources that may have gone unnoticed by themselves. They can be used to ask young people about how they manage to cope despite experiencing a difficult time. Clinicians can use questions such as 'I can see things have been really difficult for you lately, yet you keep going day-after-day. How do you manage to do that?' Or 'Even though you have been experiencing these voices, you've still managed to function really well. How have you managed to carry on?' Questions should be asked by clinicians in a respectful manner to help highlight the young person's strengths without being patronising.

Clinicians can use solution-focussed brief therapy to help young people identify goals to work on and rediscover existing strengths and skills. Conversations and questions used in the solution-focussed brief therapy are focussed in the present or future and only draws on the past to learn about the current problem.[4,35,46,47] Examples of solution-focussed brief therapy questions and conversations are presented in Box 9 below.

BOX 9 SOLUTION-FOCUSSED BRIEF THERAPY EXAMPLE QUESTIONS AND CONVERSATIONS[47]

Looking at previous solutions

Clinicians should ask young people about previous situations where stressors have not been problematic and find out how the young person was doing at this time.

> 'When you have felt distressed or overwhelmed in the past, what types of things have helped you manage this feeling?'
>
> 'You've said the voices have returned in the past, what sorts of things have you done to help you try and manage them?'

Looking for exceptions

Clinicians should ask young people about similar circumstances or situations that have not resulted in a crisis.

> 'It sounds like you've had relationship breakups before and they haven't seemed to impact on you like this … what did you do to these break ups?'

Acknowledge what is already working

Clinicians should validate young people to highlight what is currently working for them in these difficult situations.

> 'I know you're going through a difficult time. It seems to be that adding structure to your day really seems to be working. I think you're doing a fantastic job given the circumstances.'

Provide spontaneous and appreciative comments

Clinicians should complement young people to highlight their strengths and encourage them to complement themselves.

> Young person: 'You know how I have a routine where I have to touch things before I go to bed … well last night it only took me 5 minutes.'
>
> Clinician: 'Wow! How did you do that?'

‘Every time I’ve ended up in ED, I’ve either ended up having to be sedated or shackled or sectioned or whatever so I just don’t like it, it’s awful.’

Young person,
EPPIC, Orygen Youth Health Clinical Program

Use distraction techniques

Using distraction techniques and activity scheduling can help young people to learn to focus their attention from strong emotions to tasks and activities they enjoy doing and fill their time. Furthermore, these strategies can also help young people be in control when they are feeling overwhelmed. Distractions for young people can include:

- multimedia:
  - playing video games
  - listening to music
  - watching DVDs
  - YouTube
  - Pinterest
  - Instagram
- grounding activities
  - meditation
  - relaxation
  - mindfulness
- physical activity
  - going to the gym
  - walking the dog
  - skateboarding
  - soccer or basketball with friends
- evoking opposite emotions
  - watching comedy
  - listening to cheerful pop songs
- menial tasks that often make people feel better
  - household chores
- sleeping to cope or recuperate.

Managing imminent risk to self or others

Clinicians should manage the young person’s imminent risk to themselves and others during a crisis whether it be face-to-face, in a clinical setting or over the phone. It is important to establish whether a young person has access to means of attempting suicide (has a weapon or is standing on a bridge/high building etc.), is medically compromised, is physically aggressive and intending to harm others, is alone and confused or in potentially dangerous circumstances. If a young person is at imminent risk, clinicians should immediately contact emergency services. If a young person on the phone is medically compromised or has access to means then try to keep the young person on the phone while trying to get other clinicians to call emergency services using paper/text or hand gestures.

If a young person has ingested poisonous substances or you suspect that they have taken an overdose, try to ask the young person what they have taken, when they took it and how much they took. Clinicians should call the poisons line or emergency services for immediate medical treatment. Remain on the phone with the young person and ensure that they are alert until emergency services arrive.

If during a face-to-face clinical setting a young person has razor blades or a weapon and they let you know they have it on them while they are with you, ask the young person if you can keep the item for safe-keeping. Explain to them that you want to help them manage the situation and it may be difficult for you to help them knowing that they have these items on them. It might be helpful to explain to the young person that it is service policy that these items cannot be part of the interview and assessment.

Involving the police

Some crisis situations may require the assistance of the police despite the best efforts of the clinicians to de-escalate the situation. Involving the police is not considered to be first course of action, however, there will be times when it is necessary. The assistance of the police or emergency services may be required when:

- significant verbal threats to others are made
- the young person displays significant aggression
- the young person possesses a weapon
- the young person is considered to be high-risk of self-harm
- the young person is at risk of absconding
- the young person is medically compromised and is reluctant to access service
- there is a history of unpredictable and hostile behaviour.

If a young person is threatening a clinician it is advised that the clinician does not turn their back on the young person. In situations where clinicians feel unsafe, they should leave the environment immediately and inform the young person that they are leaving. Sometimes it may not be possible to tell the young person that you are leaving.

If the police are required for a situation that is not a crisis situation such as to assist with involuntary treatment or hospital admission, conducting a welfare check or home-based assessment with known risks then clinicians should contact the local police station to ask for assistance.

It is important to remember that police officers are not trained mental health professionals but are trained in negotiating challenging situations as part of their role. Clinicians should provide information on the current situation, why they need to be involved and how the clinicians are intending to manage the situation. This can also be an opportunity to provide psychoeducation to emergency services and the police focussing on the principles of early intervention and reducing trauma. In a crisis situation that requires prompt and immediate response from the police, call 000 for emergency services. Tips for involving the police during a crisis are presented in Box 10.

Often young people think they have committed a crime when they see the police and this may further intensify the paranoia a young person may be experiencing. Therefore clinicians should try to carefully explain why the emergency services and the police are present. The clinician should also reassure the young person that they are not in trouble and that the police are there to ensure everyone's safety. The clinician and police can usually work out how they can best manage the situation. It can simply be the police be present at the doorway of the young person's room while the clinician sits in the room, or the police may need to be in the same room sitting next to the young person. Clinicians and the police can negotiate how best to approach each situation depending on its nature before interacting with the young person.

An example of a potential dialogue between a clinician and a young person to explain why police are present could be:

> 'Johnny, I've asked the police to attend today because I am really worried about you and what's been going on. I've thought about what you have told me and at the moment I think you need to be somewhere safe, where you can get some help. The police are here to try make sure everyone is safe and nobody gets hurt and to make sure you get the help you need. I want you to know that you've done nothing wrong. I'm just worried that if you don't get the help you need that things may get worse.'

If a young person is transported by the police to the nearest hospital or clinic for further assessment, clinicians should try and meet them at the receiving hospital to help communicate pertinent clinical information to staff at the inpatient unit. The presence of the clinician may also help reassure the young person and prevent further deterioration of the situation. If the young person has been handcuffed, have police remove the handcuffs as soon as possible to ensure that the young person is comfortable.

BOX 10 TIPS FOR INVOLVING THE POLICE IN CRISIS SITUATIONS

In a crisis situation where the emergency services and police are contacted, clinicians should:

- provide the address and details of the emergency
- inform the police of who you are and your role
- provide accurate details of the young person, including:
  - name
  - date of birth
  - address
  - their current location, whether they are inside of outside of their home
  - who else is around
- provide a description of the current problem (i.e. aggression/suicide/unpredictable behaviour)
- provide a brief history of risks, access to weapons, information about previous contact with police and other services, information about how the young person may respond to police
- provide several contact numbers
- provide a description of your car
- arrange to meet police or emergency services at a location away from the address that is safe for everyone and will not raise the suspicion of the young person
- when police arrive, identify yourself, provide a brief introduction and reiterate the current situation
- If clinicians feel that it is safe and feasible to assess the young person with a police officer present then this should be attempted. Some young people respond well to the presence of the police, others do not. If clinicians feel that the young person's behaviour is not conducive to further assessment then it may be necessary for the police to detain the young person under the Mental Health Act and transport them back to the nearest clinic for further assessment.

Providing information to the young person and their family

During a crisis, information and feedback should be provided to the young person and their family using the principles of psychoeducation (please see the ENSP manual *A shared understanding: psychoeducation in early psychosis*). The information provided to the young person and their family should include clear descriptions of the formulation, the agreed plan to address the crisis and reduce risk (please see 'Preventing future crisis and reducing risk'), and plans for follow-up and reviews.

Towards the end of the crisis intervention, clinicians need to establish when the next clinical contact or review will be with the young person and their family. How soon the young person needs to be seen for a review depends on the clinician or the team's clinical judgment on the young person's presentation, risks and level of supports.

Preventing future crisis and reducing risk

Clinicians or treating teams should develop a risk management plan that outlines targeted interventions to reduce individual and overall risk once a comprehensive assessment of the mental state and a risk formulation have been conducted. The risk management plan should be developed with an emphasis on engaging the young person and managing the crisis in their home environment. The level of detail of the risk management plan will depend on:

- how much information clinicians have about the young person (i.e. new to the service versus an existing young person)
- the number and types of identified risks (acute or chronic risk)
- their pattern of risk
- the complexity of the young person's presentation.

Risk management plans developed for young people who are new to the service and experiencing an initial psychotic episode are more likely to be simple in structure and content compared with an existing young person or a young person with a complex presentation. Clinicians should develop initial crisis plans based on the response to the identified needs and risks of the initial assessment. Initial risk management plans should be developed collaboratively with the young person and their family where possible. Risk management plans should address a number of issues which will be described below.

Removing the means for suicide

Clinicians should ask family members or other agencies to remove the means for suicide if a young person has indicated that they have a clear specific plan with intent and access to means. This often involves getting family members to remove access to the following:

- medications
- knives and other sharp instruments
- poisons including household products.

These items can temporarily be locked away until the crisis and risks have passed, then can be gradually introduced back into the home. Young people should gradually be entrusted to be responsible for their own medications.

Facilitating hospital admission if necessary

Clinicians need to carefully consider whether a young person requires medical treatment or containment in a hospital if they are medically compromised or displaying significant risky behaviour. If a young person has self-harmed then medical treatment in a clinical setting is required to treat wounds, overdose or injuries. If a young person presents with acute psychotic symptoms and is at significant risk of assault to others then an inpatient admission should be arranged.

Enrol supports

The number and quality of supports that young people has access to during a crisis can often have an impact of where the young person receives care, whether it is at home or in clinical setting. Some young people may be estranged from their family, be geographically separated or be reluctant to have family or other supports involved. Providing successful treatment and care in the home depends on the amount of support and monitoring families, supports and other agencies can provide between visits from early psychosis services.

Clinicians should involve family and supports as collaborative partners in developing treatment and risk management plans for the young person from the beginning. Involving family and supports should be done by informing the young person, carefully explaining why they want to involve their family and asking for their consent. In circumstances where there are clear and imminent risks or there is minimal information regarding risks, clinicians may need to try obtain information from family and supports regardless of whether the young person gives consent or not.

The level of support a young person requires if treatment is provided in the home needs to be clearly communicated to family and supports by clinicians. Often, during or after a crisis, 24-hour monitoring is initially required. Families and supports need to clearly understand the expectations of home-based care to ensure that a safe and supported plan is implemented during a crisis, as a misunderstanding or variation in a plan could result in a negative outcome. Clinicians should provide families and supports with a realistic expectation of how long the support is required (i.e. 2 days or 2 weeks) and a medical certificate so that they can take time off work to stay at home with the young person if required. Clinicians should encourage parents to stay home with the young person and directly be involved with their care as much as possible. For more information, please see the ENSP manual *There's no place like home: home-based care in early psychosis*.

Involving other agencies

If other agencies are involved in providing support to the young person and are expected to be active supports during a crisis, they should be included in developing the treatment and risk management plan. Clinicians should clearly communicate the treatment and risk management plan with supporting agencies in both verbal and written forms and allow agencies the time and space to voice their anxiety and concerns about the plan. Clinicians should allow agencies the time to discuss the plan within their own teams, raise concerns and clarify any issues with the treating team.

Medical management during a crisis

Young people may be overwhelmed, emotionally distressed and physically agitated during a crisis, and the primary objective of crisis intervention is to reduce the distress and agitation of the crisis situation and prevent the crisis escalating into an emergency. Non-coercive psychological and practical attempts at de-escalation are always considered first-line management of a crisis, however such strategies may not be successful. Clinicians should carefully consider the use of medical intervention during a crisis when:

- other strategies, including verbal and non-verbal intervention, have not helped to reduce the distress of a crisis
- there is a clinically indicated need to use medication
- the crisis has the potential to escalate into a psychiatric emergency.

Young people and their families may be reluctant to begin medication because of the stigma attached with mental health symptoms and mental health service involvement, they lack understanding about the need for medication or may be mistrusting of why the medication is being prescribed.

The second edition of the *Australian Clinical Guidelines for Early Psychosis* recommends a 48-hour medication-free observation period prior to beginning antipsychotic medication to confirm the diagnosis of psychosis and exclude organic causes.[49] An oral dose of benzodiazepines can be used during this observation period to help alleviate distress, reduce agitation, and promote rest and sleep (for more information please see the ENSP manual *Medical management in early psychosis: A guide for medical practitioners*). If oral administration is not suitable or accepted then a short-acting intramuscular injection of benzodiazepine can be used.

Clinicians should give a clear rationale for why benzodiazepines are being used to treat certain symptoms to young people and their families before they begin the medication especially if the young person is treatment-naïve or new to the service. The possible benefits and side effects of benzodiazepines (fatigue, drowsiness, problems with memory, psychomotor performance) should be carefully discussed with young people and their families using plain language and translated or written down if required.

Short-term goals involving the use of medication should be set collaboratively with the young person and their family. Clinicians should allow young people and their families several opportunities to discuss their concerns about using medication and ask questions.

If benzodiazepines are prescribed, the lowest possible dose to control symptoms should be used. Antipsychotic medication can take at least 2–3 weeks to affect core positive psychotic symptoms. The dose escalation should be done slowly in a series of careful 'steps' and only if required (for more information please see the ENSP manual *Medical management in early psychosis: A guide for medical practitioners*).

Young people's mood may be significantly elevated or a young person may be significantly depressed during a crisis which may warrant a review of existing prescribed medication (whether it be mood stabilisers or antidepressants) in consultation with a medical registrar or consultant psychiatrist.

Initial adherence to medication during a crisis is important and clear communication about why medication is used will increase the knowledge and understanding of young people. Some young people will have difficulty remembering to take their medication, especially when they are overwhelmed, cognitively impaired or sedated. Helping young people with the self-administration of their medication using strategies, including:

- setting a reminder on a phone or using an App
- placing medication in a visible frequented place – near toothbrush, next to breakfast cereal or by the phone charger
- providing prompts on a whiteboard/blackboard, post-it notes (on door, bathroom mirror).

Involving family and support in the administration of medication can improve adherence during a crisis. Clinicians should provide psychoeducation to families and supports about how the medication works, how take it (with or without food), when best to take the medication and the potential side effects associated with their use. It is important that family members and supports have access to this information and understand what they have been told. Clinicians should have families and supports repeat the regime, dose and rationale to ensure they understand it. A written plan of how and when to take the medication should also be provided.

Overdose of prescription medications is common in young people with early psychosis (64% of young people presenting with suicidal behaviour).[20] Therefore, clinicians and prescribers should be mindful of the amount of medication they provide to young people in crisis. They also should enquire about how much access young people will have to previously prescribed medications in their home environment. Providing limited or a 'safe amounts' of medication during a crisis may reduce opportunities for overdose, abuse and fatalities if prescribed thoughtfully.[20]

Ensuring contact with services

Clinicians should ensure that young people and their supports have written contact numbers for the service so that they are able to communicate with them regarding risks and further supports. Providing young people and their families with business cards with all the necessary contact numbers will help to improve communication and allow treating teams to respond to and manage the young person in a crisis. These contact numbers should include an after-hours crisis number and clinicians should encourage families or supports to put this in a central place that is easily accessible. Providing young people and their families with contact numbers can help them feel reassured.

Contingency plans

During and after a crisis, clinicians need to anticipate any foreseeable increase in the level of risks for young people and their families; treatment plans should include contingency plans for anticipated risks. Clinicians should try to help young people identify previously effective and helpful coping strategies or distraction strategies they could use to help alleviate distress, symptoms or risk. These contingency plans should be clearly discussed with young people and their families or supports.

Following up post-crisis intervention

It is essential that the treating team follow-up with young people and their families after a crisis. Clinicians need to clearly explain when the next contact with the service will be, why it is important to see the service again and where this contact will take place, whether it is in a clinical setting or in the home. Following up with young people and their families, either face-to-face or over the phone, provides them an opportunity to debrief post-crisis and allows the treating team to do a comprehensive review of the young person and their crisis. Evidence suggests that telephone contact during a crisis can help reduce an individual's suicidal ideation, suicidal intent and their sense of hopelessness.[50,51]

Debrief

Clinicians should allow young people and their families or supports several opportunities to debrief following a crisis. Young people should be provided with counselling regarding their recent crisis and emotional support to help discover and draw on strengths following the crisis. Clinicians should provide positive feedback to young people regarding their attempts to manage their situation, and reassurance and hope regarding the short-term management of their symptoms, risks and recovery. Families and support should also be informed about the process of follow-up so they can be actively involved in the young person's care and help facilitate attendance and provide additional information to the treating team. Informing young people and their families about follow-up appointment can help them feel reassured and supported and can contain the initial crisis.

Families and supports should be encouraged to attend follow-up appointments with young people and be given opportunities to ask questions and express their concerns about the recent crisis. Furthermore, it also helps clinicians to get collateral and corroborative information from families and supports that helps develop their overall understanding and informs the formulation of the young person, their presentation and risks. Family members and supports should be provided with specific information about early warning signs for suicide, a deterioration in mental state and possible harm to others that helps them recognise and identify behaviours associated with increased risk.

Reviews

Reviews of young people post-crisis can:

- provide an opportunity for clinicians establish rapport and further develop engagement
- facilitate consistent monitoring of the mental state
- provide an opportunity to complete a comprehensive biopsychosocial assessment including a physical examination and baseline investigation such as blood tests and a CT scan
- help clinicians understand the personal context of the crisis and further develop a formulation
- provide an opportunity for clinicians to focus on identified risks and refine the risk management plan
- provide an opportunity for additional psychoeducation about:
  - the early psychosis service
  - medication (if required) and other interventions
  - treatment, risk management and contingency plans
- provide an additional opportunity for young people to ask questions
- provide an opportunity for the experience to be part of the ongoing therapeutic process.

Young people presenting with acute risks that are manageable in the community, should be seen again for a review within 24 hours by the acute team or by their regular treating team. This review may include a medical registrar or consultant to conduct a medical review. Young people with acute symptoms and risk should have contact, either by telephone or face-to-face, with their treating team at least 2–3 times a week or as often as required including several times a day if necessary.

Reviews should always take place in a safe environment. If clinicians need to review the young person in their home, then medical staff members should accompany the treating team and attend initially to perform the necessary assessment and begin medication if required.

Reviews should be conducted by the same clinicians wherever possible to provide consistent and reliable monitoring of the young person's mental state and risk, and to further facilitate engagement and reduce unnecessary repetition. After each review, risk management plans, treatment plans and risk formulation should be updated, documented and communicated to the treating team.

The young person should continue to be seen post-crisis every 24–48 hours until:

- mental state stabilises
- acute risks subside
- the crisis begins to resolve
- functioning improves
- the young person can start to rely on existing coping mechanisms.

Communication with the clinical service

Clinicians should clearly document and communicate the crisis and the follow-up plan post-crisis to other members of the treating team. The crisis and the follow-up plans should be discussed during clinical review meetings. During the clinical review meetings, a clear action plan outlining who is involved the young person's care that is, either the acute team, the case manager or the psychiatrist, or all of them.

TRUNG

CASE SCENARIO (CONTINUED FROM PAGE 63)

Trung was seen the following day by members of the mobile outreach team and one of the clinicians from his initial assessment returned for the home visit. Because rapport had already been established, Trung was more conducive to sharing information and this allowed workers to focus on relevant risk content. Areas of the assessment that were not previously covered in as much detail were discussed. The follow-up at home allowed workers to observe if there was any further deterioration, fluctuation in or improvement in symptoms or any change in level of distress and risks.

Trung continued to experience paranoia and persecutory ideation; however, he was less distressed and preoccupied about his safety than before. He said he was sleeping well because of the night-time medication and was reassured by his stepfather sleeping in his room. Trung said 'I felt safer with him being there'.

He continued to experience auditory derogatory and command hallucinations, with the voices telling him to 'kill himself', however his experience of the voices was less intense and distressing. He said 'I still hear them most of the time but they don't seem as loud this morning … and I'm not getting as upset'.

Overall, he felt more in control of his behaviour, was less agitated and less anxious. He said he was still experiencing ongoing low mood, but felt slightly more hopeful given the support and reassurance workers had provided.

The workers reviewed Trung's adherence and tolerance, and the efficacy of the prescribed medication. Further information regarding the rationale and potential therapeutic actions of medication was provided. The workers emphasised the therapeutic effect of the medication in terms of reducing his anxiety and agitation and promoting sleep. This was also a good opportunity for workers to introduce information about antipsychotic medication and the role it has in helping reduce distressing auditory hallucinations and ongoing paranoid themes in the longer-term; the potential side effects of this medication was also discussed. Trung and his family were receptive at the suggestion if this would help treat Trung's symptoms and aid his recovery.

The interaction also involved conversations in a further attempt to understand more about Trung's premorbid functioning, his goals, aspirations, interests and who he is as person.

Corroborative information regarding Trung's behaviour over the previous 24 hours was obtained from his parents. The family were joined by Trung's older sister Tien. Staff continued to provide brief phase specific psychoeducation to Trung and his family, building on the information provided the previous day, clarifying points and offering additional opportunities for his parents to ask questions. They were provided with an opportunity to reflect and debrief on the events of the previous day.

TRUNG

CASE SCENARIO (CONTINUED)

The existing treatment plan, including the safety plan and suggested interventions, was re-evaluated to see if was effective in reducing risks, providing adequate supervision and symptomatic relief over the previous 24 hours. Both Trung and his family felt that overall things had improved and that the current interventions seemed to be appropriate and helpful. Trung's family were very grateful for the home visit, ongoing support, monitoring and information regarding his presentation.

Trung was encouraged to adhere with medication and make use of the as required medication when necessary. Trung and his family were encouraged to contact services if they had any concerns about his behaviour especially if this behaviour indicated an increased risk. They were reminded of service contact details and were encouraged to ask questions during home visits.

Together, Trung and his family were provided with reassurance and optimism regarding his potential for recovery. They were provided feedback and asked whether they needed extra support.

References

1. Gililand RK and James RK. The six-step model of crisis intervention. In James RK (ed). *Crisis intervention strategies*. Belmont, CA, 2008.
2. National Advisory Council on Mental Health. Early psychosis feasibility study report. 2011.
3. Stavely H, Hughes F, Pennell K et al. *EPPIC Model and Service Implementation Guide*. Melbourne: Orygen Youth Health Research Centre, 2013.
4. Roberts AR. *Crisis intervention handbook: assessment, treatment and research*. New York: Oxford University Press, 2005.
5. Bloch S and Singh B. *Foundations of clinical psychiatry*. Melbourne: Melbourne University Press, 2001.
6. Henry LP, Amminger GP, Harris MG et al. The EPPIC follow-up study of first-episode psychosis: longer-term clinical and functional outcome 7 years after index admission. *J Clin Psychiatry* 2010; 71: 716-28.
7. Guo S, Biegel DE, Johnsen JA et al. Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization. *Psychiatric Services* 2001; 52: 223-228.
8. Jethwa K, Galappathie N and Hewson P. *Effects of a crisis resolution and home treatment team on in-patient admissions*. 2007.
9. Robin M, Bronchard M and Kannas S. Ambulatory care provision versus first admission to psychiatric hospital: 5 years follow up. *Social Psychiatry and Psychiatric Epidemiology* 2008; 43: 498-506.
10. Tomar R, Brimblecombe N and O'Sullivan G. Home treatment for first-episode psychosis. *Service innovations*. 2003; 27: 148–151.
11. Gould M, Theodore K, Pilling S et al. *Initial treatment phase in early psychosis: can intensive home treatment prevent admission?* 2006.
12. Morgan S. *Clinical risk management: a clinical tool and practitioner.* London: Sainsburg Centre for Mental Health, 2000.
13. Power P and Robinson J. *Suicide prevention in first-episode psychosis*. Cambridge: Cambridge University Press, 2009.
14. Flewett T. *Clinical risk management: an introductroy text for mental health clinicians*. Sydney: Churchill Livingston, 2010.
15. Hider P. *Youth suicide prevention by primary healthcare professionals: a critical appraisal of the literature. New Zealand health technology assessment (NZHTA) 4.* 1998.
16. Klonsky ED. The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review* 2007; 27: 226-239.
17. Hunt IM, Kapur N, Webb R et al. Suicide in recently discharged psychiatric patients: a case-control study. *Psychological Medicine* 2009; 39: 443-449.
18. Power P and McGowan S. *Suicide risk management in early intervention*. Iris Initiative, 2011.
19. Lambert M. Initial assessment and initial pharmacological treatment in the acute phase. In Jackson H and McGorry P (ed). *The Recognition and Management of Early Psychosis: A Preventive Approach*. New York, 2009.
20. Fedyszyn IE, Robinson J, Harris MG et al. Suicidal behaviours during treatment for first-episode psychosis: towards a comprehensive approach to service-based prevention. *Early Interv Psychiatry* 2014; 8: 387-95.
21. Power PJ, Bell RJ, Mills R et al. Suicide prevention in first episode psychosis: the development of a randomised controlled trial of cognitive therapy for acutely suicidal patients with early psychosis. *Aust N Z J Psychiatry* 2003; 37: 414-20.
22. Robinson J, Harris M, Cotton S et al. Sudden death among young people with first-episode psychosis: An 8-10 year follow-up study. *Psychiatry Res* 2010; 177: 305-8.
23. Douglas KS, Hart SD, Webster CD et al. *HCR-20 (version 3): assessing risk for violence*. Burnaby, Canada: Mental Health Law and Policy Institute Simon Fraser University, 2013.
24. Borum R, Bartel P and Forth A. *Structured assessment of violence risk in youth (SAVRY)*. Thousand Oaks, CA: Sage Publications, Inc., 2008.
25. Grove WM, Zald DH, Lebow BS et al. Clinical versus mechanical prediction: a meta-analysis. *Psychol Assess* 2000; 12: 19-30.
26. Johnson S, Nolan F, Hoult J et al. Outcomes of crises before and after introduction of a crisis resolution team. *Br J Psychiatry* 2005.
27. Bryan CJ and Rudd MD. Advances in the assessment of suicide risk. *J Clin Psychol* 2006; 62: 185-200.

28. National Health and Medical Research Council. *Clinical practice guideline for the management of borderline personality disorder*. 2012.

29. Brewer WJ, Lambert TJ, Witt K et al. Intensive case management for high-risk patients with first-episode psychosis: service model and outcomes. *Lancet Psychiatry* 2015; 2: 29-37.

30. Statewide Quality Branch Rural and Regional Health and Aged Care Services. *Victorian clinical governance policy framework: a guidebook*. Melbourne, Victoria: 2009.

31. Power P, McGuire P, Iacoponi E et al. Lambeth Early Onset (LEO) and Outreach & Support in South London (OASIS) service. *Early Intervention in Psychiatry* 2007; 1: 97-103.

32. Edwards J and McGorry PD. *Implementing earlyintervention in psychosis: A guide to establishing early psychosis services*. London: Martin Dunitz, 2002.

33. Petersen L, Jeppesen P, Thorup A et al. A randomised multicentre trial of integrated versus standard treatment for patients with a first episode of psychotic illness. *BMJ* 2005; 331: 602.

34. Sjolie H, Karlsson B and Kim HS. Crisis resolution and home treatment: structure, process, and outcome - a literature review. *J Psychiatr Ment Health Nurs* 2010; 17: 881-92.

35. Roberts AR and Ottens AJ. The Seven-Stage Crisis Intervention Model: A Road Map to Goal Attainment, Problem Solving, and Crisis Resolution. *Brief Treatment and Crisis Intervention* 2005; 5: 329-339.

36. Shea SC. *Psychiatric interviewing: the art of understanding – a practical guide for psychiatrists, psychologistd, counselors, social workers, nurses and other mental health professionals*. Philadelphia, PA: W.B. Saunders Company, 1998.

37. Orygen Youth Health. *The acute phase of early psychosis: a handbook on management*. Melbourne, Victoria: Orygen Youth Health Research Centre, 2004.

38. Hawkins R, P. Selection of target behaviours. In Nelson R, O. and Hayes S, C. (ed). *Conceptual Foundations of Behavioral Assessment*. New York, 1986.

39. Smith B, Fowler DG, Freeman D et al. Emotion and psychosis: links between depression, self-esteem, negative schematic beliefs and delusions and hallucinations. *Schizophr Res* 2006; 86: 181-8.

40. Padesky CA. "Socratic questioning: changing minds or guiding discovery?". European Congress of Behavioural and Cogntive Therapies; London, 1993.

41. Sands N, Elsom S, Marangu E et al. Mental health telephone triage: managing psychiatric crisis and emergency. *Perspect Psychiatr Care* 2013; 49: 65-72.

42. Cormier WH and Cormier LS. *Interviewing strategies for helpers*. Pacific Grove: Brooks/Cole Publishing Company, 1991.

43. Persons JB. *The case formulation approach to cognitive-behvaior therapy*. New York: The Guilford Press, 2008.

44. Hoffmann TC, Legare F, Simmons MB et al. Shared decision making: what do clinicians need to know and why should they bother? *Med J Aust* 2014; 201: 35-9.

45. Mental Health Drugs and Regions Division. *Reducing restrictive interventions: a literature review and document analysis*. 2013.

46. Richmond JS, Berlin JS, Fishkind AB et al. Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med* 2012; 13: 17-25.

47. Walter JL and Peller JE. *Becoming solution-focused in brief therapy*. New York: Brunner/ Mazel, 1992.

48. Roberts A. *Bridging the past and present to the future of crisis intervention and crisis management*. Oxford: Oxford University Press, 2005.

49. Early Psychosis Guidelines Writing Group. *Australian Clinical Guidelines for Early Psychosis*. Melbourne: Orygen Youth Health, 2010.

50. Gould MS and Kramer RA. Youth suicide prevention. *Suicide Life Threat Behav* 2001; 31 Suppl: 6-31.

51. Gould MS, Marrocco FA, Kleinman M et al. Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. *JAMA* 2005; 293: 1635-43.

NOTES

Printed on 100% recycled paper, made carbon neutral.

This manual has been funded by the Australian Government and Orygen, The National Centre of Excellence in Youth Mental Health with kind support from Orygen Youth Health Clinical Program

9161_15_Orygen Studio