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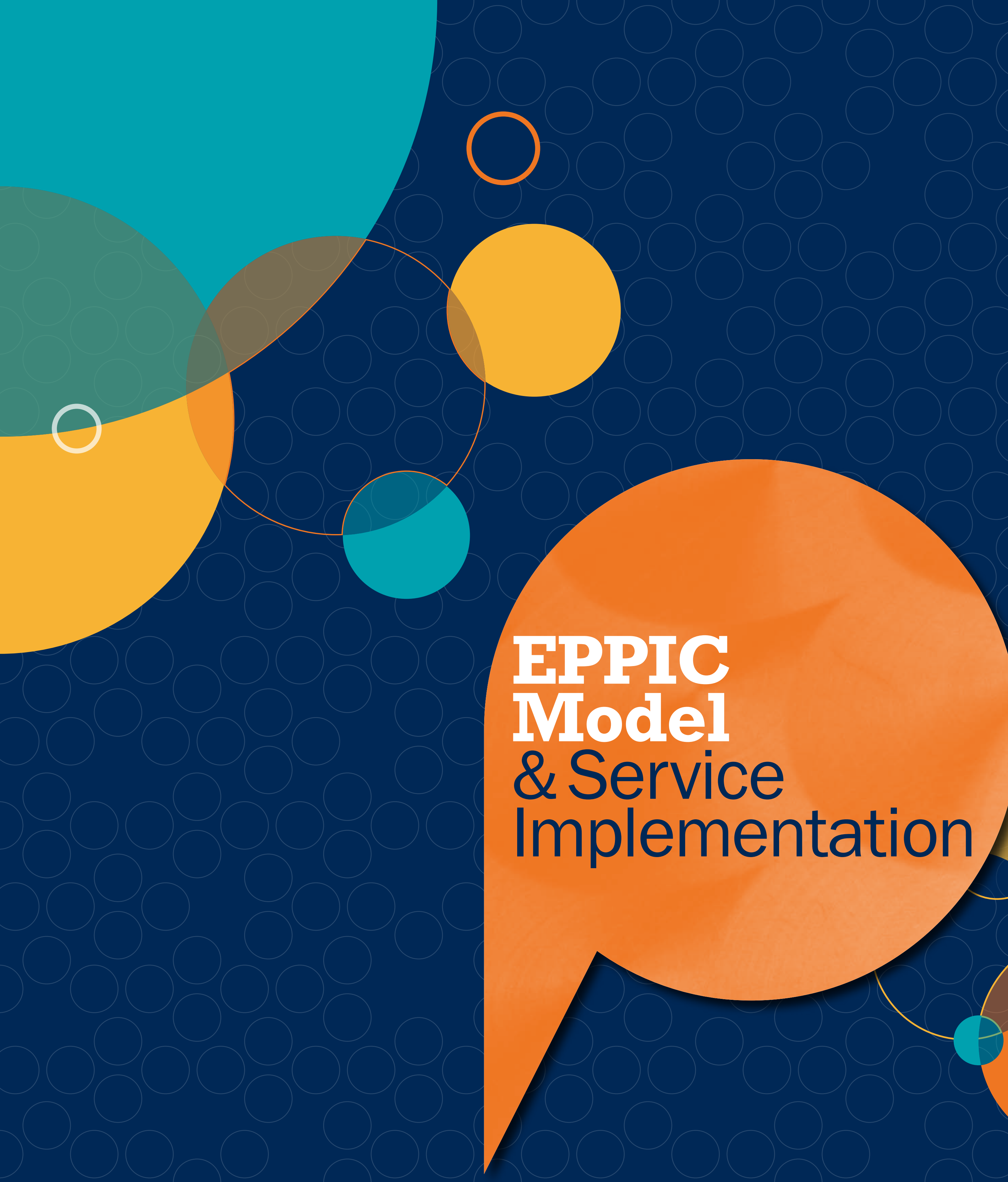

EPPIC Model & Service Implementation

Orygen YOUTH Health
Research Centre

EPPIC
Early Psychosis Prevention and Intervention Centre

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

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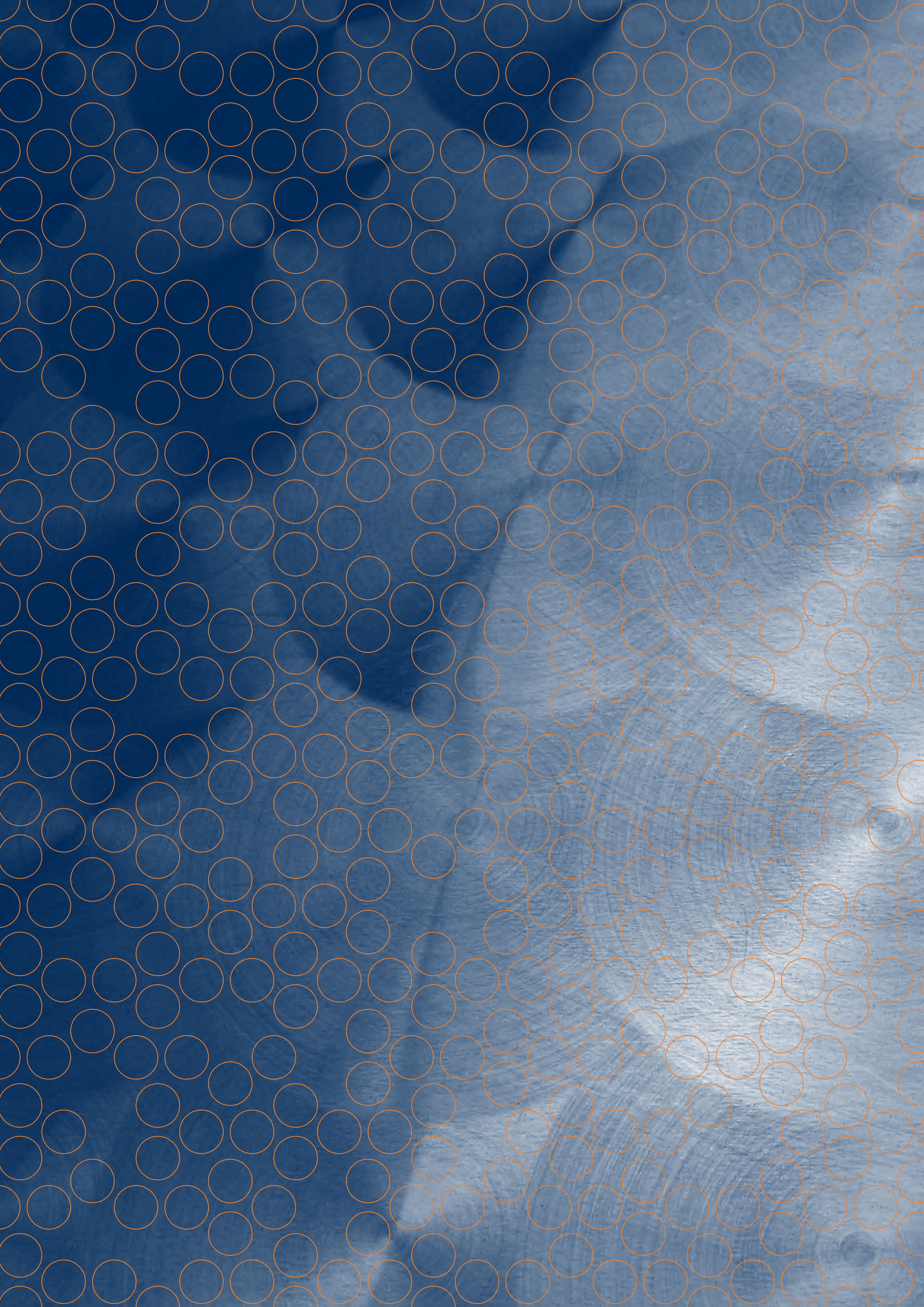

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Preamble

This document has been produced by the EPPIC National Support Program of the Orygen Youth Health Research Centre as a way to explain the Early Psychosis Prevention and Intervention Centre (EPPIC) model and to assist services when thinking about and planning for the implementation and provision of an ongoing EPPIC service.

The philosophy, aims and comprehensiveness of the model, along with a detailed description of each of the core components is provided. In particular, there is discussion about the four critical factors that are essential not only for the successful implementation of an EPPIC service, but also for sustaining one. These four critical factors are strong and empathic leadership, a clear and independent governance structure, a culture with a youth-friendly and collaborative approach and sufficient resourcing to provide a best practice service for young people.

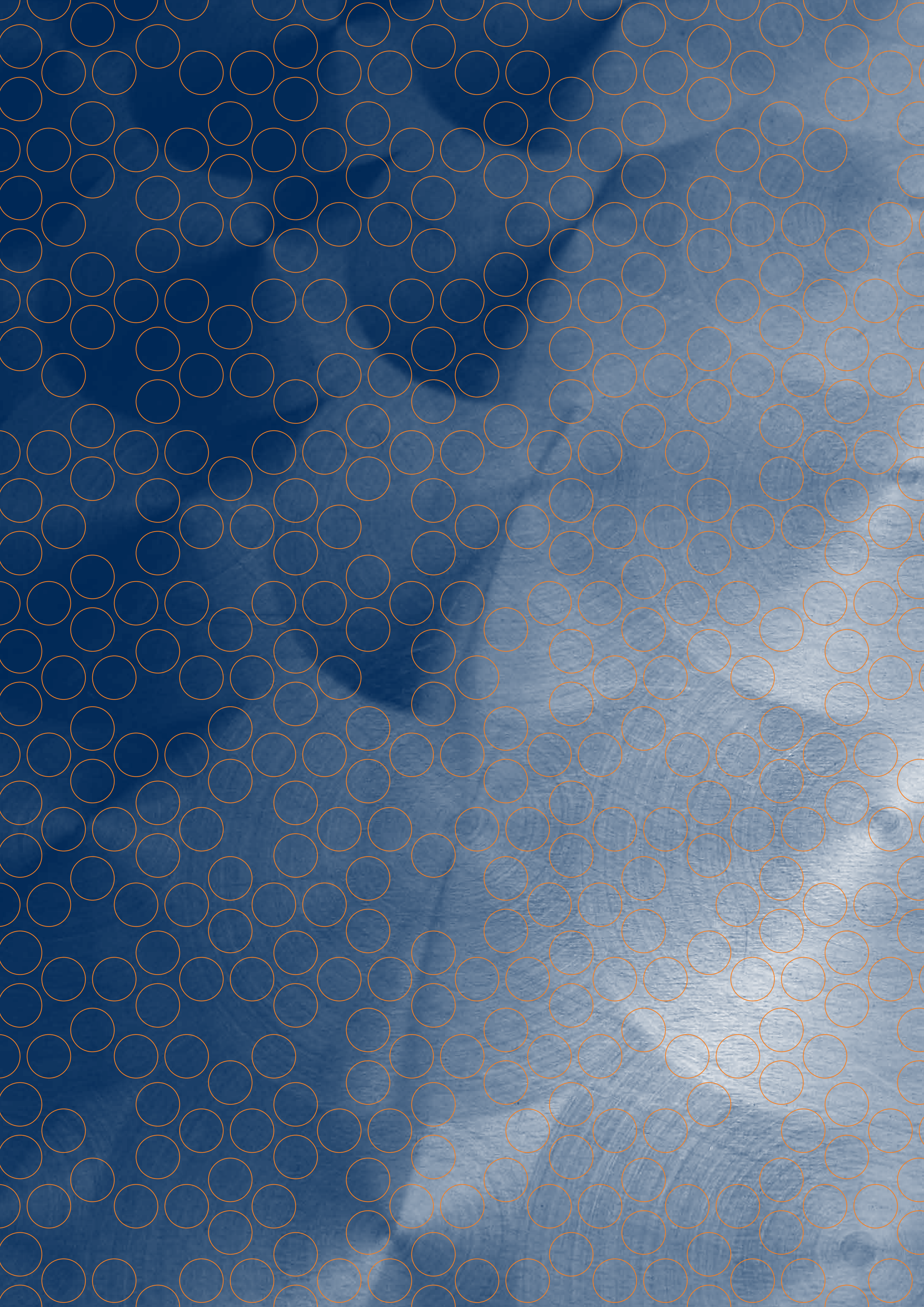
While each of the core components can be read separately it is important to note that the EPPIC model can only exist when all of the core components are provided. They also interrelate, so it is only when each of these core components are in place that an integrated and comprehensive service can be provided and achieve fidelity to the EPPIC model.

It is not only an exciting opportunity for services to be able to understand and implement the EPPIC model; but also a highly deserved focus on the whole area of youth mental health.

Included in the discussion on each of the core components are the opportunities and factors that facilitate success, as well as the challenges and enablers that can help in meeting both the service level and clinical level issues that may arise. There is a section on scaling up of services, as this can be one option to assist after initial implementation.

Clear detail is provided of all of the EPPIC standards, and these are divided into three groups. The first of these are the minimum essential or ‘given’ standards that will occur when implementing the model with the core components. The next are the secondary standards that need to be achieved, and the third are the guidelines that also incorporate the Australian Clinical Guidelines for Early Psychosis (2nd edition). By services taking note of and achieving these standards, fidelity to the model should be reached. In order to provide best practice care for young people experiencing the early stages of a psychotic disorder, and to their family and friends, it is recommended that services read this document fully and also for clinicians to work to the standards listed and to the Australian Clinical Guidelines for Early Psychosis (2nd edition).

It is not only an exciting opportunity for services to be able to understand and implement the EPPIC model; but also a highly deserved focus on the whole area of youth mental health.



SECTION 1

The EPPIC Model

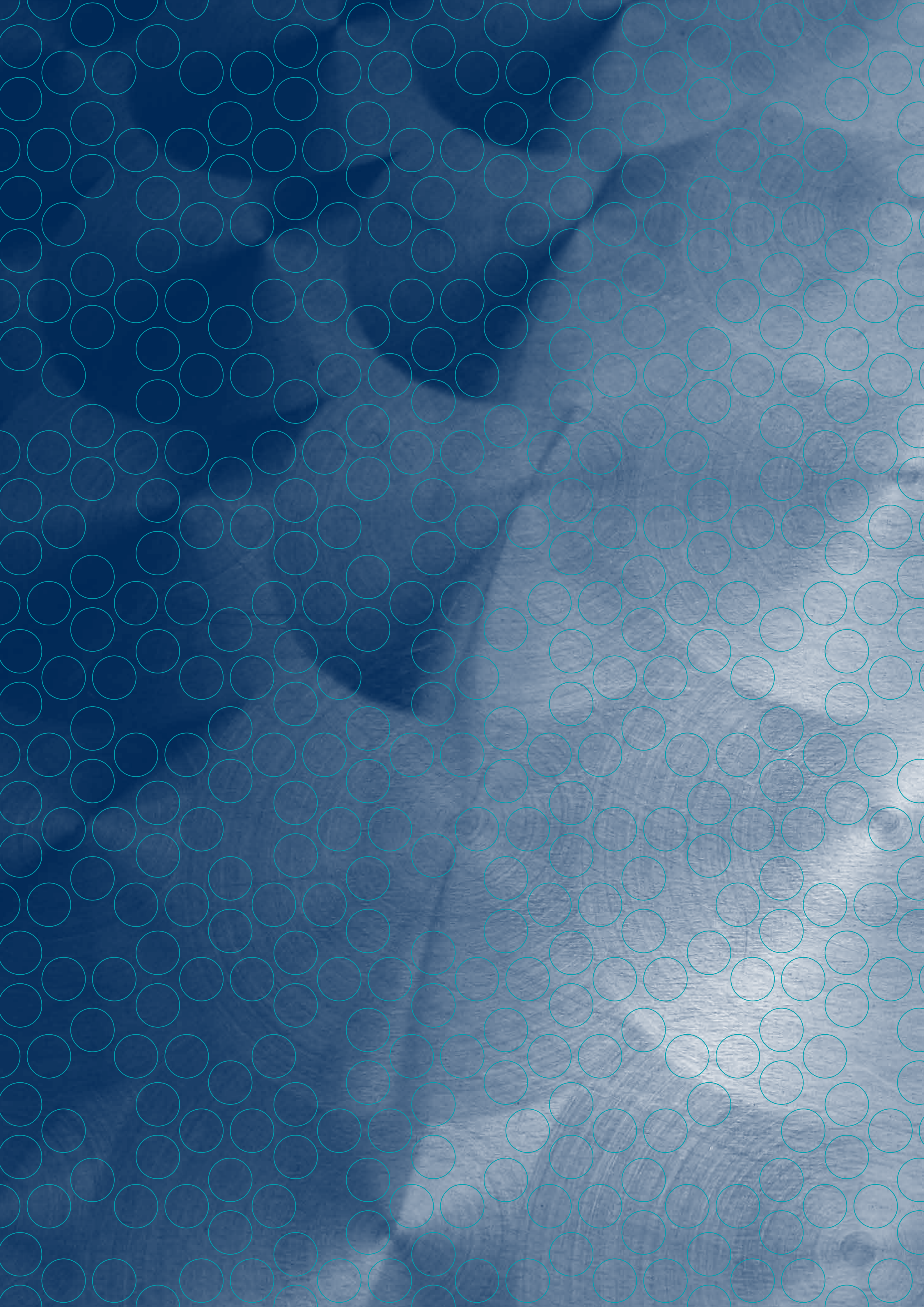
1.1 EPPIC Model Description

1.1.1 Introduction

EPPIC is a model of specialist early intervention in psychosis (EIP) care developed by Orygen Youth Health. Since first established in Melbourne in 1992, EPPIC has become the template on which many of the specialist early psychosis services throughout the world have been designed. There is a continuing growth in the numbers of early psychosis services, largely based on the compelling evidence of the clinical and cost effectiveness of EIP over standard care and the greater level of satisfaction and engagement of patients and families. Building upon the work of the EPPIC operated by Orygen Youth Health, we have devised the EPPIC Model, which takes account of the model in Melbourne, the current international evidence and experience of operating early psychosis programs and recent work conducted for the Australian Federal Government's previous National Advisory Council on Mental Health, it is this new model that will now be utilised as the template for the rollout of early psychosis services nationally.

1.1.2 Aims of the EPPIC Model

- To detect early those young people who are at risk of developing a first episode of psychosis, or have experienced a first episode of psychosis.
- To reduce the risk of transition to full threshold psychosis, or to delay or attenuate the impact of such transition in those young people who are manifesting early clinical features indicating incipient risk of a first episode of psychosis, and who seek and have a need for care.
- To restore the normal developmental and functional trajectory of those young people who are at risk of, or have experienced, a first episode of psychosis as early as possible.
- To minimise the impact of a first episode of psychosis on the family system through the provision of education, support and care.



1.2
EPPIC Model Guiding Principles

A number of guiding principles are utilised in order to achieve the aims of the EPPIC model:

- **Expert care is easily accessible.** This is enabled by the responsiveness of the service structure, the 'youth-friendliness' and agility of the service, and community awareness programs for mental ill health and psychosis in young people and for understanding direct referral pathways.
- **There is a holistic biopsychosocial approach to clinical interventions.** Interventions have a recovery-oriented focus and take into account the developmental stage, clinical stage of illness and goals of the young person.
- **The service approach is comprehensive and integrated.** Young people and their families have access to a comprehensive range of interventions that are integrated within the service.
- **Clinical practice is guided by an evidence base.**
- **A youth-friendly culture, reflected in attitudes, behaviours, décor, context and youth engagement is evident throughout all parts of the service.** See the section on 'youth-friendliness' below.
- **A spirit of hope and optimism is pervasive throughout the service.**
- **All aspects of the service are family-friendly** and family members are included wherever possible in the approach to care.
- **The service has the mindset and skills to deliver culturally sensitive care to all patients and families** from indigenous and multicultural backgrounds.
- **A high level of partnerships with local service providers,** to ensure effective and timely pathways into, and out of, the service as well as supporting additional aspects of service delivery during the episode of care.

1.2.1 Implementing the EPPIC Model

Establishing and implementing new EPPIC services requires a strategically planned process using a major project management approach. **Four critical factors** for the successful implementation of a new EPPIC service are described in Section 2.

A number of the EPPIC core components that reflect the guiding principles have been developed in order to achieve the overall aims of the EPPIC model. A full description of these core components can be found in the subsequent section, and they are listed below:

- Community awareness and education
- Ease of access to service
- Home-based care and assessment
- Access to streamed youth-friendly inpatient care
- Access to youth-friendly sub-acute beds
- Continuing case management
- Medical treatments
- Psychological interventions
- Functional recovery program
- Mobile outreach
- Group programs
- Family programs and family peer support
- Youth participation and peer support
- Workforce development
- Partnerships
- Ultra high risk (UHR) detection and care

Intake Criteria

Intake criteria into the clinics of the EPPIC service need to be clearly defined in order to ascertain who is (and who is not) eligible for service. This is particularly important as the new service is a specialist, comprehensive, tertiary youth mental health service.

The following are intake criteria for both full threshold psychosis and those at UHR for psychosis, based on the local and international experience of the EPPIC model.

First Episode Psychosis Intake Criteria

Age: 12–25 years (at entry to service, 25th birthday)

Catchment

The EPPIC model has been based on a defined catchment area as this sets the boundary conditions for first episode psychosis (FEP) and the number of potential incident rates. Early Psychosis services will need to define a broad geographical area or catchment area for certain components of the EPPIC model, such as home-based treatment by the Early Psychosis Assessment and Community Team (EPACT) and any assertive mobile outreach required. It is recommended this be approximately one hour's drive from the main hub of the Early Psychosis centre. Those young people who live outside the geographic area, but who meet the intake criteria for entry to the service, may not be able to be fully serviced by all the core components of the model; however, they will receive a service via the core components where they are able to attend the Early Psychosis centre. This will likely impact on the clinical outcomes, and hence the full fidelity of the model in some cases.

Clinical Intake Criteria

Admission to EPPIC is based on a clinical assessment that determines that a young person has experienced:

- Definite full threshold FEP as indicated by the presence of full threshold psychotic symptoms (hallucinations, delusions or formal thought disorder, see the EPPIC Assessment Guide*), which are present for longer than one week (7 days) within the previous two months.

***Note:** Psychotic symptoms must have been experienced **every** day for more than seven consecutive days, or for periods of **longer than one hour per occasion** on 3–6 days in a week in order to meet the psychosis threshold. Refer to EPPIC Assessment Guide (1.2.2) for more detailed descriptions of full threshold psychotic symptoms, and information on intoxication and psychosis due to organic causes.

Non-Definite Psychosis (Diagnostic Uncertainty)

For cases where there is doubt about the presence of definite FEP, usually due to threshold or a disparity between the account of relatives and the direct clinical evidence from the young person, further assessment may be required. It is important to note there also needs to be evidence of distress due to symptoms, or behavioural change in the case of manic psychosis (distress may not be present) or functional impact for acceptance into the service. It is often difficult to be clear on the basis of a single assessment and young people should not be rejected too quickly if there is prima facie evidence of psychosis.

Specifically, where there is doubt about the veracity or severity of reported psychotic symptoms, the following will also be required:

- Functional decline or sustained low functioning (30% drop in SOFAS score maintained for one month within the last 12 months, or SOFAS score lower than 50 for the last 12 months or more),

  and/or

- Significant distress associated with the psychotic symptom(s). These cases will require assessment by an EPACT consultant psychiatrist in order to determine (a) if the young person is accepted into the service, and if so, whether this should be to the EPPIC or UHR clinic, or (b) whether the young person will be referred out of the service and actively engaged into a more appropriate service. The young person, the family and the new service provider need to be informed that they can be reassessed if the clinical situation becomes clearer or changes.

See the following EPPIC intake criteria algorithm (page 11) which can assist in the decision-making process. In particular, young people should be accepted into the Early Psychosis service; however, in certain circumstances there may need to be a prolonged assessment or if there is difficulty regarding decisions then consultation should occur with the medical or clinical director within a short period of time and no longer than 7 days after consultant review.

EPPIC Exclusion Due to Prior Treatment (aged 15–25 years)

The EPPIC service is not available to young people who have had:

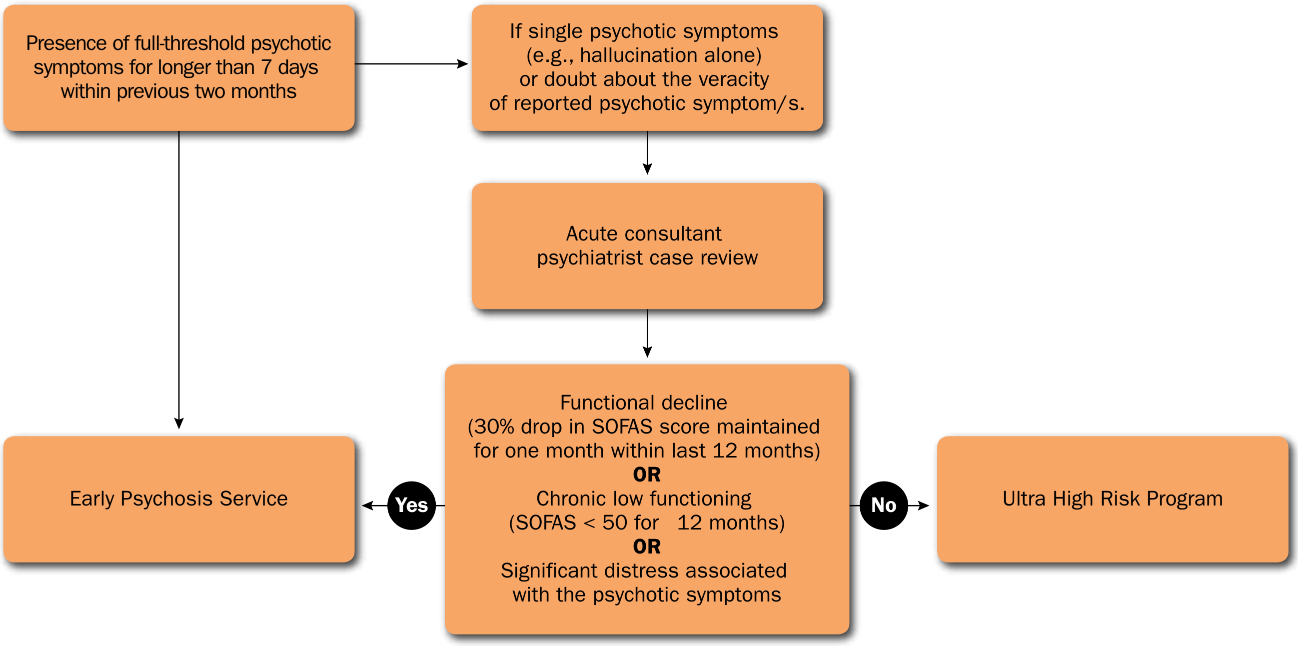
- Greater than 12 months of treatment for psychosis by another public mental health service.
- Greater than 12 months of appropriate treatment for psychosis by a general medical practitioner or private psychiatrist. The appropriateness of prior treatment is to be determined on a case-by-case basis by the triage/intake processes.

Duration of EPPIC Care for FEP

- The EPPIC service provides an initial two-year window of care at which point the need for ongoing care is reviewed. In a proportion of cases a further period of care of up to a total of five years will be available for those with persistent, recurrent or complex needs.
- The commencement date of the two-year window is the date of entry into the EPPIC service.
- For those young people under the age of 16 years, the duration of care within the EPPIC program is provided for longer than two years, up to the 18th birthday. Appropriateness is to be determined by clinical judgement on a case-by-case basis.

We would like to acknowledge the work of Orygen Youth Health Clinical program who have developed the 'Clinical Intake Criteria' and we are grateful to them for allowing us to include these above.

EPPIC Intake Criteria Algorithm



Young people should be accepted into the Early Psychosis service; however, certain circumstances may require a prolonged assessment. If there is difficulty regarding decisions then consultation should occur with the medical or clinical director within a short period of time and no longer than 7 days after consultant review.

We would like to acknowledge the work of Orygen Youth Health Clinical Program who have developed the ‘EPPIC intake Criteria Algorithm’ and we are grateful to them for allowing us to include.

1.2.2 EPPIC Assessment Guide

The following is a guide when considering what are full threshold psychotic symptoms during initial assessment, either at the intake level or the face-to-face assessment. The triage part of the EPPIC service will determine whether a comprehensive face-to-face assessment is required for either UHR or FEP young people.

Full Threshold Psychotic Symptoms

Perceptual Abnormalities

This symptom type refers to true hallucinations e.g., hearing voices or conversations, feeling something touching the body, seeing something that the young person believes is real during, and after the occurrence, or that the young person is only able to question with considerable effort. The experience may be frightening and distressing. This has been experienced daily for more than 7 days.

Unusual Thought Content

This symptom cluster includes delusional mood and perplexity (things seem odd, changed), ideas of reference, thought and feeling insertion/withdrawal/broadcasting/control/reading. The young person has experienced unusual thoughts containing original and highly improbable material that is held with delusional conviction (no doubt). This has been experienced daily for more than 7 days.

Bizarre Ideas

This symptom group includes suspicious, persecutory, grandiose, somatic, guilty, nihilistic, jealous, religious and erotomanic ideas. The young person has experienced unusual ideas of one or more of these types that contain original and highly improbable material, which is held with delusional conviction (no doubt). This has been experienced daily for more than 7 days.

Disorganised Speech (Disorder of Thought Form)

There is a lack of coherence in the young person’s speech, or unintelligible speech and a difficulty maintaining a line of thought. There may be evidence of loose associations, incorrect word usage, circumstantial or tangential speech. This has been experienced daily for more than 7 days.

Comorbidity

A young person experiencing full threshold psychotic symptoms should be referred to EPPIC regardless of whether they are experiencing co-occurring disorders or the psychotic symptoms are formulated to occur in the context of another disorder, e.g., PTSD, depression, personality disorder, drug use or a medical disorder.

Intoxication

Young people who present with perceptual disturbances secondary to intoxication and have insight into the aetiology of these symptoms, i.e., they are aware that they are due to drug use, should be considered to have an intoxication syndrome. If symptoms persist beyond a period of 3 days then a psychotic disorder should be considered.

Organic Causes of Psychotic Symptoms

There are many medical causes of psychotic presentations and these should be screened at entry to the service as much as possible (see the following table). This is primarily the role of the psychiatrist and GPs. Possible organic causes should be assessed as early as possible in the face-to-face assessment by the EPACT clinician, in conjunction with the EPACT registrar or consultant psychiatrist.

If a young person is referred to the service with a confirmed medical condition causing the psychotic symptoms, or if a young person is accepted into EPPIC and it later becomes clear there is a clear organic cause for their psychotic symptoms, then specialist medical expertise may be required. This may mean that the service will need to liaise with the medical specialists in the required field and a period of shared care with careful communication should be considered. However, the young person should still be eligible for the full 2 years of care within the Early Psychosis service, with the further option of 5 years of care.

The following table outlines medical conditions often associated with psychotic symptoms:

Delirium
Epilepsy (e.g., temporal lobe epilepsy)
CNS infections (e.g.,+/- intracerebral lesions, neurosyphilis, other viral encephalitis)
HIV infection (early manifestation of AIDS)
Neurodegenerative disorders (e.g., multiple sclerosis)
Huntington’s disease (psychotic symptoms are very common)
Autoimmune disorders (e.g., systemic lupus erythematosus)
Endocrine disorders (e.g., thyroid or parathyroid dysfunction, cushing’s syndrome, addison’s disease or phaeochromocytoma)
Metabolic disorders (e.g., B12 or folate deficiency [chronic alcohol abuse], porphyrias)
Wilson’s disease
Others, such as such as chronic hypoglycemia
CNS trauma (e.g., frontal lobe syndrome)
CNS neoplasms

UHR Intake Criteria

Each caller should be offered the PQ-16 questionnaire as a screening assessment by the telephone triage/intake. This will assist in identifying those young people with early psychosis or FEP (See Appendix 1 for a copy of the PQ-16). Referrals are accepted for young people who have not had a previous psychotic episode but who may be at increased risk of developing a psychotic disorder and who have experienced a recent significant drop in functioning or have been functioning at a low level for more than a year. While we have outlined the specific criteria here, it is good clinical practice to adopt an open mind and a flexible approach to young people with this potentially 'prodromal' picture, which is often hard to characterise clearly according to these criteria in a single assessment; hence the 'index of suspicion' approach is the key.

Clinical Assessment of the At Risk Mental State

The Clinical Assessment of At Risk Mental State (CAARMS) should be administered to all UHR referrals to assess eligibility when conducting the initial face-to-face assessment.

Functioning Criteria

All UHR clinic patients must have experienced either a recent deterioration in functioning, i.e., a 30% drop in SOFAS score from the premorbid level, sustained for a month and having occurred within the past 12 months OR persistent poor functioning, i.e., a SOFAS score of 50 or less for the previous 12 months, in addition to meeting criteria for at least one of the specific intake groups listed below:

1. Vulnerability Group

The young person has a reported family history of psychosis in a first-degree relative (e.g., biological parent or sibling, including half-siblings) OR has a schizotypal personality disorder and has functional and symptomatic change.

2. Brief Limited Intermittent Psychotic Symptoms Group

The young person has experienced less than a week of daily frank psychotic symptoms that resolved spontaneously (i.e., without a daily therapeutic dose of antipsychotic medication). These frank psychotic symptoms have occurred during the last year.

3. Attenuated Psychosis Group

The young person has experienced subthreshold psychotic symptoms within the last year. That is, they have/had symptoms that do not reach threshold levels for psychosis due to subthreshold intensity or they have psychotic symptoms that do not occur often enough.

The following criteria are based on the CAARMS. The CAARMS scores have not been included in this document for the sake of clarity.

i) Subthreshold Intensity

Thought Content

A feeling of perplexity/uncertainty regarding thoughts or unusual thoughts that are not held with delusional conviction or are not believed all the time.

Disorganised Speech

Evidence of at least mild disconnected speech, circumstantiality, tangentiality with increased feeling of frustration in conversation, but may respond to structuring during an interview.

Perceptual Abnormalities

Puzzling experiences, e.g., vivid distortions/illusions or fleeting transient experiences such as hearing name being called, phone ringing; may be able to give plausible explanation for the experience. These symptoms occur above a minimum frequency: at least once a month to twice weekly for more than an hour, or 3–6 times per week for less than an hour for at least a week. All symptoms should have occurred within the past 12 months.

ii) Subthreshold Frequency

Intensity

Frank psychotic symptoms (hallucinations, delusions, marked thought disorder).

Frequency

The above symptoms occur once a month to twice a week for more than an hour per occasion, or 3–6 times a week for less than an hour per occasion within the past 12 months. They do not exceed three times per week if longer than 1 hour on each occasion or daily for less than an hour per occasion.

Duration of UHR Care

The EPPIC service is resourced to provide a total of seven months of care for those young people between the ages of 15 to 24 years. This may consist of shorter periods of care. Those young people who make a transition FEP will transfer to the FEP service and receive two years of treatment dated from point of registration in that stream of care. Those young people who do not transition to the FEP service and have reached the 7 months of care can then be referred to the usual Early Psychosis centre as needed.

Exclusion Criteria for UHR Care

The EPPIC service will not accept young people for UHR care who have had a previous psychotic episode or who do not meet the functioning criteria.

> In order to optimise ease of access to the EPPIC service, referrals are taken from any source.

1.2.3 EPPIC Clinical Pathways

The following section describes a brief summary of each step of the clinical pathway. A flow chart also follows that outlines the clinical pathways.

Referrals

In order to optimise ease of access to the EPPIC service, referrals are taken from any source. There should be one contact point of referral, with referrals responded to immediately if possible and at least within a 24 hour period. Community awareness and education activities have a key role to play in ensuring possible referral sources understand how to recognise psychosis and the referral process and pathway into the service.

Triage/Intake

The entry point for all referrals is triage/intake, with subsequent referral of UHR and FEP young people to the EPACT team. As in other health services, triage/intake plays an important function in the initial assessment of referrals not only to determine the initial eligibility of a referral for service, but to prioritise the urgency of the referral. With early psychosis a particularly low threshold for face-to-face assessment MUST be maintained and the reports of third parties, especially parents, must be taken very seriously. From triage/intake, a prompt assessment can be facilitated if the person referred meets initial criteria for acceptance by the EPPIC service and can advise on response times; e.g., immediate or can hold for 24 hours etc. A 'no wrong door' policy exists where referrals that are not eligible for service, e.g., out of age range, are actively assisted to link in with a more appropriate service. The PQ-16 (Loewy RL et al. 2005) questionnaire can be offered as a screening assessment to every caller by the telephone triage, which will assist in identifying those young people with early psychosis and FEP.

EPACT Assessment

The EPACT assessment is the first stage of a comprehensive assessment of the young person and their presenting problems. EPACT is a multidisciplinary team comprised of consultant psychiatrist, registrars, nurses, social workers, occupational therapists and psychologists.

Flexibility is required in assessment, in that it may occur in a variety of venues that are conducive to the engagement of the young person into the EPPIC service. This will require a high degree of mobility. Responsive crisis intervention is also necessary to minimise trauma associated with psychosis and potential hospital admission by supporting intensive home treatment in a least restrictive manner when possible.

Entry into the EPPIC service (including the UHR clinic) based on intake criteria will be determined following (often serial) assessment and initial case formulation. Referral of those young people deemed eligible to the appropriate clinic for continuing case management will occur following assessment. For those young people not eligible for the EPPIC service, active assistance will be made to engage the young person with a more appropriate service.

EPPIC Continuing Care

Referrals for continuing case management are sent to the EPPIC team leader or program coordinator for review and allocation to the appropriate clinicians. All new young people accepted into the service are allocated a case manager and primary treating doctor who will be either a psychiatry registrar or consultant psychiatrist. All psychiatry registrar allocations are also allocated a consultant psychiatrist in order that all young people of the service have an allocated consultant psychiatrist. The team leader's decision as to which clinician to allocate to is influenced by factors such as clinician caseloads, young person presentation and complexity and clinician experience.

Handover of the young person from the EPACT team to the continuing care team should be a smooth process, with clinicians from both teams present with the young person (and family) at handover. This enhances continuity of care and reinforces a message of 'one service approach' to the young person and family.

As case management is one of the main cornerstones of early psychosis intervention, where possible and appropriate, one case manager remains the young person's case manager for the whole of episode of care until discharge, to enhance continuity of care.

If young people have an incomplete recovery at 21 months, they can be considered for an extended tenure of care for an extra period of up to three years that will offer maintenance of the core components as required. More detail and suggested criteria for this appears in the case management component description.

UHR Clinic

The same referral and allocation process applies as above.

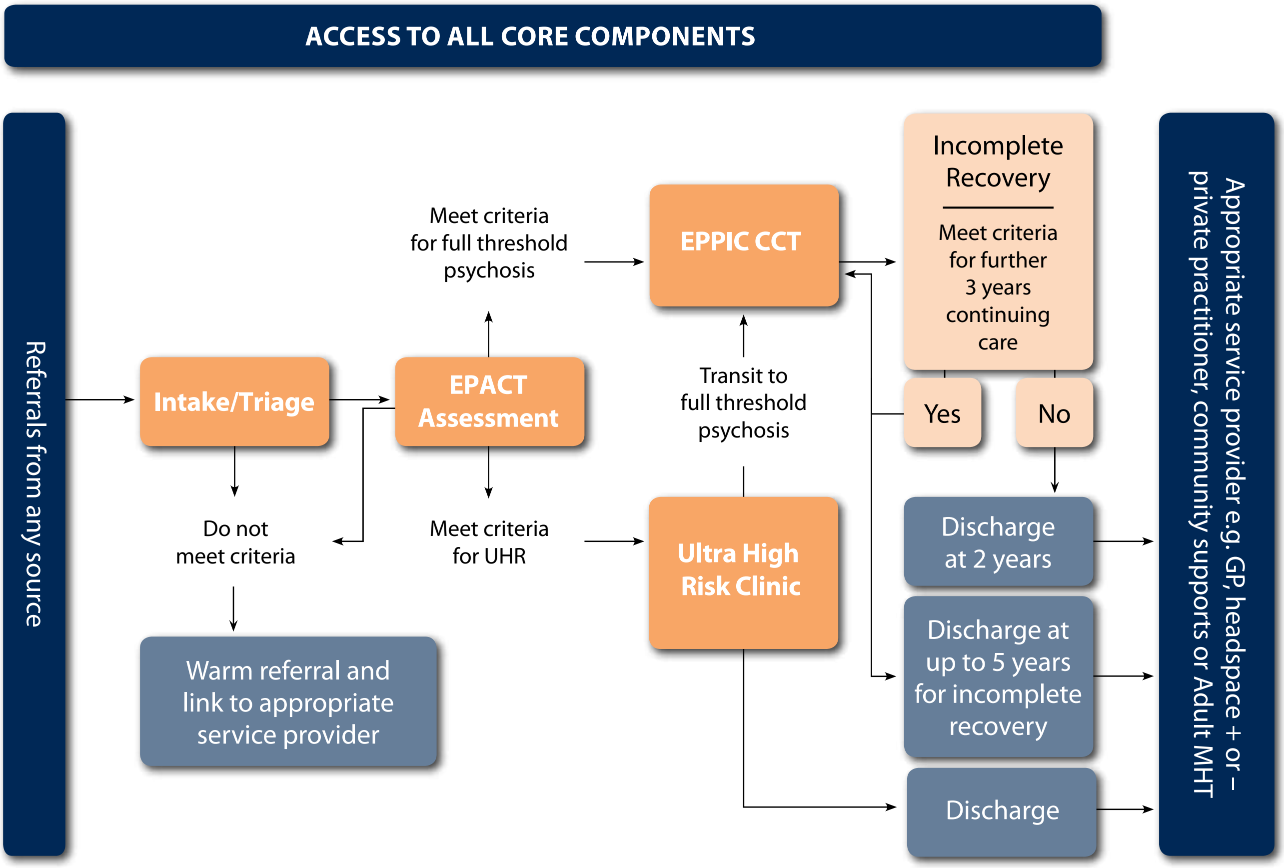
Discharge

All young people and their families should be informed of the tenure of care for the EPPIC service and plans for eventual discharge should be discussed to varying degrees at appropriate times through the episode of care. There is more of a focus on this towards the last three months of an episode of care, when clear collaborative discharge plans are in place. The focus of discharge planning involves:

- Developing self-efficacy over relapse prevention plans and strategies.
- Developing self-efficacy over crisis management strategies for both the young person and the family.
- At discharge, young people may be referred to the existing or new **headspace** centres or other community services, with a period of engagement and transition including a handover occurring face-to-face with the new clinician, young person and the family (wherever possible). This process should also occur for any other service provider that a young person is discharged to.

All discharges and handovers should include a comprehensive discharge summary being forwarded to the new service provider and GP, as well as a copy being kept in the EPPIC service clinical case notes.

EPPIC Clinical Pathways



1.2.4

Context of the EPPIC Service

Implementing an EPPIC service is not just about establishing the core components; it is also about the context, ethos, feel and environment that the service is provided within. Some factors, such as youth friendliness, appropriate workforce, service structure and service processes need to be incorporated into any Early Psychosis service.

Providing a youth-friendly approach in the EPPIC services helps improve access and utilisation. This in turn helps to achieve one of the key aims of early intervention in psychosis: reducing the DUP and minimising the subsequent negative sequelae for young people and their families.

EPPIC services within an Early Psychosis service can continue to embed youth-friendliness into the fabric of the service and provide interventions with young people as their focus and starting point. As Crago et al. (2002, p. 44) succinctly put it, ‘Once we get our foot in the door, we want to offer you a service you couldn’t possibly refuse…’

Context of the EPPIC Service

Youth Friendliness

Youth-friendliness is a concept that is embedded in early psychosis philosophy. It is incorporated into the guiding principles on which EPPIC services operate, in that there should be embodiment of youth-friendly ethos throughout all parts of the service. The evidence suggests that whenever services address youth friendliness in whatever format, there is a subsequent increased utilisation of, and access to, services by young people (Hyman et al., 2007; Tylee et al., 2007). Successfully engaging young people into an early psychosis service will have an impact on one of the fundamental aims of the service: to reduce the duration of untreated psychosis (DUP) and minimise the subsequent impact of a first episode of psychosis on the young people and their families. The following section looks at the meaning of youth friendliness and suggests ways in which services can develop and enhance their youth-friendliness and embody it as part of the fabric of an early psychosis service.

The World Health Organization (2012) identified a service level framework of accessibility, acceptability, equitability, appropriateness and efficacy as being a guide for youth-friendly services, which can be translated as providing services in the right place, at the right time, at the right price and in the right style (Muir et al., 2012). This framework has been utilised for evaluation purposes to assess the youth-friendliness of youth mental health services (Muir et al., 2012). Crago et al. (Crago et al., 2004) identify that being youth-friendly means ‘adopting practices and strategies of engagement which make and sustain positive connections with young people and through which they feel valued, respected and increasingly capable of taking charge of their lives’ (p. 39).

One of the key aspects of youth friendliness is that it is built on the principle that service provision should be congruent with the stage of development of the individual. Young people who experience mental ill health, and particularly psychosis, often develop or manifest developmental delay at a psychological and social level so their chronological age overestimates their maturity. There are many implications of this fact. This means that clinical interventions need to be tailored to the young person and their developmental stage, and the policies and procedures that may influence the youth-friendliness of the service and infrastructure on which the service is provided. Barry et al. (2002) suggest that services be designed from a youth-centric perspective by taking the young person as the starting point and developing a service around them rather than adapting an existing service to become ‘youth-friendly’. It also means families, including siblings, and often peers and friends need to be welcomed and included.

Strategies to make a service youth-friendly are broad and so it may be helpful to categorise interventions under the headings of service structure, service processes and clinician factors.

Service Structure

The organisational and physical structure of a service can have a large impact on the youth-friendliness of EPPIC services. Young people are the best evaluators of what is youth-friendly, and therefore a youth participation program is a critical structural component for EPPIC services. Youth participation programs are now acknowledged as being an essential part of early intervention services in order to plan, deliver and evaluate services (Monson & Thurley, 2011). Young people knowing that there is a contribution to service development and ongoing improvements by young people themselves can in itself enhance the feeling of respect and of being valued as well as developing confidence and new skills for those participating (James, 2007).

The location of the service is an important factor, both in terms of geography and hours of operation. At a minimum, the service needs to be accessible by public transport and ideally located where mainstream youth-oriented activities occur, such as leisure or sports pursuits (Patel et al., 2007). **headspace** centres have also very successfully considered the issues around access and youth friendliness. With the Early Psychosis services it will enable a ‘one-stop-shop’ and seamless access to a variety of youth-oriented care. The physical space in which the service exists is also an important factor in creating youth friendliness. A warm, welcoming environment which is stigma-free, safe, offers privacy and is appealing to young people is imperative (McIntyre, 2002). In the real world, consideration would be given to the ‘look’ of the place with the following suggestions:

- First and foremost, ask young people what they think.
- Although safety for all people onsite is a priority, an open plan feel with the absence of window security screens and security doors is achievable without an increase in risk to safety. Numerous sites throughout the country which operate in this way.
- Use of colour schemes which move away from the drab colours associated with officialdom.
- Provide age-appropriate reading material and refreshments in waiting room and reception areas.
- Provide a ‘drop-in room’ where young people can meet youth peer support workers or other young people visiting the service and get access to relevant information leaflets on youth issues.
- Consider having computer terminals or iPads with access to a variety of youth-related resources on them.
- A relaxed atmosphere, such as in a cafe type ‘feel’ with an open foyer and youth-related activities or equipment.

Service Processes

The operational processes of an organisation are an important factor in bringing about the youth-friendliness of a service. Many of the young people using the service will be going through the normal developmental stage of individuation and asserting their self-determination over life events, and so service processes that minimise power differences are particularly worthy (Crago et al., 2004). Services should provide choice, up-to-date information and flexibility about treatment options and environments in which to provide care, and should be those in which young people feel comfortable (home, school, coffee shop etc.). Therefore, having a mobile, assertive service that offers a quick response is an important service approach to achieve youth-friendliness. Flexible appointment times are important to minimise disruption to normal life routines (after school or work and after hours or weekend access).

Engaging young people into a service is particularly challenging and so service processes that aim to achieve consistency of clinicians are important at the initial contact period and then throughout the tenure of care. Strategies to engage young people are explored in other literature (recommended reading French et al., 2010 pp. 35-43; Macneil et al., 2009 pp. 21-36; Edwards & McGorry 2002, p. 32). As young people may be naive to health service use or have preconceptions about expectations, it is important that information is provided on how to access and what to expect from the service. This may occur on a face-to-face basis or by using multimedia approaches such as providing a 'young person's and family service information guide' which provides basic information on the service or by providing web-based video stories from youth participation workers. Waiting times when young people arrive for appointments should be minimised but if there are any, these should be explained to them on arrival. Information about privacy and confidentiality should be readily available, either in a reception area display format or in information resources such as a website or booklets.

For most young people, the uses of information communication technologies are an acceptable and integral part of daily life and an embedded aspect of youth culture. However, there remains a disconnect between the use of technology by young people and the level of engagement with technology by clinicians working with young people (Blanchard et al., 2011). Examples of information technology strategies that may add to the youth-friendliness of a service include the use of texting for appointment reminders and general communication, the availability of web-based information, including social media, to enhance access to care and provide stigma-free information about psychosis and treatment approaches, the use of 'touch-screen' self-report outcome measures and other therapeutic technologies such as a mood diary in an app format.

However, Blanchard (Blanchard et al., 2011) warns that strategies to enhance youth-friendliness using information technology need to overcome a number of service level barriers, which include poor infrastructure, availability of supporting guidelines and policies to ensure safe and constructive use of technology, and awareness of the most effective technologies. Services looking to provide a youth-friendly approach will need to address these barriers.

Workforce Factors

Another factor that will have an impact on the youth-friendliness of a service relates to clinicians and support staff. Ideally, a youth-friendly ethos will exist as a whole-of-service approach throughout all levels of service, ranging from service leaders to support staff such as cleaners, administration and reception staff. The effectiveness of interventions targeted at young people will be improved if young people experience the clinician to be youth-friendly. The WHO (McIntyre, 2002) identifies that a youth-friendly service employs health professionals who are motivated to work with young people. Hyman et al. (2007), studied the youth-friendly characteristics of mental health clinicians as identified by young people themselves. Twelve youth-friendly characteristics emerged, with three characteristics being most frequently endorsed by young people; 'positive characteristics' (qualified as being 'someone who is friendly and nice or a patient person), active listening and being understanding ('someone who cares and can relate to what you're saying').

Services can influence the workforce factor in a number of ways. Role position descriptions can be written to incorporate expected attitudes, qualities and activities that clearly alert prospective candidates to the importance of youth-friendliness within the role. These will also assist in signalling youth-friendliness as being part of the culture of the organisation at an early stage. This can be further enhanced during the recruitment phase by assessing prospective employees as to their ability to work with young people. Interview panels may include questions to assess attitudes and motivation and their ability to work with young people and their families. Ideally, another way is to include young people from the youth participation program in the whole of the recruitment process, including interview panels.

Workforce training and education of clinicians and support staff is a requirement in order to develop and support staff to work with a youth-friendly approach (McIntyre, 2002). Beyond influencing tertiary education institutions to include working with young people as part of the undergraduate curriculum, workforce training and education should ideally be part of an orientation period within the service. In doing this, it provides grounding in a youth-oriented framework from the outset and will help to embed youth-friendliness as part of the cultural norm of the service. Training activities involve developing knowledge, skills and attitudes in working with young people.

Knowledge needs to be developed related to understanding young people's behaviour from a developmental and cultural context. Attitudes related to optimism, stigma regarding mental health and illness, and working with young people in a non-judgemental way, particularly given that sexuality and drug use are likely to be prominent issues are important. Skills need to be developed and applied related to communicating and working collaboratively with young people, particularly in order to enhance strategies for engagement.

A summary of strategies to promote youth-friendliness is presented in the table below.

Service Structure Strategies
Seek the advice of young people in all aspects of service design, including through developing a youth participation program
Service location should be in a location easily accessible by public transport and ideally near mainstream youth-oriented activities, leisure and sports pursuits
Co-locate with other youth-oriented services to provide a ‘one-stop-shop’
Provide a warm, welcoming environment which considers the ‘look’ and ‘feel’ from a young person’s perspective and is stigma-free yet provides privacy and safety

Service Process Strategies
Provide choice and flexibility around treatment options
Provide flexibility in the location of care (home-based, school, cafe) and hours of operation (after school or work hours)
Provide as much clinician consistency as possible throughout the whole episode of care
Provide information on access to, and what to expect from, the service in multimedia format
Minimise appointment wait times, and if there are any, explain these when the young person arrives for their appointment
Provide information on privacy, confidentiality and rights in accessible areas, including online
Utilise information communication technology to support engagement and clinical interventions, and support the workforce to utilise this in the most effective and safe manner

Workforce Strategies
Utilise young people in the whole recruitment process, from position description development through to interview and selection
Incorporate expected youth-friendly attitudes, qualities and activities into job position descriptions
In interviews, include questions to ascertain youth-friendly characteristics from prospective employees
Build links with local academia to promote youth mental health in undergraduate and postgraduate curricula
Support staff with training and education related to the necessary knowledge, skills and attitudes required to work in a youth-friendly way

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1.2.5 Recovery Phases

Throughout this document terminology is used that discusses the different recovery phases of FEP. The following brief description of each of these phases can be used as reference to understand when discussing the particular phases or stages of recovery for young people. Since all young people are unique, so are their phases of recovery. It is difficult to give specific timelines for each young person. The description provides some of the characteristics for each phase.

Early Recovery Phase

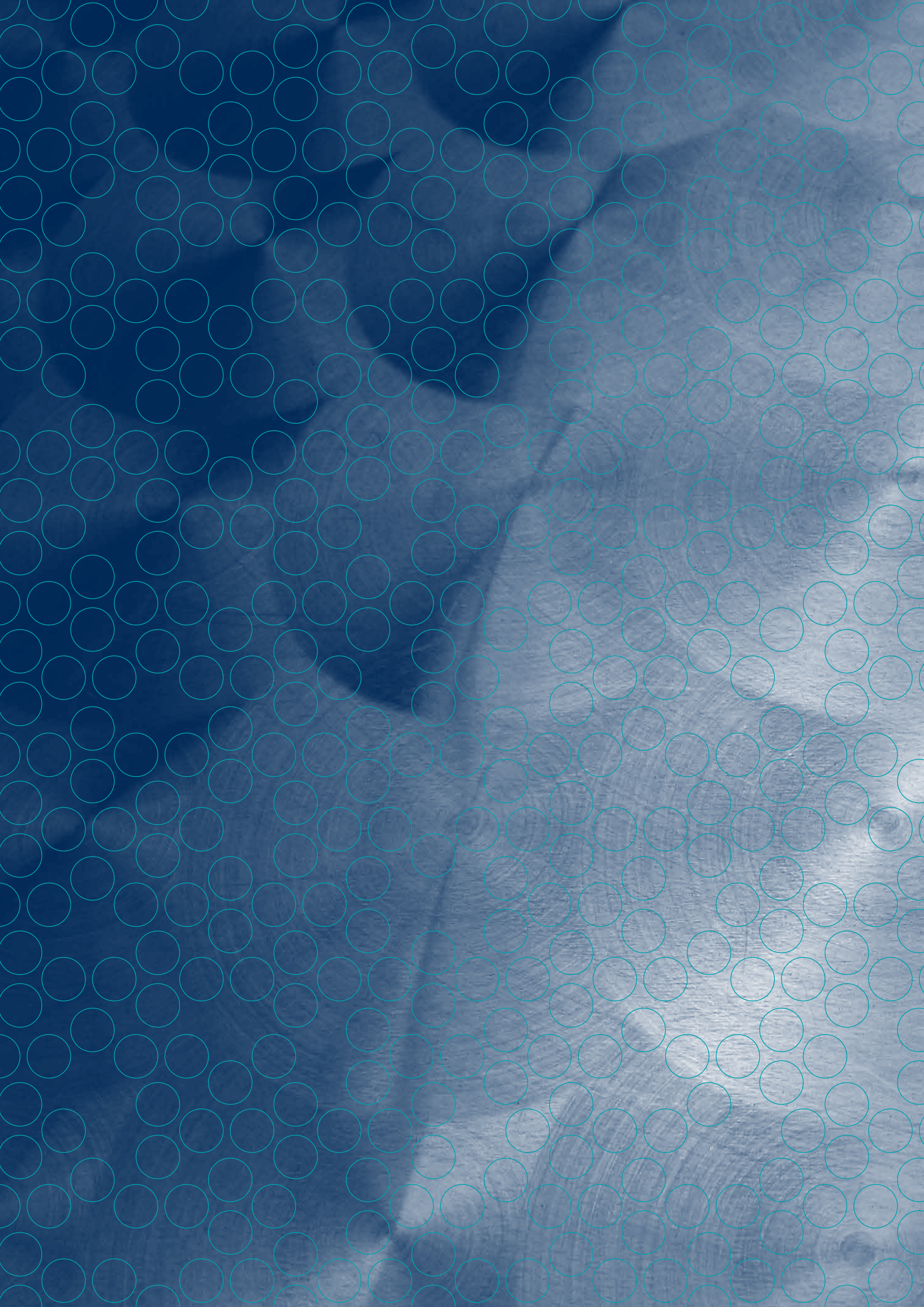
In the early recovery phase we start to see a remission of the positive symptoms of psychosis. So the experience of hearing voices or paranoia may start to settle down and be much more manageable. The young person may be thinking more and be more active about returning to school or work, although there may be some barriers to this.

Late Recovery Phase

The late recovery phase is characterised by a remission of positive symptoms, with the young person returning to their normal level of functioning at school, work, in their friendships, social activities and family lives, and continuing to live meaningful lives.

Incomplete Recovery

These young people will have ongoing positive and negative symptoms and/or a lack of functional recovery, which occurs anywhere from the three month post treatment time point.



The 16 core components are the essential parts of a comprehensive EPPIC model and service provision for an Early Psychosis service.

1.3

Core Components

1.3.1 Introduction

The 16 core components are the essential parts of a comprehensive EPPIC model and service provision for an Early Psychosis service. However, the core components do overlap and link together, and need to be integrated in order to provide a comprehensive service. It is essential to provide the ‘whole’ of the EPPIC model, with each of these core components, to promote the recovery of young people. As Fowler et al. (2009) concluded when reviewing different models of early intervention, ‘partial implementation using limited specialist workers in collaboration with traditional care appeared to have a more limited effect…’

To assist in implementing each of the core components they are now described in detail with their associated success factors, opportunities, challenges and enablers. A summary box is provided at the start of each core component with a more in-depth discussion following it. It is important to read the whole discussion on each of the core components in order to understand all the essential elements and to assist in planning for implementation.

1.3.2

Community Awareness and Education

Summary

Community awareness and education is provided to:

- Reduce DUP
- Provide community awareness of clear referral pathways
- Reduce stigma
- Improve mental health literacy
- Promote mental health support and care in the community

It involves a range of activities:

- Mental health promotion
- Education, training and consultation
- Strategic planning
- Needs analysis
- Development of a team
- Commences prior to opening an Early Psychosis service

Community Awareness and Education Challenges and Enablers

Challenges are:

- Community awareness and education workers prior to opening
- Development of psychosis resources
- Working as part of the community
- Maintaining hope and inspiration longer term
- Development of a team of clinicians

Enablers are:

- Strong leadership and support
- A designated clinician to commence 1–2 months prior to opening
- Multi-level approach to promotion, consultation and training
- Strong partnerships
- Getting out into the community
- Team approach

Community awareness and education activities may have ongoing challenges; however, a recognition of the importance and development of a team approach can ensure an EPPIC service will not only meet these challenges, it will also meet the community needs and further empower a community to promote recovery and support young people with their mental health issues.

Description

Interventions to treat the onset of a first episode of psychosis are crucial but become redundant if those young people who are experiencing the early signs of psychosis go undetected and never reach the point of accessing appropriate mental health services. If this is the case, it will ultimately lead to longer DUP in young people. Meta-analyses of the association between the length of DUP and impact on recovery have shown that a prolonged DUP has a negative impact on recovery (Marshall et al., 2005; Perkins et al., 2005). In these studies, DUP was shown to be both a marker and an independent risk factor for poor recovery. Further, the relationship between DUP and outcome has been shown to be sustained over many years (Harris et al., 2005); i.e., that a longer DUP will mean that these people take longer to recover, if at all.

The pathways to care are influenced by an array of factors, many of which are addressed by the community education and awareness component of the EPPIC model. This component has four main aims: to reduce community (and self) stigma related to mental health issues, particularly in young people; to improve the mental health literacy of the community, in particular those organisations and people who have significant contact with young people such as schools and tertiary education, youth workers, GPs and community health workers; to improve knowledge and awareness of how to access appropriate local care; and to promote mental health support and care in young people and the community.

As the title suggests, community education and awareness involves a range of activities, including mental health promotion, education, strategic planning, needs analysis and the development of a team or designated staff who can perform these range of community and young people focused tasks, and also see the broader picture of what is needed for improving the mental health of young people in the community.

Bertolote and McGorry wrote a consensus statement in 2005 (Bertolote & McGorry, 2005) on behalf of the World Health Organization and the International Early Psychosis Association, which included a vision with the following fundamental objectives:

- To challenge stigmatising and discriminatory attitudes so that young people are not disadvantaged by their experiences and are truly included in their local communities
- Generate optimism and expectations of positive outcomes and recovery so that all young people with psychosis and their families achieve ordinary lives
- Raise wider societal awareness about psychosis and the importance of early intervention
- Attract and encourage practitioners from a wide range of health, social, non-governmental agencies (e.g., charitable, voluntary and youth), educational and employment services to reflect on how they can better contribute to supporting young people with psychosis, their families and their friends

Bertolote and McGorry suggested that some ways to achieve these objectives were to:

- Support public campaigns directed at young people that reduce stigma and discrimination against mental health issues
- Initiate evidence-based mental health promotion and early intervention programs in collaboration with other sectors
- Provide primary health care and practitioner awareness and training regarding young people and early psychosis
- Become part of the training package for all primary health and social care practitioners
- Help specialist mental health practitioners develop advanced skills and knowledge about early detection, care and treatment of psychotic disorders in young people
- Ensure that psychosis awareness training is provided to teachers, youth and welfare workers, police and criminal justice services and other relevant community agencies
- Provide and strengthen school and workplace mental health programs

These objectives are also ‘higher order’ ones. Ideally, improving the mental health literacy of every member of society would result in better mental health outcomes for young people and their families. This requires a more global intervention and sits beyond the resourcing and remit of a tertiary mental health service, although working in partnerships with broader or national campaigns may have beneficial synergies in working towards this.

Having established the importance of community awareness and educational work, how does a new EPPIC provide this service? As shown above, community awareness and education activities are important for a range of reasons: reducing stigma, reducing the length of untreated psychosis, increasing community knowledge of services and referral pathways so that young people with early psychosis can obtain effective, timely and appropriate assessment, treatment and care. However, not only does a service want appropriate service users to utilise it, there is also a strong element in empowering the community regarding their own mental health self-care and resilience, while increasing the community capacity to support young people and their mental health needs.

EPPIC Community Awareness and Education

Community awareness and educational activities can change over time with the life and growth of a service. The EPPIC service in Melbourne has demonstrated this. From the beginning of the EPPIC service there was a strong focus on community awareness and education, with a designated position and associated planned activities. A focus initially was also on the likely community of referrers to the EPPIC service and on local health providers who had reasonable mental health literacy, who may already have been working with young people, so as to support them and inform of the EPPIC service, the nature of early psychosis, early intervention and the clinical pathways to obtain a timely and appropriate service for the young person. Basically the service needs to become well known so that other community services understand the role of the EPPIC service and to know when and how to utilise it and to refer early.

It was also seen that community awareness and education was vital to receiving appropriate referrals for the young people who needed the service, were able to access and receive it, and for this to be in a timely and acceptable manner. However, raising general mental health literacy in the community not only gives a greater understanding of the signs and symptoms of early psychosis, but also assists in ‘stigma busting’; it helps to demystify the service and increases help-seeking and allows greater transparency and improved community inclusiveness for young people who use the service.

Therefore, the mental health literacy activities of an early psychosis service need to be targeted to the local community and to those who have most contact with young people. Typically, this will involve education for people and organisations such as (but not restricted to) school teachers, school counsellors, university or TAFE counselling and support programs, community youth workers, health professionals and GPs.

The Scandinavian Early Treatment and Identification of Psychosis (TIPS) Study (Johannessen et al., 2001) has shown that by providing community education targeting GPs, social workers and school welfare workers, and providing mobile detection teams, reductions in DUP can be achieved that translate into short and long-term benefits (Johannessen et al., 2005). This was reinforced in the long-term follow-up when looking at the effects on 10-year outcome. It was found that the early detection area had significantly higher rates of recovery where ‘early detection of FEP appears to increase the chances of milder deficits and superior functioning’ and ‘confers a significant and lasting advantage for a considerable group of patients with FEP’ (Hegelstad et al., 2012).

While the role of community awareness and education also sits with every clinician in the service—such as when a case manager is liaising with the school a young person attends—they need to be conscious of explaining and educating about early psychosis; it is also essential to have some designated positions to have the time, knowledge and skills for mental health promotion and to access the broader community. The EPPIC service developed a team approach incorporating a coordinator position and part-time positions for mental health promotion to enhance and identify gaps in knowledge and service provision; a mental health consultation role, and education and training positions.

Early in the EPPIC service provision, secondary consultation or mental health consultation was established. This is providing support to professionals who are assisting young people and who may have some concerns about their mental health. This can be provided in face-to-face or telephone sessions, where the community awareness and education worker speaks with health professionals, either individually or in groups, so that they can raise their issues concerning young people, seek advice on addressing mental health concerns and when referral to tertiary services may be necessary. Not only does this allow for professional workers to become more knowledgeable about mental health signs and symptoms, but it also increases their confidence in dealing with young people with these issues. This also increases appropriate referrals, so that the transition to an EPPIC service can be made in a timely, smooth and supportive way for the young person and their family.

A further facet of community education and awareness activities that can be provided is to establish educational and training sessions. These can be adapted to the particular community group and the needs of the local community, or to the relevant mental and health professionals. Education can be tailored to the particular needs of the group but usually covers specific information on what is psychosis, the rationale for early intervention, how to refer to services, what the essential information to provide is and what referrers may be asked, plus treatment approaches and how to support and promote recovery. In turn this also aims to broaden community understanding and care for young people.

Challenges and Enablers

There can be a range of challenges and enablers in providing community awareness and education activities. The challenges can include:

- A service needs to acknowledge resources and see a designated community awareness and education position as an imperative, and for this to commence prior to an EPPIC service opening
- The development of early psychosis resources that are youth-friendly and suited to particular groups is important and to be available prior to the service commencing
- Resourcing and funding that allows for both initial and ongoing positions and multimedia resource production
- For a service to become part of the wider community and not ‘work in silos’, so as to avoid becoming isolated and disconnected, where any empowerment of the community is lost
- Services are often caught up with providing the ‘here and now’ of the clinical work, which is of course essential; however, the role of community awareness and education can become less of a priority when funds and time are taken away from these roles
- Sustaining the campaigns about mental health awareness and education over time can be difficult if staff become less enthusiastic or innovative, or the service loses hope and inspiration
- There can be a tendency to just leave community awareness and education to the case managers in a continuing care team. However, this can place undue burden on case managers who have full caseloads. While they can contribute and provide community awareness and activities, this is not sufficient to meet community needs and dilutes the effectiveness of any strategies

- It can be a challenge to have the time for sufficient strategic community awareness and educational planning, particularly when considering developing and sustaining partnerships or engaging in joint work in the community with other services. These can be long-term goals as services can be different, services have diverse goals or different missions and it takes time to understand, build trust and work collaboratively

How can these types of challenges be addressed, and what are the particular enablers than a service can utilise to avoid any pitfalls? Several enablers can assist services to address these challenges. These include:

- The leadership and governance group should strongly support the essential element community awareness and education activities
- Choosing to employ skilled mental health professionals that embody hope and optimism, as well as knowledge of early psychosis and early interventions within a community education framework
- The community awareness and education staff should conduct needs analysis and review current information and resources available to the community and to utilise innovative ways of providing appropriate information
- Having a designated community awareness and education worker is a starting point for a service, and with scaling up it would be useful for a service to have a dedicated team of staff who can develop skills and get to know the community while working through the development or phases of activities. This not only protects the community awareness and education role within the service but also reduces any burden on case managers to provide all the aspects of community awareness and educational work. However, close links need to be maintained with the clinical program and consistent relationship-building. Case managers can be very helpful in articulating a gap in service provision or seeing a service that could benefit from a community education approach and so they can refer to the community awareness and education worker or team.
- Taking a multilevel approach to community awareness and education allows for mental health promotion, mental health consultation and training
- Developing strong partnerships can assist with sustaining culture change, help with sharing resources, meeting gaps in service provision and to assist with smooth transition points for young people. A further enabler is for the community awareness and education team to establish themselves within the community. This means actively getting out into the community, attending network meetings and forums, seeing common problems or issues and working out solutions to them
- Providing education and training sessions for the range of community groups and services. Links to tertiary institutions have the added benefit of helping develop a future workforce

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1.3.3

Ease of Access to Service

Summary

Ease of access to services is provided to:

- Reduce prevalence and morbidity
- Reduce the DUP
- Promote recovery
- Engage young people and their families
- Be accessible

It involves a range of activities:

- Home-based assessment and care in whatever setting, as early as possible
- Triage/Intake
- An EPACT team
- A low threshold for assessment
- Flexible approach
- One clear contact point 24/7
- Referrals accepted from any source
- Youth-friendly
- Promotion of the service
- Focus on specific groups at times for referrals
- Secondary consultation
- Partnerships
- 'Warm' or active/direct links to other services for referrals not accepted

1.3.3
Ease of Access to Service

Ease of Access to Service Challenges and Enablers

Challenges are:

- Being youth-friendly and engaging
- Relationship building with other services
- Designated staff to deal with issues arising and from other services
- Developing, promoting and sustaining the culture for home-based care
- Security concerns
- Effective and responsive triage (discussed in detail later in this section)

Enablers are:

- One clear contact point
- An effective and responsive triage (discussed in detail later in this section later)
- A no wrong door policy
- A youth-friendly approach, both in attitude, culture and physical attributes
- Mobile outreach to enable rapid detection of early psychosis by seeing the young person in whatever setting they are comfortable in
- A location that is accessible by public transport and has adequate car parking
- Clear referral pathways
- Provision of secondary consultations
- Positive working relationships and partnerships with other community organisations and 'warm/active transfer' referral processes
- Active consultation with young people
- Planning and training in risk management and aggression

With careful consideration to all of the above factors and thinking through the best way to address any challenges, an EPPIC service can certainly attain a youth-friendly, easily accessible and engaging service for young people with early psychosis and their families.

Ease of Access to Service

Summary of Triage/Intake

- Within the Early Psychosis service triage/intake may not necessarily be under the umbrella of the EPACT team. However, there must be a close connection between triage/intake and EPACT. Triage/intake must be part of the whole approach for ease of access to services.

Triage/Intake involves a range of activities:

- Engage over the telephone with young people and 'walk-ins'
- Engage with, and positively respond to, all referrers and family members, taking any concerns by anyone seriously
- Explain the service and be knowledgeable regarding early psychosis and FEP
- Understand and work from intake criteria
- Screen for appropriate referrals and utilise the PQ-16 questionnaire
- Make decisions about potential referral pathways
- Manage crisis calls
- Refer to and liaise with the EPACT team
- 'Warm' transfer referrals as necessary
- Provision of a very responsive service

1.3.3
Ease of Access to Service

Triage/Intake Challenges and Enablers

Challenges are:

- Having consistent clinicians who are skilled and experienced in early psychosis and FEP work
- Clinicians keen to work in triage
- Some senior staff
- A responsive service
- Clinicians who have excellent assessment skills, including risk assessment, and can manage any crisis calls well
- Clinicians who can engage with young people, families and all referrers
- Adequate documentation and clinical handover systems
- Throughput of referrals/workload management
- Immediate consultation process on complex and/or risky referrals
- Up-to-date community resource contacts
- Clear and rapid clinical transfer processes
- One triage contact number operating 24/7
- Adequate staffing
- Orientation/supervision/professional development
- Clinicians who can work under pressure and multitask

Triage/Intake Challenges and Enablers

Enablers are:

- A leader/consultant attached to triage and senior staff employed
- Regular training and up-skilling of clinicians
- Leadership and seniors available for immediate consultation
- Sufficient EFT and planning for leave
- Infrastructure for suitable work environment and IT systems for documentation and access to medical files
- Part-time and full-time roles
- Designation of responsibility for up-to-date resource base
- Daily clinical handover adhered to
- Emphasis on decision making at the time of the referral
- Acceptance of triage decisions by EPACT team
- Process for conflict resolution, both internal and external to the service
- Physically close to, and frequent liaison with, the EPACT team
- Regular and frequent supervision and support to clinicians
- Review days
- Evaluation processes
- Clinicians who are keen to work in triage
- Some clinicians who can work across triage and acute EPACT
- Recognition of the status and importance of triage
- Good liaison with external services

Early detection and easy access to services are crucial elements in an EPPIC service.

Description

Early detection and easy access to services are crucial elements in an EPPIC service. Early detection and short timeframes for access can reduce the prevalence and morbidity of psychotic illness as well as promote recovery.

As discussed in the Australian Clinical Guidelines for Early Psychosis (Early Pscyhosis Writing Group, 2010) reducing the DUP leads to both early and sustained benefits in reducing the severity of the illness and improving social functioning. Engagement with youth and accessibility are all essential parts of the process of early intervention in early psychosis and must be embedded in any EPPIC service. The TIPS study also found that early detection in FEP gave vast advantages for recovery, which was also supported in their long-term study at the 10-year period (Hegelstad et al., 2012). Hence early detection and easy access to a specialised EPPIC service and stage-specific treatment are extremely important.

Several factors will assist an EPPIC service in providing easy access. An essential feature is that accessibility to the EPPIC service be through one clear contact point. This means a telephone number that is free call, or only the cost of a local call, that can be easily remembered and has 24/7 coverage. Triage/Intake by experienced clinicians will allow prompt referral to the EPACT team for assessment, or referrals from elsewhere can be easily facilitated. Referrals to the service will be encouraged and accepted from any source. There needs to be a ‘no wrong door’ policy in place to ensure that however contact is made with an EPPIC service, the young person is connected to a prompt and appropriate service response from the first contact, and that this begins a positive and engaging experience for them.

The importance of the uniqueness and role of an effective triage service, along with the opportunities and challenges that can occur, cannot be underestimated. For this reason the following discussion focuses in detail on the triage area.

Triage/Intake

Historically triage/intake was embedded in the EPACT acute team function; however, this has evolved over times, such that it has become a more separate function. Originally it was beneficial to have an acute team member take referrals as this helped in the engagement process; often the staff member was the same person who then saw the young person and their family and knew the ‘story’ of the referral, and thus a quick response was able to be given, as well as education for others not only on the role of EPACT, but also on early psychosis.

A team of mult-disciplinary clinicians will fulfil a triage/intake function for the Early Psychosis services, providing, after referral, a brief intake screening with the aim of seamless referrals to the EPACT team.

The role of triage/intake is a very important element as it is often the first point of contact with a young person and is a crucial decision-making point.

Critical Factors to Consider for the Success of a Triage/Intake Service

Historically, within mental health services triage/intake has not had a very high standing, and staff were often reluctant to work in this area; resources were stretched and there tended to be the view within services that the aim was to keep referrals out and only take those with immediate and acute risks. With the evolution of triage/intake within EPACT there have been changes in attitude, increased status and the importance of the triage/intake role has been acknowledged with increased opportunities to provide best practice within an early intervention framework. The particular factors that have assisted in successful triage/intake can be broken into clinical and service levels; however, it should be noted that these often intertwine.

Triage Clinical Factors

Philosophy of Approach and Youth Friendliness

Hope, optimism, early intervention, recovery, prevention, respect and easy access to services all need to be embedded in the philosophical and treatment approach of an EPACT team. Staff need to understand not only the integrated model of care with a biopsychosocial perspective, but also the rationale for this and to incorporate this understanding in all their clinical approaches and interactions with young people.

Status

A positive triage/intake service has high status with clinicians who are keen to work in triage/intake and who have the necessary clinical skills and experience. It will require skilled triage/intake clinicians who can identify and fast-track UHR and FEP referrals. This will be assisted by all triage/intake clinicians completing the screening questionnaire (the PQ-16 Loewy RL ea 2005) as a way to quickly identify initial referrals.

Engagement and Responsiveness

Engagement with a young person with early psychosis and their family is a crucial factor as it is often the first point of contact with them or a referrer and can embody how the service views them, as well as the type of service provided. Engaging well with a young person can mean they are more likely to receive treatment, be compliant with the treatment process and have an improved recovery. A responsive service, without delay, can give increased benefit to all as well as reduce the DUP.

Clinical Skills

Staff need to have excellent clinical skills in all areas, which will not only assist with the engagement of the young person, but also set the scene for a collaborative treatment approach. Staff need to be able to 'triage well', by being able to engage over the telephone, explain the service, have excellent assessment skills (including risk assessment), be able to obtain the relevant information at the time of the call to then make appropriate decisions and management strategies. Basically, triage/intake staff must be able to understand and manage young people with all types of early psychotic symptoms and experiences. Senior staff can often have the expertise and knowledge of early psychosis, which increases the status of working in triage/intake for all clinicians. They also need to be able to work well under pressure, as calls can be high at times, as well as be multiskilled. These staff can train others, be role models and be the 'culture carriers' for early psychosis clinical work.

Clinical Standards

Knowledge of EPPIC minimum clinical standards and guidelines is necessary for clarity and adherence.

Documentation and Clinical Handovers

All referrals and clinical notes need to be recorded, with staff being able to give a succinct, yet comprehensive, presentation at a daily clinical handover or similar review process. This may well be influenced by the number of referrals being received on a daily basis. However, attendance of triage/intake clinical staff, the consultant and the coordinator at the clinical handover is crucial, with a documented plan and rationale for the decisions being made. Throughput of referrals is one of the aims; however, this needs to occur with appropriate clinical decision-making. The clinical handover meeting needs to have no interruptions. It can also be a learning environment for all staff.

Liaison and Resources

Triage/Intake clinicians need to know where else they can refer young people, as well as have excellent liaison skills, not only with all types of referrers, but with the EPACT team, so as to seamlessly address the assessment and proposed management plan for young people. It is essential for the EPACT team to accept the triage/intake decisions and not to resist the intended plan.

Clinical Transfers

There need to be clear processes and sound clinical decision-making for when triage/intake passes a young person with early psychosis to the acute part of EPACT, along with all acute team acceptances of the triage/intake decision-making and proposed management plan. Assessment and decision-making processes err on the side of a low threshold; so if it appears that this is a young person with early psychosis, then they are seen face-to-face for assessment. The emphasis needs to be on triage/intake clinicians promptly passing on FEP referrals so that home-based assessment and care can be commenced. Triage/intake assessment usually involves the triage/intake clinician talking to the acute EPACT clinicians regarding the referral and for the EPACT team arranging for a home visit so that the young person and their family can be informed. This is all part of the engagement process and responsive best practice service, and should be provided as soon as possible.

Orientation, Training, Supervision and Professional Development

Clinicians need to have a thorough orientation program for the work in triage/intake, with associated support and supervision arrangements. They need a coordinator or team leader available to consult on difficult or complex cases for decisions that need to be made immediately and outside of the clinical handover.

Ongoing professional development is necessary to maintain and also improve skills. The emphasis needs to be on engaging young people and understanding psychotic symptoms. Young people with early psychosis and FEP may be fearful of being removed from their environment and need sensitive and understanding management with encouragement for them to meet with the EPACT team. This EFT may change as demand and referrals increase. There also need to be attendance at EPACT review days at least once a year, and a flexible approach to changing the triage/intake processes as needed.

Triage/Intake Service Level Factors

Intake Criteria

This needs to be absolutely clear, within a defined geographic area, and focused on taking appropriate young people with early psychosis into the service rather than keeping them out. The intake criteria need documented, easily accessible, and well known by all triage/intake staff.

One Triage/Intake 24 Hour Phone Number

Young people with FEP or early psychosis and their families need an immediate and responsive service that understands what is occurring and can be supportive during an often stressful and bewildering acute phase.

The EPPIC model has operated on one triage/intake number that has been extensively promoted and is well known. It is a free call service and is answered directly by senior triage staff. This started the process of easy access and engagement. It is operational 24 hours a day, 7 days per week, even if it is diverted to other numbers for management (such as for after hours contact), and the community has known only one number to call.

Within an Early Psychosis service setting, the local centre may have a local contact number. This needs to allow prompt access for referrals to the triage/intake clinicians during the centre's opening hours and a system of diversion of calls to the EPACT team for after hours contact.

Staffing

There clearly needs to be sufficient staff to manage the workload and the funding arrangements have allowed for this. Population size, geographic area and anticipated number of referrals will assist in deciding on the staffing levels for an EPACT team and triage service at the Early Psychosis centre.

The staffing profile for an EPACT team would include a multidisciplinary team of allied health and nursing professionals, including some senior level positions, a consultant psychiatrist and registrars, team leadership/coordinator and team administration. The FTE may change as demand and referrals increase. There needs to be flexibility with rostering and sufficient senior clinical staff experienced in early psychosis and FEP work. There will be a need to manage and staff the on-call system, which often involves the after hours triage/intake work. There needs to be cover for attendance of clinicians at clinical handovers. Initially an EPACT team may work extended hours such as 8 am to 7 or 9 pm with the on-call/recall function to cover the 24 hours. These hours may be adjusted over time with workload changes and demand, such as 8.30 am to 10 pm. Basically, a 24 hour triage/intake service will need to be provided.

Orientation and Operational Manuals, Policy, Procedures and Protocols

These are needed for clarity of procedures and to assist clinicians in knowing how the team works. Clinicians will also need to refer to these at times when questions arise after hours. On-call registrar and consultant psychiatrist cover will also assist with this. The role of the consultant psychiatrist is crucial in all of these processes, as they lead the clinical operation of the team and need to be available for the EPACT on-call clinician to discuss all assessment and/or crisis information, risk factors, medico-legal issues and treatment plans for the presenting young person. The psychiatric registrar needs to be available to meet with the young person face-to-face if needed, particularly if requiring medication or to maintain home treatment or if hospital admission is being considered.

Review Days, Team Building and Evaluation

Triage/Intake need to participate in all EPACT review days to promote the concept of working together, to support each other and to allow the possibility of staff being able to work across the programs of triage/intake and EPACT, which means all clinicians are skilled in the same areas. This allows more flexibility with rostering and seamless referral processes as there is increased understanding of the different roles. Review days also help reinforce the focus of the team, such as providing home-based care, which is an essential part of the role.

Evaluation of the triage/intake and EPACT teams needs to be built in from the start of the service, to capture the raw data and referral numbers, and as a way to focus on any gaps in the service delivery and ongoing workload management. For instance, this will allow the determination of who and what other community or mental health services are young people being referred to, and how many assessments are being completed, compared to how much of the EPACT time is spent in providing home-based treatment or crisis response for current young people.

Infrastructure

For triage/intake, there needs to be suitable office area to take confidential phone calls, so headsets, a phone system, computers, a noise reduced environment, a meeting area, a clinical handover system such as a data projection system, a secure recording system, accessible resources, EPACT pamphlets, business cards, photocopy and fax machines, whiteboards and an interview room for ‘walk ins’ are all required.

Triage/Intake Structure

The triage/intake structure in an Early Psychosis service must complement the strong focus on a seamless approach to care, with prompt referrals to the EPACT team and a focus on engagement with the young person and their family.

> Many of the factors that contribute to the success of a triage/intake team can also be challenges. The important issue is how to best manage these, and establishing and adapting processes as needed.

What are the particular challenges for a triage/intake service?

Staffing

Adequate and skilled clinicians and leaders who enjoy triage/intake work and who can provide a consistent approach are required. Having senior staff in triage/intake assists with engagement, clinical decision-making and improved clinical response, but they can also be role models and support for other staff. Clinicians need to be flexible and open in their approach with excellent engagement skills. Consistency of staff can be difficult to achieve, but this can be improved with training, supervision and support. Clinicians that are not skilled in triage/intake work are also less likely to stay working in that setting.

There needs to be a balance for clinicians and some flexibility to have part-time and full-time staff, with the ability for staff to work across both triage/intake and acute EPACT roles. This can maintain clinicians’ interest in their work, their skill levels and helps with liaison issues with the EPACT team, as well as rostering arrangements.

Leadership

Not only does there need to be senior staff involvement in triage/intake management, there also needs to be consultant psychiatrist and team leader/coordinator coverage at the triage/intake clinical review or handover meetings for FEP or UHR young people. This allows for appropriate and best practice decision-making processes, for overseeing the work and for ongoing evaluation of the service. It also gives triage/intake the required recognition and status, ensures processes are followed and gives staff support while directing the clinical workload and throughput of referrals, and ensures risk and medico-legal issues are carefully considered. However, leaders need to be able to ensure this time is available for them to attend with no interruptions and also to have leadership or senior staff available at other times for clinicians who may need consultation regarding complex cases, risk issues and where difficult decisions are required.

Triage/Intake Workload Management

It is anticipated that the EPPIC service will not be overwhelmed by referrals. As a general guideline it is anticipated that for every 10,000 of population there will be 2–2.5 cases of FEP. For a population of 1 million, the EPPIC modelling tool gives 230 new FEP cases and 120 for the UHR group. The referral rate in the first year would be expected to be 1,100, which will include young people triaged only and those that may be seen face-to-face for assessment. It is likely for every 2–3 young people seen for assessment only one young person may meet the criteria for being taken into the service. So potentially the referral rate may be much higher than the actual numbers of young people who enter the service. This will need to be managed. Those young people not taken into the EPPIC service may still need referral to a headspace service or to other community services. The focus needs to be on having a low threshold for assessment so that early detection of young people with early psychosis or FEP can occur and young people are not missed.

As the service becomes better known, the triage/intake calls may increase or can become more complex in nature. Complexity can involve a range of issues such as substance misuse, comorbid issues, risk and so forth. However the emphasis is on obtaining sufficient information to make decisions, engage and to get out into the community to see young people with early psychosis or FEP.

For clinicians working in triage/intake there may need to be a system of short periods of time off-line in order to complete notes, document plans or do any follow-up calls. A further impact of triage/intake workload can be that there is a build up of referrals with plans to make follow-up calls, which are then delayed, meaning that decisions are delayed and the service becomes less responsive.

Triage/Intake processes as described above can assist with this, and an emphasis on triage/intake clinicians obtaining the relevant information at the time of the call, so that decisions can be made at that time. An aim can be to reduce the number of information-seeking phone calls by triage/intake clinicians and hence follow-up calls. Triage/Intake training and having a triage/intake ‘pro forma’ of information to obtain when taking a call, along with outlined triage/intake processes, will all assist in addressing these issues. Supportive leadership that oversees these processes will enhance the responsiveness.

Time, Orientation, Supervision

It can be challenging for a triage/intake service to build in sufficient time for clinicians to have supervision; for initial adequate orientation to the role and ongoing professional development. However, these must be built in to become part of the culture and way of working and will assist in staff retention. Coordinators need to ensure this occurs and can have a rotated system of clinicians that covers triage during these times.

Internal and External Liaison

Internal Liaison

Within an EPACT team, there can be issues arising regarding workload management, questioning of the triage/intake decisions made and requests for more information. Triage/Intake must not be a barrier for early psychosis referrals, as the aim is to detect and respond early, with any hint of psychosis to be offered an assessment. In other words, for these referrals there is a low threshold for assessment. All team members, whether in triage/intake or the EPACT team, need to understand and work in this manner. This type of understanding can also lessen any heightened tensions within a team. Having a consultant or coordinator that attends both triage/intake and acute clinical handovers can also reduce the questioning and give the rationale for decision-making, plus having a general rule that triage/intake referrals to acute will be accepted without question, within reason.

External Liaison

Good relationships and liaison with external referrers can be lost if a triage/intake service is not clear at the outset regarding the intake criteria, or does not follow through on what it says it will do. Clinicians need to be able to easily explain the criteria and follow up on promised actions. They need to inform a referrer if a young person does not meet the current criteria, give other options, actively link by ‘warm transfer’ the young person to appropriate services and to also encourage that the referrer can call back if the situation changes and the young person is more likely to meet the criteria. A welcoming and respectful approach is essential for all.

Triage/intake clinicians need to have a good knowledge of other service options, and with this, access to a comprehensive and updated database of services. However they need to be mindful of not suggesting to the referrer that another service will definitely accept the young person. This is not a decision for triage/intake to make, although it is their role to offer other appropriate options. Relationships with other external services can be lost over these types of issues.

Infrastructure

A crucial element of triage/intake work is to be in a setting where clinicians can speak openly with referrers and not be impacted on by noises around them or other staff speaking loudly. A culture of quiet ways of working can be created, but also much thought needs to be given to the setting, where it is functioning in a noise reduced zone. Spatial requirements, including where clinicians actually sit, headphones and noise barriers all need to be considered, yet the triage/intake clinicians need to be where they can easily access the tools necessary for them to do their job and feel part of the team, rather than feeling isolated. This can be a delicate balance to achieve.

A workable phone system, with a recorded message facility for callers on hold, is needed to advise of waiting times and who to contact if the situation is an emergency, or to give the general reception number for young people who are registered with the EPPIC service. If workload demand is high there may need to be a system where callers can leave their number to be called back on within a certain short timeframe. However, this call back must be strictly adhered to by triage/intake clinicians if it is to be in any way effective. It is only recommended to have this arrangement as a last resort, as the preference is to be able to take calls as they come through and provide prompt access to the EPACT team.

IT that allows clinicians to access current mental health databases or medical records can help when assessing any past treatment and also to provide further information on new referrals. Handwritten referral documents or notes can be easily lost and difficult to read, so a computer-based system is preferable and allows capture and collection of data more easily.

As with all of the EPACT team, location within close proximity of triage/intake and acute clinicians can enable easy discussions, coverage and work across the teams when acute clinicians are not in the office.

A breakout area is required to accommodate meal times, particularly for after hours shift workers, and should be fitted with a microwave, dishwasher, kitchen sink and storage areas.

Other Key Factors in Ease of Access

A key strategy in early detection is having mobile outreach, such as home-based assessment and treatment as provided by EPACT, described later (1.3.4). There needs to be an assertive access strategy that involves quick action in going out into the community to identify those young people who have early psychosis or FEP and a subsequent low threshold for assessment. There needs to be a strong ability to provide this within the EPPIC service. This also allows flexibility and improves engagement with young people.

As discussed, a youth-friendly approach is also essential for easy access, whether this be in the physical surroundings or the engagement approach of the clinicians, or by seeing young people in the environment that suits them.

The promotion of the EPPIC service needs to be highlighted and done in a youth-friendly manner and can include the stories of young people. The role of the community awareness worker will be pivotal in this. As youth participation workers become part of the service they can be incorporated into assisting with this. Radio promotion and a multimedia approach where young people's views and needs are promoted and where it is cost effective, plus online services, can be used by the EPPIC service to continue to promote the service. Listings can also be made on local service directories.

The EPPIC service needs to promote itself to all community services, particularly those that work with young people. This will involve direct attendance at organisations to explain the EPPIC service, including how referrals can be made, the phone number, criteria, the aims of early intervention and treatment for early psychosis, and the distribution of leaflets, pamphlets or websites that include this type of information. Medical clinics and educational services, such as schools, universities and TAFE organisations need to be specifically targeted by the EPPIC service. This is often where referrals come from, and these services cater to the EPPIC age group, where young people with early psychosis can sometimes present for the first time. Future training, consultation or professional development sessions for staff can also be offered and encouraged.

A good understanding of the function of an EPPIC and clear referral pathways to the service by the local community services will also aid appropriate referrals. This will ensure that young people are not directed to services that cannot assist, or turn a young person or their families' efforts to find help into navigating a complex bureaucratic system, with the result of a greater likelihood of the young person not being seen or helped by anyone and being lost to any form of assessment or treatment. This can then create the scenario of a young person continuing to have early psychotic symptoms and a lengthy DUP, which will impact on all aspects of the young person and their family's lives, as well as reduce the prospect of recovery.

Secondary consultation can be a very worthwhile service to provide to community services and often GPs and educational institutions find this of great assistance. This is further detailed in the core component 'Community Education and Awareness'. Having a process where other services can consult specifically on a particular young person and gain some insights and a suggestion regarding appropriate management plans, plus the types of services that may assist, is often very beneficial to other services. This also helps with workload management for an EPPIC service in the number of referrals, and of referrals that may not require an EPPIC service at that time.

In particular, community services that have specific links, or where it is aimed that there will be a close future working relationship or partnership established, need to be paid special attention in the promotion role of the EPPIC. This needs to be not only in terms of understanding the role of an EPPIC, but also in being the source for referrals for young people back from the EPPIC service, where it is seen that the young person does not currently require the EPPIC services. This will involve good leadership from the EPPIC service in liaison and suitable negotiation of the relationships and any partnerships, memorandums of understanding and any protocols that are developed.

Specific local arrangements may need to be considered, such as regular attendance by EPPIC staff at a local community service clinical review or staff meetings. This will enable not only continued education about the EPPIC service, but also allows a review process of appropriate referrals to the community service and what they can offer to young people.

When a young person is seen at an EPPIC service and is assessed as not currently requiring the EPPIC service then referral to the headspace centre or an appropriate local community service needs to occur. This requires excellent engagement with the young person and active work by clinicians to ensure that the right assistance and transfer to another service is completed. This 'warm transfer' must be done in a manner that continues engagement and supports the young person, while ensuring their linkage to the other community service. The minimum tasks required for this would be verbal referral by an EPPIC clinician of the young person to the headspace or other community service and arranging who, when and how they can be seen. This should occur in collaboration with the young person. Depending on the location of the community service it could also involve directly taking the young person there to introduce them to the team and a designated worker. The EPPIC clinician would also need to indicate that referral again in the future to an EPPIC service is always available.

Opportunities and Challenges

All of the above factors can be used as opportunities to ensure that young people have easy access to services. These factors do need careful consideration and planning in terms of actual location, buildings, processes and procedures, policy direction, and how to ensure the service is youth-friendly, as well as accessible, engaging and provides a prompt, seamless service. This will always involve specific detailing of each of the factors discussed above in the planning stages when establishing an EPPIC service.

These factors can all involve particular challenges. One to highlight is the relationship-building with other services, so as to have referral pathways for young people that do not need to be seen at the EPPIC service. Services become very frustrated if referrals come to them from another service where the referring service has told the young person that they would definitely be seen by the other community service. It can only take one incident of miscommunication between services to result in weeks of rebuilding the bridges and relationships between services. This is also time consuming and takes workforce resources away from other necessary work. The best way for this to be dealt with is to pre-empt situations by having planning meetings with other community agencies in the initial stages of establishment of an EPPIC service to create partnerships or design agreements and protocols for referrals and a clear process for resolving any disputes or concerns. There also need to be designated staff within an EPPIC and other community agencies to deal with these issues, as well as to promote the liaison and relationship-building between services. Partnerships are discussed in more detail in a separate core component.

It can be a challenge for a service to be attractive to youth and to be really seen as youth-friendly. Simply putting up a few posters is not sufficient and will be seen as tokenism by young people. It is the combination of the physical environment, attitude and culture of the service that will truly make an EPPIC service youth-friendly. Sufficient time and detailed planning must be given to this in the initial stages. The choice of building and location are crucial. It can be tempting for services to use existing buildings or locations; however, a service needs to think about not only the building chosen for the EPPIC service, but who else or what other organisations are associated with the building or the use of the facilities, or in close proximity to the location, as these can either promote or detract from a youth-friendly atmosphere. EPPIC services and headspace centres have been very active in ensuring that they are youth-friendly, accessible and have consulted with young people for best access planning. Promoting and developing a culture that supports mobile outreach for early detection and stage-specific care needs to be a continual process.

Security concerns can be a major challenge for an EPPIC service and staff can feel uncomfortable with the notion of relatively open reception, waiting and interview areas. The aim of easy access is to also create a 'normalising' environment and to not be overtly focused on security or a highly 'clinical' atmosphere or setting. Of course security is a necessity, but this can be done in a manner that is less confrontational in style, aiming for the least restrictive options and interventions. Having duress systems, staff who have been trained in aggression management, and building relationships with the local police force will also be essential in creating a youth-friendly and easily accessible EPPIC service. This will also help allay staff fears and concerns.

The time commitment and availability of staff needed to promote and link with other services, in not only the promotion of the EPPIC service, but also in the ongoing relationship-building can be a further challenge. It can also be tempting for an EPPIC service to focus on just commencing the service and believe that some of these tasks can be done later, or that by having a designated worker in the community awareness and education role will be sufficient. While some of these tasks will be ongoing, it must be stressed that sufficient time must be given to completing a majority of these tasks in the early stages of establishing an EPPIC service and building working relationships and protocols with other community services. This can take time and sensitivity, and often needs to commence prior to an EPPIC service opening.

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1.3.4
Home-Based Care and Assessment (EPACT)

Summary

Home-based care and assessment is provided to:

- Reduce the severity of the illness
- Promote a more rapid recovery
- Reduce the DUP
- Improve prognosis
- Preserve psychosocial skills
- Preserve family and social supports
- Reduced need for hospitalisation
- Reduce the trauma and distress to the young person and their family/friends
- Engage with the young people and their family/significant others as often this is the first point of face-to-face contact
- Provide hope

It involves a range of activities:

- It is mobile, flexible and adaptive to the needs of the young person
- Provides 24/7 contact, with one contact point
- It utilises a multidisciplinary team approach
- Works collaboratively and holistically with young people and their families/friends
- It conducts assessments as early and quickly as possible, if not immediately, after referral
- Conducts a comprehensive biopsychosocial assessment based on the stress vulnerability model
- Crisis responses, early intervention and treatment
- Engages with young people and their families/friends
- Provides hope and optimism within a stage- or phase-based recovery framework

EPACT Acute:

- EPACT Acute is the team of multidisciplinary clinicians who provide mobile home-based face-to-face assessments, treatment and crisis responses, working shifts and with a daily designated on-call worker for a 24/7 clinical response.

Home-Based Care and Assessment (EPACT) Challenges and Enablers

Challenges are:

- Having clinicians with expert skills and knowledge in all areas of early psychosis and FEP
- Ensuring a multidisciplinary team
- Some senior staff
- Clinicians who can be independent, make appropriate clinical decisions and be able to work well in a team setting
- A team with a ‘can do’ attitude and ability to work ‘out on the road’ via home-based care
- Clarity with respect to on-call and EPACT roles, as it is not an emergency service
- Clinicians able and willing to do on-call and shift work
- Establishing a roster system and adhering to it
- Workload management: equal emphasis on assessment, treatment and crisis response
- Relationship-building and liaison issues, both internal and external, e.g., IPU, CCT, triage
- Maintaining current operating manuals and protocols
- A youth-friendly but safe working environment
- Adequate infrastructure to support clinical handovers for both office and home-based work
- Limiting the number of clinical phone calls for information-seeking and for treatment. The emphasis is on face-to-face work
- Medical staff who are keen and able to provide home-based care
- Clinical staff who can engage not only with the young person but also with their family and friends

1.3.4
Home-Based Care and Assessment (EPACT)

Home-Based Care and Assessment (EPACT) Challenges and Enablers

Enablers are:

- Separate, yet integrated triage/intake and acute processes that are efficient, have equal status and clarity of roles, clear criteria and one local contact point for referrals
- A philosophy that home-based community treatment, assessment, crisis response and triage are all equally important as part of Early Psychosis and EPACT service provision
- Recruiting skilled and experienced early psychosis and FEP clinicians, including senior staff for leadership tasks, role models and to be 'culture carriers'
- Comprehensive coordinator/s, consultant psychiatrist and psychiatric registrar leadership with 24 hour cover
- Process systems that address throughput and workload management with flexibility to adapt as required, while still meeting required service and clinical standards
- Appropriate and supportive infrastructure
- Thorough orientation, training, supervision, mentoring for staff and operational manuals
- A designated leadership group that is available for consultation and decision-making as required
- A culture of youth-friendly, engaged and responsive clinical work provided in the least restrictive manner possible
- Review days for team evaluation and team-building
- Ongoing and built-in evaluation processes
- Daily clinical handovers and documentation
- Current operation manual, protocols and any service level agreements that staff may need to be familiar with

> **The way that a psychotic illness is first managed provides a unique opportunity to reduce the immediate and future harm associated with an episode and establish a positive basis for future care aimed at recovery.**

Description

The onset of a psychotic illness occurs most commonly in late adolescence or early adulthood. Acute psychotic symptoms are often an extremely disturbing and frightening experience for a young person and their family and friends, and at times can lead to a highly emotional and volatile environment. The way that a psychotic illness is first managed provides a unique opportunity to reduce the immediate and future harm associated with an episode and establish a positive basis for future care aimed at recovery.

EPACT is a flexible, mobile, home-based assessment and intervention team. EPACT is a 24-hour, seven days per week service that offers triage, assessment, community treatment and crisis intervention services for young people with early psychosis, within an early intervention framework, in a designated geographic area.

The EPACT team is the first point of face-to-face contact with the EPPIC service for a young person and/or their family or significant others. As such, it is important that this is a positive and engaging experience for everyone concerned and EPACT's mission is to provide an early intervention and treatment service to young people who are experiencing significant mental health problems, such as early psychosis and FEP. EPACT works collaboratively and holistically with young people and their families, in the least restrictive environment, to ensure that young people have the best possible chance at recovery.

The EPACT team is part of the overall acute care provided by an EPPIC and consists of a multidisciplinary team from the nursing, psychological, occupational therapy, medical and social work professions. The EPACT team offers a flexible and adaptive approach to the young person that includes providing a comprehensive biopsychosocial assessment based on the 'stress-vulnerability' model and to provide this in the community, if possible, as an alternative to inpatient treatment for acutely unwell young people and for treatment to be in the least restrictive environment possible.

It is very important that EPACT works effectively at getting it 'right' at the front end of the service as it can impact on all other areas of service provision within an EPPIC service, as well as on early detection and engagement with young people.

The components of the EPACT service involve assessment, home-based community treatment and crisis response. It may also involve triage, particularly in the after hours on-call role.

EPACT Acute

What are the opportunities and challenges in the acute part of EPACT? Many of the clinical and service level issues discussed with triage/intake are also relevant for EPACT Acute. However there are some extra factors that need thorough consideration, as discussed below.

Clinical Factors

Clinical Skills

Expert clinical skills and knowledge of biopsychosocial assessment, early intervention, the stress-vulnerability model and a youth-friendly approach are needed by clinicians to engage young people and conduct an initial assessment that provides some initial decision-making along with a management plan.

Clinicians also need to be flexible and understand that assessment is an ongoing process. Clinicians need to be able to manage making decisions and cope with crisis call work. As well, they need to have a 'can do' attitude and be willing to be 'out on the road' and seeing young people in the community for home-based care.

Assessment and community treatment are to be given the same clinical status and input from staff. The acute part of EPACT is about comprehensive assessment, engagement and treatment, such as identifying problems, treating symptoms, looking at the severity, intensity and risks, and getting in early with young people with early psychosis or FEP.

Clinicians need to be aware of physical presentations and possible organic causes of psychotic symptoms. Routine bloods and CT or MRI scans are to be offered as a matter of course.

Staff selection is therefore a crucial part of providing an excellent EPPIC service. Clinicians need to be able to not only manage the nature of the work, but also to understand the type of team they are working with, where clinicians are required to be independent decision-makers at times, as well as work well with a team approach and cope with the on-call role and associated shift work.

Clinical Handovers

As with the triage/intake service, consultant cover and coordinator cover is crucial for clinical decision-making at daily clinical handovers. Clinicians need to be able to present a comprehensive and succinct presentation of the early psychosis and FEP clinical presentations. Plans need to be clear, detailed and documented immediately in the clinical notes during the clinical handover.

After Hours On-Call

Clinical decision-making can be crucial after hours, and as a way to address this, along with supporting staff and commencing treatment, it is necessary for a team to have an after hours consultant psychiatrist on-call and available to discuss all clinical issues as required, and ensure that young people are being appropriately assessed and treated.

Service Level Factors for EPACT Acute

Liaison Issues

Within the EPACT team, as well as the EPPIC service, there will be considerable liaison work with other parts of the program, such as the continuing care team. These can be great opportunities for understanding the work that is done, for positive relationship-building and for building a seamless service for young people. However, it can create challenges for staff in building and maintaining relationships.

An acute team often require inpatient beds to be easily available or for a continuing care team to pick up new referrals quickly. While funding for inpatient care will not be provided within this EPPIC model via the Early Psychosis service, there will still be service level issues to consider with the state-run or private inpatient units. These can be dealt with by building in mechanisms for relationship-building and streamlining processes. Service level agreements could be reached with inpatient units that allow EPACT Acute clinicians to attend regular inpatient unit handovers to discuss potential discharges and pick up community treatment cases, which will help to alleviate these issues. These meetings need to be given priority by all concerned and for discussion between coordinators if issues arise. However, having an EPACT team that is focused on home-based care can reduce the need for inpatient unit admissions.

It is necessary to have protocols in place and agreements about working arrangements between EPPIC teams or programs so as to be able to deal with issues as they arise. The EPACT acute team need to be clear regarding what are necessary and appropriate internal referrals to them of existing EPPIC young people for home-based community treatment and to aim to manage these well. External community relationships are also crucial. These need to be maintained and agreed, with problem-solving mechanisms established.

Financial

Financial considerations are important, as staffing costs will increase, staff penalty rates will be incurred for shift work and on-call work, along with wear and tear on equipment and facilities. The EPPIC modelling tool allows for this to occur when scaling up the EPACT team; however, local or state-specific guidelines and costs will need to be taken into consideration.

Location

As with all of EPPIC services and Early Psychosis centres, the location of an EPACT team needs to be easily accessible and youth-friendly, with appropriate waiting areas and interview areas that can be containing for any agitated young people. These need to be youth-friendly, but safe for all concerned, with a suitable duress system but not in an overly ‘clinical’ or sterile setting. Access to up-to-date databases and medical records is vitally important, particularly when managing crisis situations and responses.

Staffing

Clinicians need to be multiskilled and flexible, with excellent clinical skills and particular personal qualities. There needs to be a combination of senior staff and regular grade staff. A multidisciplinary team is needed, with consideration of how many nurses are on the team in terms of being able to conduct basic biological screening, medication distribution and monitoring. Adequate staffing levels are required, particularly to cover two staff going out on home visits and for the on-call role, plus cover for the roster during leave and other absences.

Adequate consultant psychiatrist and registrar cover is needed to be able to directly see young people, and this is to be focused on home-based care. Medical staff are also required to provide this type of care, so they need to have the time available and agree to provide this. Home-based community treatment involving these staff can assist with the engagement of young people with early psychosis and FEP and their families, and to deal promptly with medication, biological, diagnostic and treatment issues.

Workload Management

For a busy EPACT acute team a major challenge can be managing the workload of assessment, risk management, crisis response and home-based community treatment, particularly for EPPIC service users. Constant prioritising can be required and it can become easy for a team to always respond to immediate risk issues and delay home-based treatment.

Staffing levels, clinical handovers, regular attendance at inpatient unit discharge meetings and established protocols within the service can all assist with these issues. A leadership group that promotes the essential need for home-based community treatment and ongoing review of how this is being managed, and direction regarding the overall management of the workload is also crucial.

A further challenge can be managing the number of phone calls required. This needs constant review so that an EPACT team does not spend the majority of their time in the office making calls to young people and families and not seeing them face-to-face in the community. Protocols must be established on the type of, and when, phone calls are required. This can be particularly useful for interface between EPACT and the continuing care team.

On-Call, Rostering and Shift Work

Clinicians will work a rotating roster system and could be able to work across both triage/intake and acute. This allows some flexibility with rostering, helps coverage and skill development. In a larger EPACT team the roster can become time consuming, so it is helpful to have some standard roster procedures and policies that everyone understands. It also requires procedures for if overtime is to be used and how staff coverage will be managed when after hours clinicians need to be replaced or when deciding whether this is required. Again, this can impact on workload management.

The on-call component is a vital service as it responds to the 24 hour nature of the work and needs to be covered daily. It can be a great opportunity for all areas of liaison, education and engagement. It is therefore necessary to have clear role description and the designated on-call worker to be seen as being the shift leader who manages the workload and directs staff, as well as receiving back-up by an on-call consultant and registrar for those initial FEP presentations, admission possibilities and medication queries. Having medical staff participate on a roster system is crucial.

When and how the on-call and actual overnight face-to-face contacts occur needs to be clear. EPACT is not an emergency service, and this needs to be clear to the community. As EPACT provides a crisis response and home-based care, the community can understand this to mean they will home visit at all times of the night. Clarity is required regarding this role, and it must be clear if and when EPACT will attend emergency departments or police stations. Depending on local arrangements, there may need to be provisions with other teams, such as triage in emergency departments, as to whether EPACT attends or if young people are seen initially by other services and then referred to the Early Psychosis service. The rationale for any sort of decision-making and establishment of protocols is still to be able to fulfil the mission that young people with early psychosis or FEP will not be missed by the EPPIC service and intervention is early, engaging and youth-friendly. However, it is recommended that seeing young people in a hospital emergency department or a police station should be avoided if possible. It is highly preferable to see a young person for the first time in their home or a community setting rather than an emergency department or police station. It is likely that the young person has had no previous contact with mental health services; they can be very frightened and need the reassurance of their own setting along with a youth–friendly and engaging team approach. At times, though, this will be unavoidable and the preference is that they be referred to the EPPIC service for prompt assessment.

Orientation, Operation Manuals, Policies and Procedures, Supervision, Professional Development, Review Days

The EPACT leadership group needs to ensure that clinicians are fully cognisant of, and able to, fulfil their work functions. Therefore it is imperative to have clear descriptions of roles, operation manuals, policies and procedures, plus excellent orientation to the team and ongoing clinical supervision and professional development. Senior staff can fill some of these leadership tasks and give continued motivation for the work, plus create a supportive learning environment. Review days are a way to address and discuss service and team level issues and work out strategies to implement. The team and leadership group need to have a flexible and problem-solving approach to their work. The EPACT team can have their own leadership group meetings to assist in planning and processes.

EPACT Team Building

For an EPACT team to be effective and for clinicians to manage the complex demands of this type of work it requires a nurturing, supportive and learning environment, where issues can be discussed in a positive manner. This takes continued work by the leaders, utilisation of senior staff to assist in these processes, role modelling and processes for airing grievances. Clear expectations need to be voiced. Staff business meetings, review days and some social functions are all helpful to create a positive work environment. Supervision and ongoing professional development are all necessary. Clinicians having designated portfolios provides a focus and opportunities to develop programs and skills in other areas of work.

Infrastructure

As with triage/intake, appropriate infrastructure requirements are needed. There needs to be a suitable area for young people to have medical consultations and physical assessments. Vehicles must be available and well-serviced to enable the team to be out on the road. The team will also require mobile phones and IT. The clinical handover or review process needs to be streamlined, clearly documented and have a system, such as a data projection system, that enables all the team to see the clinical descriptions and plans.

Evaluation and Audit Processes

As with any complex organisation, the EPACT team may increases in size and diversity of roles. Ongoing management and review of all EPACT processes, opportunities and challenges is required. Ongoing evaluation of its service provision needs to be built in, along with regular audit processes for both clinical and service level factors so that the fidelity to the model and meeting of key performance indicators can be achieved, which ensures best practice.

For a summary of the factors that enable the successful implementation of the EPACT team see the summary box.

Home-Based Care

Home-based care in early psychosis treatment is a service that offers exciting potential for not only young people and their families, but also for the clinicians involved. It can help promote recovery, reduce stigma by being an alternative to inpatient care, reduce secondary morbidity and assist young people to get back to their usual lifestyle. All of this allows for greater satisfaction with the service and enhances engagement, while providing valuable support, information and hope to young people and their families.

As McGorry (2005) states when reviewing evidence-based reform of mental health care in Johnson and colleagues' study in England, 'treatment at home did not increase risk, patients were less exposed to the disruption and the often harmful effects of inpatient care... also indicates that home treatment could be highly cost effective.'

Factors for Success in Home-Based Care

Home-based care seems self explanatory. It is treating young people with early psychosis or FEP at home or in their own environment. While this sounds simple, it is a process that does need careful thought about all of the key factors involved for it to give a successful outcome.

There have been many reviews and studies done over the years and in various countries, with a majority of studies seeming to compare home-based care with inpatient care and covering number of days in hospital. Johnson and colleagues (2005) demonstrated in their study that intensive treatment at home for acutely ill people with severe mental disorder substantially reduced the use of inpatient care, patients were less exposed to the disruption and possible harmful effects of inpatient care, and that home-based care was seen as highly cost effective.

Within the EPPIC model of care one of the strong messages is that the comprehensiveness of the service's approach to the young person and the consideration of all the factors in their life with a biological, psychological and social approach to care is essential in any treatment approach. In describing home-based treatment of FEP in Melbourne, Kulkarni (1999) gives an excellent discussion of the essential considerations. These are broken down into three main areas to consider: the individual, the family and the treating team. The EPACT team model of home-based care takes into consideration the following factors:

- A thorough assessment of the young person and family regarding their capacity to manage and cope with home-based care. What are the risks involved, such as suicidal and homicidal risks, drug use and compliance with the treatment approach? Can these be managed? Does each of the family members have an ability to cope and/or to learn?
- Can there be agreement between the young person, their family and the treating team regarding the treatment and management plan and ongoing compliance with this? This needs to be written down and agreed in a simple and concrete way on a daily basis.
- Is the family able to cope with 24 hour care if necessary, manage medication compliance, and manage a range of issues such as a young person not driving and be able to give directions to the young person for a required period of time? This can require a change in the current parenting style for a period of time.
- Is the young person able to comply and accept management from family and others?
- Can the clinicians providing home-based care cope and manage with a change in the type of work setting, such as being 'guests' in the family home? Can they feel safe and have flexibility to manage whatever issues arise?
- Can the clinicians provide a clear, specific, comprehensive and phase-specific treatment plan and a written, practical management plan to the young person and their family?
- Are the clinicians experienced and confident enough to make independent decisions if required? Is there the ability to call a consultant or registrar if needed?
- Is there sufficient staffing to cover a roster for 24/7 care, or extended hours care, and to be able to visit frequently, regularly and with two staff involved? Home visits may include visiting up to three times per day in an intense acute phase. Is there capacity to have some consistent staffing for the young people and families to help with engagement?
- Is there a consultant psychiatrist and/or a registrar embedded and able to attend home visits? How will medication be obtained and distributed?
- Is there a multidisciplinary team approach and adequate staffing to manage the workload?
- Is there sufficient infrastructure, such as motor vehicles, phones, pagers?
- Can the clinicians and family manage the issues of confidentiality and be flexible in the setting when seeing the young person, such as in their bedroom or elsewhere?
- Can the clinicians provide appropriate psychoeducation and communicate well with all concerned with practical solutions to issues, plus provide optimism, hope and a recovery perspective regarding early psychosis and FEP?
- Clinicians need to be able to provide a comprehensive, yet individualised approach, and liaise with school or work settings as needed, to enable the young person to return to these. Are they able to provide this adequately?
- Physical health and the ability to obtain and perform physical health checks needs to be available and appropriate. Liaison with GPs and other health practitioners is essential. Can this be conducted?
- If admission to hospital is required, everyone must still be optimistic and not view this as a failure. Often hospital admissions can be for a shorter time period due to still being able to provide home-based care, either prior to hospitalisation or afterwards. Can a positive approach to this be imparted to all?
- The EPPIC service has the ability to not only manage crisis responses as home-based care but also to have the option for ongoing home-based care depending on needs during the phases of recovery. Home-based care provision may include a period of two years or longer, for example, up to five years. Can this be supported?

References

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1.3.5
Access to Streamed Youth-Friendly Inpatient Care

The Early Psychosis service may need to use state-run or private inpatient care facilities for young people, either within the adolescent or adult mental health systems. If an Early Psychosis service is not operating an inpatient unit themselves, it is still important to consider all of the following issues when considering negotiating inpatient use for young people.

Summary

An inpatient unit is provided to:

- Give specialist acute care for FEP young people
- Be youth-friendly and engaging to young people and their families
- Facilitate further assessment and treatment
- Promote recovery and early intervention
- Provide a safe and containing environment
- Provide 24/7 care

Access to Streamed Youth-Friendly Inpatient Care Challenges and Enablers

Challenges are:

- Creating a youth-friendly and engaging environment
- Providing specialist care for FEP young people
- Having a multi-disciplinary team, including consultant psychiatrists and other specialist staff experienced in FEP
- Creating a collaborative, empathic and understanding approach
- Providing a suitable infrastructure, accessible location and engaging physical environment
- Creating a positive culture for young people
- Providing age-appropriate activities and a flexible approach based on individual needs
- Accommodating all age ranges and both genders
- Clear admission and discharge processes and planning
- Appropriate management of risk situations, drug use, aggression and containment
- Bed and workload management
- Creating positive relationships with all community-based teams

1.3.5
Access to Streamed Youth-Friendly Inpatient Care

Access to Streamed Youth-Friendly Inpatient Care Challenges and Enablers

Enablers are:

- A specialised unit or part of a unit for early psychosis young people and a service level agreement with state or private providers
- An accessible location for young people and staff of the EPPIC
- A youth-friendly environment in all aspects of physical location and facilities, culture and day-to-day activities
- A least restrictive and flexible approach, including for risk management strategies
- Short-term admissions in most cases
- Clear admission and discharge processes, a clinical review structure and operational manual to assist in bed flow and all areas of the management of young people
- A multidisciplinary team with key worker roles and understanding of developmental issues for young people
- Home-based community treatment for follow up after discharge
- Infrastructure and design that is youth-friendly and protective, such as separate bedroom areas for males and females
- Ongoing promotion of a culture of mutual respect and collaboration with young people
- Discharge planning commences as soon as admission occurs and acceptance that re-admission rates may be higher in this population
- Orientation, training, supervision and mentoring is provided to all staff in the area of young people's mental health and early psychosis work
- Clear roles for clinical nurse educators and senior registrars
- All new EPPIC staff to attend orientation sessions to the unit
- Continued relationship-building and attendance at meetings by continuing care case managers and EPACT team clinicians

Description

Choice of treatment setting is an important element in the management of young people experiencing a first episode of psychosis. Engagement and the initial experiences of treatment by a service can flavour the interactions and outcomes for young people over the long term. This can be particularly so for young people when they may be experiencing distressing psychotic symptoms for the first time and facing a bewildering array of emotions. Minimising the trauma of symptoms and the way in which these are treated needs careful consideration. Home-based treatment can often be the preferable option; however, there will be occasions where a short-term stay (in most cases) in an inpatient facility is necessary. This is usually based on the severity of the presentation, the assessed level of risk, and the extent and quality of the social and family support.

Access to a youth-friendly inpatient setting that provides specialised early psychosis care supported by a multidisciplinary team can be of great assistance to a young person and their family during an acute psychotic episode, as well as for their future recovery. Where inpatient care is required for a young person it needs to occur in a setting that can cater for, and is appropriate to, the young person's age and stage of the illness. Clinical experience has demonstrated that placing young people in adult facilities with older patients with a more long-term or chronic stage of illness is not appropriate for FEP young people. These settings can impact on the morale, hope and recovery aspects of a young person's care, and older people can be at a very different developmental stage than that of the young person.

When acute inpatient care is required for a young person, the ideal setting is an inpatient facility that can cater specifically to young people, with staff trained in working with youth and first-episode/early psychosis care. Where a hospital admission is required but there is no identified FEP stand-alone unit, then a special section of an existing general unit should be provided. Negotiations will need to occur with local state-run services regarding inpatient unit care, including any service level agreements that may be appropriate.

A specialised early psychosis inpatient unit provides short-term care to a young person until they are ready for discharge, when they can then receive ongoing community treatment from the EPACT team or the case manager from the continuing care team. To minimise the trauma of having an inpatient stay for a young person, admissions are aimed to be as short as possible, with an average length of stay being no longer than ten days. This is in order to return the young person to their familiar environment and to gain ongoing support and treatment by the community teams. In some cases longer inpatient unit stays may not only be necessary, but are desirable, as no young person should ever be discharged to an unsafe community setting or to be homeless, and some young people may require longer treatment in order to promote their recovery.

A youth-friendly specialised early psychosis inpatient setting operates 24 hours, 7 days per week. The multidisciplinary team ideally would include psychiatric nurses, medical staff, and allied health staff. Consideration should be given to include the staffing profiles of nurse unit manager, nursing staff, clinical nurse educator, consultant psychiatrist, registrar, psychologist, occupational therapist, social worker, music therapist, family peer support workers and peer support workers. It is also highly recommended that a unit has access to specialist staff, such as family workers and vocational workers, and that these staff are part of the staff FTE on a unit.

Inpatient Unit Location

When negotiating use of an inpatient care facility, consideration should be given to the following points. Clearly an inpatient unit needs to be easily accessible to those young people and their families that it is aiming to service, and so location is important. Is it near public transport? Is there sufficient parking, and what is the cost for this? Is parking available for staff and service users? What is the proximity of the inpatient unit within the catchment area? Is it close to, or part of, general medical hospitals or medical clinics? Is it easy for people to locate? Does it have good signage and visibility?

Is the Unit Youth-Friendly?

There are many issues to consider when designing or using an existing inpatient unit facility. A major focus needs to be on how youth-friendly or welcoming the actual building design is, both internally and externally, as well as how well it meets the clinical operational needs. The following questions cover some of the areas that need consideration: What are the physical attributes of the building? Does it look welcoming, and is it easily accessed? How is it painted and decorated? Is it bright and inviting? What is the layout inside? Are there male and female areas, individual bedrooms; is it safe but not looking like a prison setting? Where is the nurses' station, is it easy for staff to see young people and all areas inside the unit? Does it have the 'fishbowl effect' or can young people and staff mix easily? Is the nurse's station in a central location in the unit? Does it have a sense of easy access or more of a 'barricaded feeling' to it? Where are the intensive care area and seclusion rooms? How many are there? Where is the meals area? Is there facility for self-serve drinks? Is there a common room for young people with a television, computers or age-appropriate activities? Is there an activity area both inside and outside of the unit? Is there some garden area for both quiet time and activity sessions such as basketball? Are there sufficient interview and meeting rooms for not only staff meetings but for families and young people to see each other in? Is there readily accessible information available on the unit for young people and their families, posters regarding rights, EPPIC service provision? Does it have a physical environment that imparts hope and recovery? Is the furniture bright and comforting? Are there pictures or photos that young people can relate to? Is there a reception or waiting area? Is there an area or beds separate from an area for older, possibly more chronic, adult mental health patients?

There can be a long list of questions and issues to consider in the planning stages of any inpatient unit. While risk management is often a priority for inpatient units, how to achieve this in a way that relates to young people by creating an environment that provides containment, yet a collaborative approach in the care of a young person, is the key. The particular layout or design of both the internal and external areas of the unit needs to be thought through specifically in terms of what are the opportunities, but also the challenges, for both staff and young people in these areas.

Infrastructure

Many of the questions just raised cover the infrastructure elements that need to be considered. Careful thought is necessary regarding the equipment needed, such as types of beds, door quality, soundproofing, floor coverings, the special needs in the ICA and seclusion areas, storage facilities, medical rooms for physical assessment, medication storage, faxes, photocopiers, landlines, mobiles, paging systems, duress systems, security, building access, vehicles for transport, medical file storage, courier service if not close to the location of medical records, meal and kitchen equipment, activities rooms and equipment, office space and all equipment, such as desks, chairs, computers, intercom system, linen, cleaning, catering and so on. These need to be considered in terms of what are the risk elements that staff or young people may be exposed to, or could use as risk enabling situations? How can these be addressed in the least restrictive manner?

Training, Culture and Engagement

A youth-friendly culture and engagement with young people with early psychosis is necessary not only for assisting young people with FEP, but also for ensuring the smooth running of a unit. Staff attitudes and interactions with young people need to convey optimism, hope and recovery to not only engage, but to have young people understand and accept a treatment plan. Work with young people can be very different to working with an older adult mental health population, and requires multiple skills and intensive work with the young person.

Whatever model of inpatient care is used, clinical staff need to have training in the unique developmental needs of young people, the impact of FEP, the necessary engagement and the ability to deal with problems and issues in a positive manner. Training as well as ongoing supervision and professional development is essential for all clinical and other staff and to assist in creating a positive culture in the unit.

Activities

Young people need age-appropriate activities while they are on an inpatient unit and during recovery. This also helps to promote an optimistic therapeutic environment. Experience has shown that on an inpatient unit young people tend to like ‘action’ activities, such as basketball, billiards, walking outside, a cooking group, or a music group rather than therapeutic groups. Personal trainers and the use of gym equipment can be very engaging for young people. Of particular assistance can be the contact with peer support workers (See the section on youth participation and peer support workers). In addition to the highly structured group programs that all young people may attend, there needs to be a range of activities with a flexible approach that can cater to the individual requirements of the young person and their stage of illness.

Length of Stay

For young people with FEP the aim is to work within an early intervention framework. This means engaging them, and during the acute stage, to make sure that all concerned are safe with the least trauma occurring during the assessment and treatment periods.

As a general rule hospitalisation for lengthy periods does not assist in engagement, treatment or recovery, and can seriously disrupt a young person’s life. Hence one of the aims of an inpatient unit is to provide short-term care. This can only work well if there is good and prompt support for home-based community treatment by the EPACT team and/or the continuing care team. However, there will be exceptions to this, depending on the individual needs of each young person.

Policies, Procedures, Protocols

A youth-friendly specialised FEP inpatient unit or sub-unit of a general ward requires clear operational manuals and policies and procedures for all areas. In particular, clear admission and discharge processes are required. Policies regarding bed management are essential, including policy regarding whether to have leave beds and if so, their use during leave periods. A unit that faces a high demand, particularly with short-term stays, will need to have a system for prioritising access to beds, decisions regarding use of beds and admission and discharge priorities. Streaming of care related to stage of illness and appropriate care for young people that is separate from older adults is crucial.

The Primary Nurse or Key Worker Role

Each young person needs to have an allocated primary nurse or key worker during their stay on the inpatient unit. This allows the nurse to get to know the young person, to look at their goals while on the unit and work towards these, as well as being one of the liaison people for the young person, their family, the doctors and the community treatment teams.

All Staff Roles

A multidisciplinary team on a unit brings a variety of breadth and experience from particular professional backgrounds that add to staff knowledge and skill levels. Clarity of roles and responsibilities need to be provided for all clinical staff, along with clarity regarding joint work, whether this be the joint running of any group activities, meeting with a family, looking at housing options and so on.

The Continuing Care and EPACT Teams

While a young person is a current inpatient and has a current case manager from the continuing care team, the case manager needs to see if the inpatient unit has flexibility so that they can continue to work with the young person. This continues engagement, helps the inpatient unit staff to understand the young person and address any particular issues with the young person and/or their family.

The EPACT team, after agreement is reached, also needs to be available to attend the inpatient unit. This to not only to facilitate admissions, but is also important to allow them to respond to young people who need home-based community treatment. These processes can be assisted by attendance at the regular clinical reviews, as well as by the service being in close proximity to the inpatient unit.

Clinical Review Meetings

Within inpatient units there is usually a daily clinical review meeting, held early in the morning on the inpatient unit. This includes all staff involved in inpatient care, and agreement should be reached to include any EPPIC clinical staff.

Young people with early psychosis should have an initial comprehensive presentation provided by a registrar at this time, together with their proposed or commenced treatment plan. Each young person should be reviewed daily in terms of their current symptoms, treatment plan, medication, physical health, psychosocial issues, family concerns and any other factors arising with possible changes to the treatment plan, along with clarity over future plans and discharge planning. The young person's medical records will also need to be updated and stamped with the outcome of the clinical review meeting, with agreed tasks being designated and recorded.

Governance, Leadership, Culture and Resources

As previously outlined, these four areas are critical for a successful EPPIC service and access to a streamed youth-friendly inpatient unit. Factors that come under these that may impact are whether the unit is stand-alone or part of a general ward in a hospital setting. Either setting will need to have a clinical director. Governance, leadership, culture and resources may vary depending on how the unit is set up, with the operational procedures and any service level agreements with state-run or privately run services. Whatever the set up of any inpatient facility an EPPIC service uses, there will need to be careful consideration given to all of the areas discussed so far, with a particular emphasis on ensuring accessibility and youth-focused work for FEP young people.

Opportunities and Challenges for an Inpatient Unit

Working with young people with FEP in an inpatient unit setting can provide a very real opportunity to develop not only a culture, but also develop staff expertise, skills and knowledge of the particular issues that are relevant to young people.

Age Range and Gender Areas

The age range of 12–25 years (or potentially 29 years if considering a young person is taken into the EPPIC service at 24 years and may receive up to 5 years of care) can bring some unique challenges; however, also great opportunities. For example, while there may be some reticence by staff to have a 15-year-old female with psychotic symptoms coming from an intact family on a unit with a 24-year-old male with psychotic symptoms who may have more of a history of difficult behaviour and poor family relationships, it has been our clinical experience that as long as there are appropriate behaviours encouraged on the unit, the age groups can mix well, and in fact this have a more calming influence on the relationships, as it balances out the unit.

From clinical experience many young women express concerns regarding inappropriate sexual contact and they may also have a past history of trauma and abuse, so they can feel quite vulnerable. For these reasons it is important to have a unit where there are designated bedroom areas for females and a separate designated bedroom area for males.

Drug Use, Aggression, Rules

Often there are particular concerns regarding drug use and aggressive behaviour by young people with early psychosis, and the management of these on a unit. It has been found that the best way to manage these issues is 'setting the scene' at the initial admission interview with a young person. Staff need to use the language of youth, to not have many limit-setting rules, but to be able to clearly articulate what the expectations of behaviour on a unit are, along with fostering a culture of respect and understanding. There can be creative ways to manage behaviour; however, there also needs to be acceptance that very unwell young people who may have a range of symptoms and issues, need sensitive and understanding management. Often the relationship with an empathic and understanding team will greatly improve any management issues. It can take time to build up an understanding and culture of mutual respect and have a collaborative approach to issues. It will be found that particular issues, such as drug use, will tend to fluctuate at different times or phases in the unit.

Admission, Discharge and Bed Management

One of the biggest challenges an inpatient unit with a short length of stay can face is bed management and the competing demands for beds. At times there may be a shortage of beds and multiple requests for admissions. A system for bed management needs to be set up and reviewed that allows for prioritising fast and easy access to beds and for other options, such as home-based community treatment, being utilised. This will have to be decisively and carefully managed by senior staff on an inpatient unit, with clear lines of accountability and processes for any dispute management. Relationship-building with the identified inpatient unit by the EPACT team should be a priority.

There may be a policy of 'no leave' beds, which would allow young people to have the option of receiving community treatment, not usually an option when a young person is placed on leave, as they are still under the responsibility of the inpatient unit.

Discharge planning and throughput of young people will need to occur at the commencement of an admission, with the understanding that home-based community treatment will be utilised. This expectation that the young person may not be fully recovered from their psychotic episode at the point of discharge needs to be clear at the commencement of the admission, both to the treating team as well as

Young people need to have an outlet and to be able to focus on some short-running activities.

the young person and their family or significant others. This assists in clearer discharge plans and may also impact on the readmission rate. It can be understandable and necessary for some young people to be readmitted to an inpatient unit, and it is helpful if an inpatient unit understands this.

Home-Based Community Treatment

Discharge of young people who are not yet fully recovered, their compliance with treatment, and their need for support and continued engagement can be readily maintained if an EPPIC can initiate home-based community treatment for a period of time at the point of discharge from the inpatient unit. This can be a challenge to arrange unless there are agreements in place and good communication processes between the continuing care team, if a current case manager is involved, or with a busy EPACT team. The best way to manage this is for the continuing care team and the EPACT team to regularly attend the inpatient unit clinical handovers with a focus on potential discharges and those requiring home-based community treatments. The continuing care and EPACT team staff can then inform their respective teams of the plans and expectations regarding community treatment. This needs to be supported by the leaders of the respective programs and services.

An added issue can be the location of the inpatient unit relative to that of the continuing care and the EPACT teams, so that they can more easily attend the inpatient unit meetings. The ideal is for the inpatient unit and these teams to be in close proximity to enable regular attendance at the regular clinical review meetings and any ad hoc meetings required, as well as to be able to attend and maintain engagement with the young person.

Case managers who are part-time can find it difficult to provide assertive home-based community treatment and attendance at inpatient unit meetings, so processes for agreement and referral to the EPACT team for an interim period are needed in the early phase of community treatment, until the case manager can then take back this role.

Staff Retention

The majority of multidisciplinary clinical staff working in mental health do not have specific training in the youth mental health area. The environment in youth inpatient units can at times be quite intense, with wide-ranging and variable behaviours occurring, which can create anxiety for staff. In particular, staff are often appointed at lower grade levels, with minimum opportunity to move into senior positions within a unit as there are very few of these positions.

These issues can be addressed in several ways. One is to provide substantial training for staff on working with young people and early psychosis, so they feel they have the necessary skills to deal with situations and relationships as they arise. A comprehensive orientation program when staff commence on an inpatient unit and ongoing supervision and professional development is essential. For the nursing staff in particular, the role of the clinical nurse educator can be extremely beneficial in providing this. Regular clinical supervision for all staff is necessary and must be embedded in the unit as it provides learning, mentoring and debriefing.

Consideration should be given to the various grade levels of staff appointed. For example it can be more appropriate to have senior registrars on the unit as the work with young people can be intense and complex, requiring comprehensive assessment and treatment, with good workload management skills as the diagnostic issues need clarifying over time. Also, nursing and allied health staff may tend to leave a unit to gain experience in other areas if there are no senior staff positions to work towards. However, it can be very useful to be able to utilise these staff in other parts of the program, such as the EPACT team or the continuing care team. Their expertise is then retained and improved.

Activities

Young people need to have an outlet and to be able to focus on some short-running activities. As described, these work best when active options are offered. At times nursing staff may not see this as an important part of the care of a young person, or part of their role, and so need encouragement to participate and initiate these. This can be addressed by good leadership, training and also having clear position descriptions that articulate this as part of the role. The activities offered need to be suited to the individual young person and their phase of illness.

Liaison with the Continuing Care Team and the EPACT Team

As highlighted, there needs to be good communication between the teams within an EPPIC service, as well as with other services in order to provide seamless care for a young person. In particular, inpatient primary nurses and case managers need to communicate well, and this must occur not only between the case manager and the medical staff. Logistically, this can be difficult when there are part-time and shift work staff, so leaders need to encourage this and have protocols in place for communication processes.

As part of their orientation, and if they agree, new staff to these teams can attend the inpatient unit for a half to a full day and be attached to the shift leader as they perform their work. This can be a very effective way for the shift leader to explain what is happening, and also gives new staff a very real experience of what it is like to work on an inpatient unit, which increases their understanding while also building relationships.

Physical Layout of the Unit, Intensive Care and Seclusion Areas

Planning and the practical management of care can be compromised by the physical layout of the unit, so this needs careful consideration. The emphasis is on staff being available and participating with young people, not being continuously behind locked doors or a nursing station that is removed from the main areas of a unit.

At times there may be the need for the use of intensive care areas and seclusion rooms; however, these should only be used as a last resort. These require proper facilities for safety and risk management, clear operational procedures, short-term use as a priority and secure access for treatment. The number and use of these rooms can be challenging to prescribe, as well as their location. It assists if these areas are not in full view of all young people on the unit as this can create increased distress and anxiety, yet they need to be close to the main nursing station for access, monitoring and observation.

While there can be many challenges for any type of acute care for young people, a youth-friendly inpatient unit that has been properly planned, with appropriate facilities, engaged staff, strong leadership and effective policies and procedures in place, plus flexibility to adapt to individual needs, can work exceedingly well. Clearly, a culture that supports early intervention, hope and recovery can be created for young people experiencing a first episode of psychosis.

1.3.6 Access to Youth-Friendly Sub-Acute Beds

Summary

Access to youth friendly sub-acute beds can provide:

- A place of safety and stability with least restrictive care
- An environment that is not highly clinical, which heightens engagement not only for the young person but also for the family
- Individually tailored service for the young person
- Promotion of recovery with a focus on maintaining or picking up opportunities for social, functional or vocational activities. This may include the young person continuing with attendance at school or returning to school or work and having extra support to do this
- Short stay care, so the young person does not lose their links to their family or the local community
- Can avert crisis admissions to acute inpatient care
- A focus on recovery and work on relapse prevention strategies so that acute inpatient care is not required, hence avoiding any associated stigma and the possible psychological consequences for the young person
- Family support can still be available, with family visiting the young person or the young person visiting their home
- Families can also be given some respite, which helps to maintain relationships and reduce stress levels, giving some ‘breathing space’
- Social issues of homelessness and future accommodation can be focused on while providing physical care and psychological relief
- A less supervised environment, which can assist with engagement
- Young people will not be confronted by those who are acutely unwell, which may happen on the acute inpatient unit
- Assessment and treatment of the young person can be continued in a less restrictive manner, particularly if moving into ‘step-down’ care
- Inter-professional communication and learning can be enhanced
- The staff and unit can be supported by other parts of the EPPIC service, such as the continuing care team, mobile outreach and the EPACT team
- A setting for other young people to mix and understand there are others who have similar issues, which can help reduce stigma and build on social relationships and problem solving
- At a service level there can be a reduction in the length of stay on the acute inpatient unit, allowing greater service provision for a range of young people with early psychosis. The readmission rate can also significantly improve.

Access to Youth-Friendly Sub-Acute Beds Challenges and Enablers

Challenges and Enablers are:

- How will the intake and decision making process occur? Is it able to be equitable and accessible to all? What are suitable defined criteria?
- Who makes the final decision regarding young people coming into and out of the sub-acute unit, and the capacity to manage these young people? How much input can the lead consultant psychiatrist of the EPPIC service or clinical director have? It would seem shared collaborative decision-making would be the ideal arrangement
- Good coordination between the various EPPIC programs needs to occur for continuity of care and to maintain engagement with the young person
- The continuing care case manager needs to actively assist with the coordination of service provision and decisions regarding more intensive support for the short stay period, along with collaborative and prepared discharge planning
- Need to ensure that risk assessment is thorough and that strategies are in place so that sub-acute unit staff are strongly supported in this. This can often be an area of concern for staff and can impact on staff retention
- Conflict resolution processes must be part of the service level agreement within the partnerships, and there must be clear expectations of service provision: by whom, when and how?
- The culture of the unit needs to be youth-focused with strong attitudes of hope and optimism, which can be enabled by the philosophy of the unit, but also by the provision of appropriate staff selection and training
- Short-term stays can easily tend to become long-term stays, particularly where homelessness or family reluctance to have the young person back home is involved. At the start of the intake process the scene needs to be set with all concerned, so that the young person and their family's expectations and understandings are clear regarding the length of stay. Discharge planning also needs to commence at this time, with realistic goals established and all options considered
- The location needs to be easily accessible for young people and others, such as near public transport and not too far away from activity-based programs, or for example school; if wanting young people to attend any of these. In a large geographic area this can be a particular challenge, where access may be more difficult which in turn can impact on length of stay
- Individual goal-setting and assessment of positive and negative symptoms needs to be as collaborative as possible, since some young people may just need some space to 'chill out' for a period rather than engaging in activities, yet to still be focused on re-engaging in these. Balancing this can require staff support and understanding, which is assisted by training, supervision and ongoing professional development

1.3.6 Access to Youth-Friendly Sub-Acute Beds

Access to Youth-Friendly Sub-Acute Beds Challenges and Enablers

Challenges and Enablers:

- Exchanging information between EPPIC programs and the sub-acute unit needs to be continually worked on and prioritised so that the intensity of service and planning for the young person is not delayed
- Pressure can occur to take young people into the unit who may be too unwell, particularly if there are no acute inpatient beds available. There need to be clear criteria, policies and procedures in place to be able to address this as it arises. All staff within the EPPIC programs must clearly understand the role of the sub-acute unit
- Medication control, storage, distribution and supervision must be compliant with EPPIC minimum standards and procedures, and all mandatory regulations
- Discharge needs to be planned and backed up by the community treatment teams, whether this is provided by the EPACT team or the continuing care team case manager, and occur at a time when the plan can be successfully put in place. For all of the EPPIC programs it can be a balance between meeting crisis-driven demands and ongoing community treatment. Appropriate and timely discharge planning should assist with this, to ensure sustained improvement for the young person

A positive working relationship can be created to enhance the recovery of young people experiencing FEP by taking all of the points above into consideration when establishing a service level agreement, protocols or partnerships. Staff training and support can be particularly helpful in facilitating the clinical understanding of young people with FEP and to develop an empathic, understanding culture.

Description

For some young people the post-acute phase of psychosis requires an additional level of management and support prior to transition to full community care, or conversely, early intervention in the community with the aim of preventing an admission to an acute inpatient unit. Youth-friendly sub-acute beds in a facility that can provide 24 hour care, treatment and support for young people with early psychosis in the 15–24 year age group aim to provide intensive care early. In particular, this service is aimed at young people who need residential support as an alternative to inpatient care or to help them transition from hospital back into the community.

Within Victoria there are several Y-PARCs (Youth Prevention and Recovery Care services) now operating. They provide 10-bedroom short-term 'step up/step down' facilities for young people with serious mental health issues. Usually the service is a partnership with the mental health service and local non-government organisations. For instance, the Y-PARC in Frankston is a partnership between Peninsula Health Mental Health Service, MIND Australia and Peninsula Support Services. The staff include clinical staff from the mental health service and support staff from MIND and Peninsula Support Services. Within adult mental health services there are also PARC facilities providing the same step up/step down care.

The criteria for a Y-PARC usually consist of:

- Their clients are in the age range 16–25 years
- Clients must reside within the catchment area
- The young person has a significant mental health problem or is at high risk and vulnerable, with functional impairment associated with emotional and behavioural problems and significant psychological distress
- The young person is able to receive treatment and support safely and effectively within a community-based residential setting, and have been assessed by staff as being able to benefit from this type of care
- The young person is not at significant risk of harming themselves or others
- The young person agrees to not use illicit substances or alcohol during their stay
- The young person voluntarily agrees to participate in the program (including those who are on a community treatment order)
- The Y-PARC is seen as being part of a wider, broad and coordinated response for young people with early psychosis

The concept of step up care is for young people who are living in the community yet require short-term residential support with intensive clinical treatment and early intervention to prevent the risk of further deterioration or relapse, without which they are likely to need an admission to an acute inpatient unit.

The concept of step down care is for young people who have had an admission to an acute inpatient unit but no longer need that level of clinical intervention and treatment, yet would benefit from some further short-term intensive treatment and support in a residential setting in the community. This is a transitional step before returning to their home in the community. Both types of care are seen as being short-term, ranging from several days to a few weeks at the maximum.

In the United Kingdom both of these types of care have existed for many years, such as those in the Birmingham Early Psychosis service. This care, known as respite care, is usually offered in 3–4 houses in the local community. There is not a lot of evidence-based literature for these types of services; however, it is argued that this care is very successful in engaging young people and their families due to the youth-friendly nature and the community setting, and also reduces the length of stay for inpatient admissions and results in fewer readmissions. The focus is on recovery and providing opportunities for comprehensive intensive care that is individually tailored and focuses on all aspects of a young person's life, including the social, functional and vocational areas (Birchwood, 2012).

The key service principles of PARC care (Mental Health Division, Victorian Government Department of Health, 2010) as defined by adult services are:

- Collaboration
- Least restrictive practices
- Respect and responding to diversity
- Consumer and carer participation
- Privacy and confidentiality

Considerations for Providing Youth-Friendly Sub–Acute Beds

There are a number of considerations for an EPPIC service when establishing or reaching a service level agreement with a youth-friendly sub-acute bed service. The major one is, as described, providing a youth-friendly atmosphere in the local community catchment area. At a service level this means establishing a suitable residential setting, whether it be purpose-built or arranged as a house in the local area. Considerations of access, transport and geographic location are necessary. Where a stand-alone sub-acute bed unit is not possible, then consideration may need to be given to whether accessing a special section of an existing general sub-acute setting is necessary.

Partnerships between the mental health service and non-government organisations with a mental health focus are often established to provide this service, with clear governance and service level agreements. Continuity of care and a comprehensive focus are a priority, where the EPPIC sub-acute bed service would need to provide a youth-friendly service in terms of the physical environment as well as developmentally appropriate activities. The EPPIC programs would be closely involved in providing clinical care and support to young people, as well as providing education and support to staff related to working with young people with early psychosis. This type of care can provide many opportunities for young people, as well as for the EPPIC service overall.

References

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1.3.7
Continuing Case Management

Summary

High quality care has the potential to deliver special benefits to young people with early psychosis. Late adolescence and early adulthood are critical stages of psychological, social, educational and vocational development. Serious mental illness can cause substantial disruption to these processes, leading to long-term functional disability and poor outcomes. Early and effective intervention in early psychosis and FEP can help prevent the biological, psychological and social deterioration that can occur in the early course of illness.

A continuing care team is seen as providing team-based case management and individually focused therapeutic interventions.

The approach of the continuing case management is:

- Based on the biopsychosocial system that a young person exists within, and on the stress-vulnerability model, where consideration of stressors and protective factors in the context of underlying biological, social or psychological vulnerability can help guide an individualised treatment plan, and therapeutic interactions within a clinical staging/phase-specific model of psychosis

Continuing Case Management Challenges and Enablers

The challenges for a continuing case management team involve both clinical and service level factors.

Clinical Challenges are:

- Young people who have early psychosis face their own personal challenges. For the clinician there can be tension between reducing or avoiding the trauma associated with treatment in the acute phase and aiming to reduce symptoms and restore functioning, while ensuring the safety of the young person and others and aiming to engage in an empathic manner with a comprehensive treatment plan that suits the young person
- A case manager may need to work hard at engaging a young person and their family to ensure attendance and treatment compliance. If this is not occurring how will it be addressed in the organisation? There should be time within the caseload limits for home visits and active engagement in the community, as well as increased face-to-face meeting times
- A young person can present with a multitude of problems apart from psychosis. These can be complex in nature, and or have a range of associated risk issues and comorbidities. Assessment can be an ongoing process. A case manager needs a flexible and patient approach and the ability and skills to manage these issues
- Managing crisis situations and accessing the appropriate acute care if required
- Identifying early (at the three month point) those young people who have persisting positive and/or negative symptoms
- Have clear collaborative relapse prevention plans with young people and their families

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Continuing Case Management

Continuing Case Management Challenges and Enablers

Clinical Enablers are:

- Locating the distress and responding to young people empathically. This cannot be too strongly emphasised, not only when engaging the young person, but in all interventions and treatment provided for the young person
- Engaging around common agreed goals in addition to the case management goals. Working within a framework of least restrictive practice and aiming for collaboration with the young person and the family can help. Utilising the expertise of the clinical team in decision-making and useful clinical supervision are essential
- Training, clinical review processes, expert consultation, supervision and the comprehensive framework of all facets of the EPPIC program can assist. Advocating for young people on a range of issues can ensure they receive truly holistic care
- Rearranging the workload at the time so as to be able to respond to a crisis situation and manage the needs of all concerned. Utilising the EPACT team for either case consultation or actual referral for assistance, particularly after hours can help, along with the continuing care team duty system
- Understanding the young person's story and possible reasons for not engaging will aid in working out a plan that suits the particular situation. This will help in building the therapeutic relationship, as clinicians need to understand why and where the resistance is coming from if they are to form any empathic therapeutic relationship with a young person
- Within the organisation, reviewing cases and the clinician and team being prepared for a lack of engagement of young people at times. Raising this in clinical review meetings and considering whether referral for more focused intensive work is necessary may help; however, this should only occur after all other engagement efforts have been made, such as going out to see the young person in whatever setting suits them
- Having processes within the clinical review meeting for identifying (flagging) young people at the three-month point who have persisting symptoms
- Within the clinical review meeting checking that there are current relapse prevention plans in place

Continuing Case Management Challenges and Enablers

Service Level Challenges are:

- Having sufficient funding to commence, and to increase staffing levels as the demand on the EPPIC service grows or if the EPPIC is scaling up its service. Conversely, there may also be some slowing in cases after an initial rush. Either occurrence will need preparation
- Having sufficient planning time and meeting mechanisms to allow thoughtful endeavour and promotion of best practice
- Caseload numbers: sufficient funding, referral numbers, and caseload levels have been major service level issues for the EPPIC service in Melbourne. This has then impacted on the nature of the service delivery. With uncapped caseloads and high referral numbers it was found that EPPIC case managers were being inundated with cases, and they were unable to provide a comprehensive service for these young people and their families. Hence, responses often became reactions to crisis issues, crisis management became more pronounced, relapse prevention became harder to focus on, along with community-based treatment, and efforts at engagement were increasingly difficult. Staff also became less motivated and ‘burnout’ issues occurred
- Staffing can be a challenge in many areas, as described above. Younger or newer staff will need an adequate orientation process and time to gain experience to manage more complex issues, and this must be taken into consideration. They may require increased teaching, supervision and training time. Staff and the service may also need to meet professional requirements, such as a junior psychologist without endorsement needing supervision for a two-year period
- Acute work: while it is seen that it is within the role of a case manager to respond to crisis situations within their caseload, this can not only take time, but also requires good liaison and linkage to the acute part of the service, such as the EPACT team. At times, acute care assistance may be required. Case managers need time to respond and handover to acute services, and they are still to remain involved in the young person’s care
- Training and professional development need to be embedded in the system. In the early days of a service this can take more time until a staffing base is established that understands and can implement the psychological work required
- While the psychological interventions and the work of designated specialists, such as the family worker, are discussed elsewhere in the core components, they also need training and the ability to provide training. In order not to impede specialist workers in providing their service it is best for them to not have allocated cases as a case manager

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Continuing Case Management

Continuing Case Management Challenges and Enablers

Service Level Challenges *continued* are:

- There can be a range of practical case management issues that arise, such as case managers not being available when needed, or where the workload can increase over time in terms of demand, not necessarily in terms of total caseload number, but in the intensity of the work required
- Clinical governance, evaluation and fidelity processes need implementation as well as appropriate staffing to address, review and document
- Infrastructure not only needs to be sufficient and planned for; it also needs maintenance and ongoing problem solving
- Discharge planning processes, tenure of care and complex cases all need active ongoing work and processes for review built in
- Geographic area: the size of a geographic area and its transport and socio-economic level can all impact on the service and the way that a continuing care team operates. Obviously, a large geographic area can involve more travel time, staff can be on home visits for longer, and this lessens the number of available cars and phones available for other staff and so on. Rural locations have their own unique issues, such as medical availability and the ability to do face-to-face reviews

Service Level Enablers are:

- Planning needs to occur for commencement and scaling up with strategies for both, particularly in the initial stages of an EPPIC service. However, the service should not be overwhelmed by FEP young people and there can be some anticipation of the predicted number of cases, which assists in planning
- Planning for succinct, relevant, regular meetings and timetabling for best attendance
- The system of capped caseloads for case managers. This allows case managers to respond in an improved manner to young people, to have more time to tailor treatment plans and engage and link to other parts of the program. Staff morale can improve, as will staff retention. The funding levels with the Early Psychosis service allows for caseloads of 15–20, which is effectively capping them. The standards (see later section) also outline the expectations regarding the minimum contact a case manager should be making with the young person and their family, depending on the stage of illness

Continuing Case Management Challenges and Enablers

Service Level Enablers *continued* are:

- However, in having a capped caseload there needs to be a system to manage this where team leaders and coordinators can check databases showing episodes of care, be aware of future discharges, and commencing the discharge process from three months beforehand to ensure that discharge occurs on time. When team leaders and case managers are allocating cases they need to be aware of the level of complexity and the stage of illness of the young person that a case manager is working with, so that the level of intensity of input required by the case manager is understood. The EPACT team and mobile outreach can also assist case managers with these areas of work as necessary
- While it can be difficult to predict staff changes, there needs to be sufficient available staff for allocation of cases. Planning for staff changes needs to be at the forefront of the agenda for team leaders and coordinators so planning regarding future cover can occur. Any staff vacancies need to have a human resource system that addresses these quickly. Flow-through of cases needs to occur. If allocation to a case manager is difficult then cases needing to be allocated may need to be held in an acute team for a short period of time, by agreement However, this should not be a standard procedure
- All of the above situations need to be planned for and have sufficient senior professional staff available to provide for them
- Cover for staff leave of all types needs planning. Forward thinking regarding these issues and ideas for managing cover makes addressing them much easier. A duty system can assist and cover for unplanned staff absences on occasions. Other parts of the EPPIC service programs may need to assist with this at times as well
- There needs to be a system of management and available medical capacity to review young people in a crisis situation. Case managers need to know when referral to the acute care of the EPPIC service is required and established protocols can readily clarify this
- Utilising the EPPIC National Support training can be very useful. Having discipline seniors and other designated staff coordinate professional development sessions helps up-skilling and promotes continued learning
- A duress system and associated security needs consideration and implementation

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Continuing Case Management

Continuing Case Management Challenges and Enablers

Service Level Enablers *continued* are:

- Utilising any current systems or staff already in place within an organisation or establishing positions that address the areas of infrastructure and maintenance
- How are decisions going to be made for those young people who may need a further three years of care, what will this consist of, and where will it occur? This needs to be planned at EPPIC implementation and processes must be put in place, such as having decision-making systems in the clinical review regarding discharge and longer tenure of care being flagged early, such as at least three months prior to discharge
- Decisions about a further three years of care will involve establishing criteria for this, such as incomplete recovery, frequent relapses, engagement, complexity and risk issues. There needs to be some flexibility so that it is not fixed at the two-year point of discharge for a young person, so that they can still re-access the service if needed, up to the five year period
- Other ways of interacting and providing services need to be creatively addressed and may use newer software, IT solutions and a variety of youth–friendly approaches. Defining the geographic area, such as an hour's drive from the Early Psychosis service can assist when providing home-based care

If a continuing care team is mindful of some of these challenges and considers the enablers when implementing it is likely to have a well-functioning and stable clinical team and workforce, with processes that assist them.

Description

A continuing care team is made up of multidisciplinary staff—psychologists, nurses, social workers or occupational therapists—that are each designated as outpatient case managers and allocated between 15 and 20 FEP cases. Caseloads are capped at these numbers. A registrar and consultant are also allocated alongside the case manager to each of the cases. The case manager has a primary relationship and a therapeutic and coordinating role and works collaboratively with the young person and their family or significant others. They provide a treatment approach that is tailored to the individual needs of the young person and the stage of their illness. Case management can be provided at the centre and/or within the community, either in other community settings or as home-based work.

The specific role of the case manager is discussed elsewhere in terms of the psychological treatments they offer. However, best practice is based on the assumption that the young person will recover from the initial acute episode of psychosis and a cognitive-based case management approach is taken that focuses on treatment to meet short- and long-term goals, such as acute care that aims at controlling symptoms but also provides psychoeducation, fosters functional recovery, education/work goals and establishes the prospect of recovery. Case managers should also link and support young people with functional, vocational and educational recovery programs.

The case manager also utilises other dedicated staff, such as a family worker, to assist in treatment; however, the case manager can provide therapeutic interventions and is encouraged to do so. Empathic and understanding case managers who can build a relationship with a young person are often the essential ingredients in assisting recovery.

Tenure of Care

An episode of continuing care case management would be for a minimum of two years, with the potential for an added three years of care for those young people with an incomplete recovery. Hence this may continue up to the age of 29/30 years in a minority of cases.

Case Management Process

The process that occurs for a young person after entry into an EPPIC continuing care team is allocation to a case manager with an associated registrar or consultant psychiatrist, case formulation and treatment plans, individualised work including therapeutic approaches, linkages to other parts of the service program as required, regular clinical reviews and final discharge planning.

What are the Critical Factors for Success in Establishing and Maintaining a Continuing Care Team?

Clinical Factors Include:

- The relationship with the young person, their family or significant other is often the most crucial clinical factor in promoting engagement and recovery for the young person. This must not be underestimated by the clinicians or the service
- Staff who understand the clinical issues and case management model, who have skill and expertise in working with young people in a youth-friendly and early intervention framework, and who have the professional qualities to provide best practice in assessment, acute care and recovery processes
- Multidisciplinary staff bring their own unique professional expertise that can be well used. For instance, psychologists can undertake cognitive testing, medical staff can bring their up-to-date pharmacological knowledge, and social workers can bring a systemic view
- Staff can bring various levels of expertise to provide supervision, mentoring and professional development sessions and to create and continue the early intervention culture
- Clinical governance and documented clinical processes, particularly for risk management issues
- Staff who can work with a collaborative approach with the young person and their family and within the EPPIC service programs, both internal and external to the organisation, so that a comprehensive approach is provided

Personal Qualities

Clinicians not only need to have expertise and skill when undertaking case management work, they also need a number of personal as well as professional qualities. When recruiting to Enhanced **headspace** clinical positions it is worth noting the following points and comment box:

- Commitment and a thorough understanding of the philosophy of early intervention and recovery concepts for youth
- Good understanding of youth and family development between the ages of 12–25 years
- Excellent mental health clinical skills in engagement, assessment, holistic care, crisis response, case management, therapeutic interventions, advocacy and liaison
- Flexibility to cope with organisational change
- A flexible approach to the young person’s treatment and care
- Good negotiation skills
- A ‘can do’ attitude with a positive hopeful outlook
- Capacity to learn and create new ideas
- Excellent communication skills and an empathic, ‘good listener’ approach to the young person, family or significant other, with an ability to build rapport
- A systemic view of a young person

Service Level Factors for Success

- Adequate funding for service provision
- Sufficient multidisciplinary clinicians to provide a continuing care team of case managers and other designated staff, including sufficient senior staff and team leaders or coordinators
- A supportive team-based approach that includes regular team meetings, clinical review processes, and team review days
- Caseloads of 15–20 young people, which allows a case manager adequate time to provide a specific, tailored and comprehensive approach to each young person
- Systems in place for equitable allocation to case managers
- Guidelines, standards, protocols and policies that provide direction to staff and the community, along with clear governance structures
- Resources that provide psychoeducation and information
- Operational manuals

Infrastructure

- Adequate office space, meeting rooms, interview rooms, reception, waiting areas that all are in a youth-friendly environment
- Administrative support for reception, typing, the duty system and roster
- Duress system and security support
- Motor vehicles, computers, landlines, mobile phones, paging system
- Metabolic monitoring and medication storage facilities
- Medical records storage and access/IT infrastructure
- Databases that can track episodes of care
- Outcome measures and any other evaluation tools

Often the factors that help with success are also the factors that can be challenges. They can also intertwine with each other; for example, the geographic size of the catchment area can impact extensively. Overall awareness and planning for these factors can really assist in managing the challenges.

Reference

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What it takes to work in early intervention programs…

‘You need someone who is a good communicator and at ease in relationships, with a relaxed, easy-going style and a sense of humour who holds an optimistic, hopeful outlook. It is important to come from a value base that respects individuals and their families and culture, and sees people as people struggling to come to terms with the impact of a psychosis.’

Dr Jo Smith, NIMHE/Rethink Joint National Early Intervention
Programme Lead, UK (Ministry of Health
and Long-Term Care, 2011)

1.3.8 Medical Treatments

Summary

Medical treatments are one of the key clinical interventions in any mental health service. For those young people who have experienced a first episode of psychosis, a particular and considerably different approach to medical treatments from that utilised in older patients with established illness, both in style and content, is essential. These interventions are wide-ranging and include coordinating medical screening and psychiatric assessment as well as evidence-based pharmacotherapy to ameliorate symptoms and distress associated with psychosis, mood disturbance, anxiety and substance misuse.

The Australian Clinical Guidelines for Early Psychosis (2nd edition) (Early Psychosis Writing Group, 2010) should be utilised.

Medical Treatments Challenges and Enablers

Challenges are:

- Young people with FEP are usually antipsychotic naive
- Their first experience of antipsychotic medication will influence engagement and adherence
- Diagnostic instability may require ongoing adaption to pharmacological interventions
- Young people with FEP may be particularly sensitive to extrapyramidal side-effects, weight gain and metabolic side-effects
- Engaging with young people around treatment approaches
- Recruitment of medical staff and those with experience with young people experiencing FEP
- Dealing with physical health issues and young peoples' developmental issues
- Developing a culture of prescribing that considers dosage levels, side effects and the impact on all areas of a young person's life, whether it be physical, social, emotional or functional
- Ensuring and accepting a period of between 24 and 48 hours without medication prior to commencing antipsychotic treatment if possible, and using a 'start low, go slow' approach to antipsychotic treatment
- Monitoring all facets of the medications, including adherence and side effects, and developing strategies to manage these

1.3.8 Medical Treatments

Medical Treatments Challenges and Enablers

Enablers are:

- Appointing a medical director who oversees medical interventions, medico/legal issues and provides expert and caring leadership
- The medical director needs to have a strong value-based commitment to the service, to early psychosis principles and a robust knowledge and clinical experience in UHR and FEP work
- An inspiring medical leadership team who can provide evidence-based training along with direct clinical work
- Use of clinical guidelines (Australian Clinical Guidelines for Early Psychosis, 2nd edition) and prescriptive algorithms for a clear rationale and supportive practice
- A youth-friendly and engaging culture and an ability to hear the issues and concerns of young people and their families about medical treatment and options available
- Links with a university department of psychiatry and the Royal Australian and New Zealand College of Psychiatrists for specialist academic training
- Medical staff keen and able to work collaboratively with young people and their families
- Use of the principles of the International Physical Health in Youth Stream Working Group (iphYs Working Group, 2013)
- Accepting diagnostic uncertainty at times
- Utilising short-term course of benzodiazepines for distress, and antidepressants for moderate to severe depression
- A culture of respect and valuing the multi-disciplinary team and collaborative working relationships

A different approach to medical treatments used in older patients with established illness is essential for young people who have experienced a first episode of psychosis.

Description

An evidence-based sequence of medications and their integration with psychosocial care is a key skill set to which all young people have access to. The physical wellbeing of young people is also a focus, through the adoption of preventative approaches including collaborative decision-making, metabolic screening and preventative interventions. Although the aim of this section is to provide a guide for service level implementation, an overview of key clinical issues related to medical treatments is important for service developers to understand.

Organisational Issues for Medical Treatments Component

Within each part of the early psychosis service, there needs to be specialist psychiatrist/medical leadership with clear governance and structure. A medical/clinical director who oversees medical interventions, medico/legal issues, and provides expert leadership is essential. The person in this role will need to possess a strong value-based commitment to the service and early psychosis principles, as well as possessing a robust knowledge and clinical experience of working in the early psychosis field. This will not only influence appropriate clinical interventions but also contribute to the culture of the whole organisation, and in particular, medical staff. As early intervention in psychosis may be seen as a more ambitious and optimistic concept within psychiatry, there will need to be an enhanced level of dedication and energy required to take on this leadership role.

Consultant psychiatrists with early psychosis experience are employed to deliver direct care to young people, particularly those with more complex needs, and to provide clinical supervision to the psychiatry registrars who are also employed on rotation in the service. The influence of medical leadership within an early psychosis service is crucial in determining fidelity to the EPPIC model, particularly where medical treatments are involved. There should be an expectation that senior medical staff participate in various leadership, operational and clinical meetings and committees aimed at improving the quality of care delivered to young people and their families.

As in any other service, there is a need for senior medical staff to contribute to training and guideline development, and particularly to assist in guiding the psychiatry registrars on rotation through the service. In Australia, psychiatry registrars are usually employed by state government health authorities and placed on rotation as part of their professional college training, although the arrangements for this may vary from state to state. Staffing levels in an EPPIC model service will depend on the size of service and can be guided by the EPPIC National Support Program modelling tool.

Along with a case manager, each young person referred to the service is allocated to either a consultant psychiatrist or psychiatry registrar (under the supervision of a consultant) to collaboratively manage the medical interventions component of the young person’s care. The frequency of medical review of young people is determined by the individual needs of the young person and the phase of illness. In the acute phase, the young person should be seen within 48 hours by a doctor, and then at least weekly, but should also be reviewed by a consultant psychiatrist within the first week. In the late recovery phase the frequency of contact should be at least monthly.

All medical staff need to embrace the idea of working in multidisciplinary teams, being respectful of, and valuing, the skills, knowledge and contribution of other members of the team. This is crucial to ensure good working relationships across the whole team and in the provision of a team-based approach to deliver best practice interventions. A balanced mix of experienced and new medical staff that are open to learning new approaches is ideal.

Clinical Issues in the Medical Treatments Core Component

A range of medical interventions are required in line with the latest clinical guidelines to provide best practice treatment for early psychosis. One of the most important medical interventions required early in an episode of care is the coordination of a range of biological assessments, which are crucial in assessing someone with a suspected first episode of psychosis, particularly to rule out possible organic causes. For a comprehensive guide to the recommended biological assessments see the (Early Psychosis Writing Group, 2010, p. 35).

The prescription of medication is one of the first line treatments for psychosis, particularly where engagement in other forms of treatment is hindered until some symptomatic relief is achieved. However, a number of pharmacotherapy issues arise for people with FEP, which should influence how medical interventions are delivered. These issues are highlighted below:

- Young people with FEP are usually antipsychotic naive
- Their first experience of antipsychotic medication will influence engagement and adherence
- Diagnostic instability in FEP may require ongoing adaption of pharmacological interventions
- Young people with FEP generally show more rapid improvement in symptoms, and at lower doses of antipsychotics, than those with established schizophrenia
- Positive symptoms in young people with FEP are generally responsive to treatment, in terms of overall response rate and the degree of symptom reduction
- Young people with FEP may be particularly sensitive to extrapyramidal side effects
- Young people with FEP are more susceptible to antipsychotic-induced weight gain and metabolic side effects than those with more chronic illness

Source: (Early Psychosis Writing Group, 2010, p. 461)

With these issues highlighted, a number of principles for pharmacotherapy emerge and should guide medication use:

- Take side effect profiles into consideration when prescribing for each individual
- Medication for psychiatric emergencies is a second line strategy (behind psychological and practical supportive interventions), and must be administered safely and respectfully
- Distinguish between affective and non-affective psychosis, as this distinction will guide further pharmacological interventions
- ‘Start low, go slow’ as higher doses and rapid titration are not indicated and only increase the risk of alienating side effects
- Avoid antipsychotic polypharmacy as there is no evidence to support this practice, particularly in FEP, and it will increase the risk of side effects, drug interactions and non-adherence
- Monitor adherence to medication, particularly as non-adherence is very common in FEP
- Anticipate, monitor and manage adverse events and side effects, which may be distressing and disabling and may require the use of objective measures

For further information with key references on pharmacological interventions see the following:
Early Psychosis Writing Group (2010)
National Advisory Committee on Mental Health (2011)
EPPIC Model Briefing Pack Writing Group (2013)

Challenges and Enablers

As psychiatry training (and indeed, the usual general mental health service delivery up to this point in time) still focuses on the child and adolescent to adult service split, which is further compounded by the need for a high frequency of psychiatry registrar rotation as part of their training requirements, there is a risk that this dualistic approach is brought into clinical practice in the new service, rather than a focus on youth-oriented care and treatment. This is likely to have a significant impact on engagement with young people and the appropriateness of pharmacological treatments for a first episode of psychosis. Within the service, this issue may be managed by the medical leadership team with the provision of evidence-based training, clinical guidelines and prescriptive algorithms that provide clear rationales and support best practice. The development of an early psychosis service incorporating a youth-friendly culture will also help to address this issue. External to the service, links with university departments of psychiatry to ensure that early intervention in psychosis and youth mental health are a core part of the curriculum are important. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) now has a special interest group on youth mental health which will be a useful environment for medical staff to contribute to as well as develop their own knowledge and expertise in early psychosis.

Recruitment of medical staff may also provide a challenge to new early psychosis services. This relates not only to the projected limited supply of medical staff (Fraser & Brooks, 2012) but also to employing medical staff who embrace the early psychosis and youth mental health paradigms and have an ability and interest in working with young people. Although solutions to this issue may lie at a government or federal agency level such as those recommended by Fraser and Brooks (2012), as mentioned previously, other solutions to this issue may be fostered by specialist academic training programs and special interest support from the RANZCP, which will both inspire and promote working in this particular field. An inspiring youth mental health leadership from consultant psychiatrists and clinical directors is critical and may be usefully combined with seeking young and enthusiastic senior registrars and recently graduated specialists. Promoting the prospect of employment in an environment which is ever-developing, optimistic and cutting edge, as well as providing the appropriate level of onsite training and support to assist in professional development, will assist to overcome this challenge.

Recruitment of medical staff also has an important influence on the subsequent quality of services provided to young people. Medical staff who are interested in young people and have the ability to engage and develop collaborative, therapeutic relationships with them are highly valuable, as this aspect of care is crucial to the success of other interventions. Young people need to have control of their own sense of agency and this may not be in line with traditional approaches in both child and adult psychiatry. These qualities may be developed through training at all levels, as well as being present as personal characteristics to look out for when recruiting.

Clinically, one of the challenges that may occur in medical interventions related to medication prescription is that of issues with the physical health of young people. For those prescribing medications, there may be a tension arising between the need to ameliorate the frank and distressing symptoms of psychosis and the potential for distressing side effects such as metabolic and sexual problems. These issues are particularly more salient in young people because of their developmental stage and the social impact of these issues on peer- and self-perception.

The International Physical Health in Youth Stream Working Group (2013) have developed a document that describes the challenges, goals and key principles of intervention to address the physical health issues of young people who experience a mental ill health. In addition to local clinical guidelines, these provide an excellent guide to overcome the problems associated with physical health in young people with a first episode of psychosis.

Following on from this point, medication prescription should also take into account the impact of potential side effect profiles on functional recovery also, something which may have traditionally been put as a second order issue in the past. Functional recovery has as much focus as the amelioration of psychotic symptoms, but may get lost in the desire to treat frank psychotic symptoms which are traditionally at the epicentre of medical treatments. As well as the subjective distress associated with side effects, ignoring factors that may impinge on social, educational and employment functioning also creates a risk (and challenge) of disengagement and non-adherence to medications that may well assist recovery. However, Wunderink (Wunderink et al., 2013) compared rates of recovery in patients with remitted FEP after 7 years of follow-up of a dose reduction/discontinuation versus maintenance treatment trial and found that dose reduction/discontinuation of antipsychotics during the early stages of remitted FEP shows superior long-term recovery rates compared with the rates achieved with maintenance treatment. While further study of this area is required, as McGorry and colleagues (McGorry et al. 2013) state, ‘this study demonstrates that with antipsychotic medication in the critical period of FEP less is more’. Skilled, knowledgeable (particularly in the area of possible prescribing options for FEP taking into account age, gender and cultural issues) and collaborative ways of working are essential to address this potential problem.

Prescribers of medication may also face a challenge with the need to sit with some uncertainty of diagnosis or stage of illness which may delay or alter the way medication is prescribed. There may be a sense of urgency to address psychotic symptoms, particularly using antipsychotic medication; however, this needs to be resisted and balanced. Young people at UHR of psychosis should not be prescribed antipsychotic medication (other than in certain limited circumstances) and there should be at least an initial 24 to 48 hour antipsychotic-free period with first episode presentations (Early Psychosis Writing Group, 2010); however, other medications such as a short-term course of benzodiazepines for distress or antidepressants for moderate to severe depression are often warranted.

Medical treatments are an essential component of the EPPIC model of care. The medical leadership involved in an early psychosis service is an essential systemic contributor to the optimal culture and policy and procedures which emphasise best practice. Evidence-based interventions are important to enhance recovery, although they do come with potential risks related to intolerable side effects that are more prominent in young people with a first episode of psychosis. Skilled and knowledgeable early psychosis clinicians, working from an evidence base, are required to provide medical treatments in an acceptable way that promotes and enhances recovery.

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1.3.9
Psychological Interventions

Summary

Psychological interventions are an integral part of an early psychosis service and an essential core component. These interventions are some of the most evidence-based, with cognitive behavioural therapy (CBT) leading the way and influencing the case management approach as a whole. Psychological interventions are not only fundamental to service delivery in the eyes of service planners and health professionals; they are expected to be so by young people who utilise early psychosis services.

Psychological Interventions Challenges and Enablers

Challenges are:

- Psychological interventions may be viewed as secondary and not part of the case management role
- Recruiting sufficient clinical staff experienced to deliver psychological interventions and to support less experienced staff
- Having a wide range of psychological interventions that are relevant to the phase or stage of the illness
- Access to training, education and key resources for safe and effective psychological practice
- Access to supervision from more experienced clinicians
- Access to adequate IT infrastructure for multimedia resources
- An appropriate referral system, including criteria, to the senior psychologist

Enablers are:

- All clinicians having a sound knowledge and understanding of the EPPIC model and rationale
- Recruitment of a senior psychologist into the service with skills in not only psychological interventions, particularly CBT, but to also oversee and assist with complex cases, supervision, mentoring and training of clinicians. All these factors must be included in the position description
- All clinicians recruited to have the clinical skills and knowledge that encompasses psychological interventions to engage and promote the recovery of young people
- Understanding and acceptance by case managers that psychological interventions are part of the role, with this being indicated in position descriptions
- An embedded early psychosis culture with an emphasis on psychological interventions and methods of delivery
- Support from skilled leadership
- Workforce development strategies

Introduction

In a meta-analysis and systemic review, Stafford et al. (2013) found that individual CBT, with or without family CBT, could be the most sensible first line treatment for people at high risk of psychosis due to its effect of reducing transition to psychosis and subthreshold positive symptoms of psychosis. Individual CBT is also warranted due to the high prevalence of anxiety and mood disorders in young people who meet the UHR criteria (van der Gaag et al., 2013), CBT being clinically guidelined for these disorders. The SoCRATES study (Study of Cognitive Reality Alignment Therapy in Early Schizophrenia; Haddock et al., 1999) compared CBT and supportive counselling with treatment as usual (TAU) for promoting recovery and relapse prevention. In the initial short term evaluation, results showed that CBT had a significant positive effect in reducing reported positive and negative psychotic symptoms compared to TAU alone and was superior to counselling in reducing positive symptoms. The benefits of CBT proved to be long-term (at 18 months) compared to TAU, although there were no effective differences compared to supportive counselling at this time point (Tarrier et al., 2004). The ACE project (Jackson et al., 2008) compared CBT with 'befriending' in people who were accepted within four weeks into a FEP service. Befriending describes an intervention which allowed social contact with a clinician, with conversation focused on general chat but prohibited any emotional support being given. The CBT intervention was given over a 14-week period and showed it outperformed befriending on measures of functioning but not symptomology, with no significant differences at 12 months; however, at mid-treatment the ACE group had significantly better functioning than those in the befriending group. Both these studies suggest the benefit of CBT interventions in bringing about recovery in the acute phase of psychosis.

A systematic review and meta-analysis of pharmacological and psychosocial interventions for relapse prevention (Alvarez-Jimenez et al., 2011) showed that the combination of CBT and family interventions produced significantly better outcomes than single interventions alone. An intervention combining CBT and family interventions (Gleeson et al., 2009) reported lower relapse rates and lengthened the time between relapse compared to a standard care control group. Three psychological interventions specifically developed for FEP with promising results are Cognitive Oriented Psychotherapy for First Episode Psychosis (COPE) (Henry et al., 2002), an intervention described by Jolley and colleagues (2003) that focused predominantly on the adjustment process, and the Graduated Recovery Intervention Program (GRIP) (Waldheter et al., 2008), which focused on the domains of symptom improvement, optimism and self-efficacy in relation to illness and functional recovery. In an uncontrolled trial (Erickson, 2010), evidence is presented of the effectiveness of CBT for ongoing positive psychotic symptoms in young people with a FEP who are treatment resistant. A systematic review of CBT in early psychosis services (Bird et al., 2010) concludes that CBT for early psychosis has longer term benefits in reducing symptom severity.

Psychological Interventions as a Core Component

Psychological interventions are an integral component of the EPPIC model and are likely to be utilised by all clinicians within the service to varying degrees. The interventions utilised are wide-ranging and include engagement, providing psychoeducation to young people and their families, stress management, strategies to support adaption to psychosis, coping with psychotic symptoms such as voices or paranoia, motivational interviewing, relapse prevention and addressing comorbid or secondary morbidity issues. The use of psychological interventions crosses all phases of illness and in the UHR stream, are the mainstay of intervention.

The main arena for these interventions will occur in the continuing case management part of the service. All case managers from a multidisciplinary background are expected to use psychological (predominantly CBT-informed) interventions as part of their usual case management role; however, when indicated, referrals can also be made to the clinical psychologists (or other suitably qualified health professionals) employed within the team for those young people with more complex case presentations or who require other particular skilled therapies.

> Psychological interventions are delivered based on a case formulation approach and aim to meet the needs and goals identified in collaboration with the young person and their family. However, the cornerstone of any effective psychological intervention is developing an empathic and understanding relationship.

Services are required to provide access to training, education and key resources (e.g., clinical manuals) for all clinicians utilising psychological interventions to ensure quality and safe practice. To support this, clinicians, particularly those from non-psychology backgrounds, also require access to clinical supervision from a more experienced and qualified supervisor. It is important for there be a senior psychologist employed within the service who oversees the delivery of support to clinicians related to psychological interventions.

For more information and detail related to the cognitive behavioural case management approach and more psychological interventions in early psychosis see:

Orygen Youth Health Research Centre (2010)

Gleeson and McGorry (2004).

Service managers also need to ensure that clinicians have access to computers to enable utilisation of a range of multimedia resources that support psychological interventions. These may include access to psychoeducational fact sheets and other multimedia materials, as well as online interventions and other digital material that complements face-to-face psychological intervention.

Challenges and Enablers

One of the challenges that may occur for services relates to preconceived ideas or attitudes to clinicians having a more primary therapeutic role and the pivotal role of psychological interventions. Psychological interventions are a prominent feature in the delivery of care to young people and their families, and have equity with other interventions, including traditional psychiatric or medical approaches, at all phases of illness. For example, in the acute phase, psychoeducation is a vital intervention that will assist in engagement, anxiety reduction and normalisation for the young person and their family, whereas traditionally pharmacotherapy would have been the dominant approach. Psychological interventions such as psychoeducation and psychological support are crucial while medical interventions take effect. Interventions such as these can be viewed as being secondary, or even lost, in lieu of medical treatments where psychiatry is the dominant paradigm and treatment approach of the service.

In the EPPIC model, the case manager's main role is to be the primary treating clinician for psychological interventions as well as the coordinator of interventions, and this may mean a change in style and focus of working. The key to addressing these issues relates to all staff working in the service developing a sound understanding of the EPPIC model and its rationale, as well as the knowledge and skills associated with the psychological interventions themselves. This understanding can be developed through identifying expectations within position descriptions, access to training, education and clinical resources, and other support mechanisms such as clinical supervision. Further, embedding an early psychosis culture that emphasises psychological interventions and the method of delivery described in the EPPIC model as being fundamental to the therapeutic approach is imperative.

This model of intervention requires a level of expertise and one of the challenges in maintaining fidelity to the model will be in ensuring there is an adequate level of clinical experience and expertise within the service to not only deliver these interventions, but also to support those clinicians who may be less experienced. Recruitment of staff with the relevant experience and skills in delivering psychological interventions to young people with a first episode of psychosis is essential. Training and clinical support are critical to enable those clinicians with lesser experience to provide quality, safe interventions.

Evidence-based psychological interventions are an essential component of an early psychosis service at both the UHR and FEP stages of illness and are delivered by all clinicians within the service. Their efficacy is clear and such interventions are seen as being more acceptable to young people, who expect them to be part of the suite of interventions offered. They influence the case management approach and as such sit at the heart of overall service delivery; however, challenges eventuate related to the provision of adequate support and training to less experienced clinicians. These challenges are surmountable if the full EPPIC model is adhered to, particularly related to workforce development, support from skilled leadership, and embedding the early psychosis culture within the service.

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1.3.10
Functional Recovery Program

Summary

Within the EPPIC service, functional recovery has a high level of importance and is a crucial component of the model. The service has a strong functional recovery focus, which influences the activities and function of a number of the other components. Activities within the functional recovery component aim to restore or maintain the normal functional trajectory of the young person from the employment, educational and social perspectives, recognising that these perspectives are interlinked. Educational recovery is linked to an improvement in the chances of employment. Educational and employment activities are likely to improve social recovery given that work and education are powerful normalising activities in themselves, educational or work environments are usually the source of social networking and friendship development and employment provides the financial means for social and leisure activities. Social recovery is also likely to enhance the chances of educational and vocational recovery as it will help overcome social barriers to study or work.

Functional Recovery Program Challenges and Enablers

Challenges are:

- Engagement and access issues for young people
- Cultural changes required when employing non-clinical staff
- Recruiting suitable vocational and educational consultants who are willing and keen to work in a youth mental health setting
- Clinical staff accepting non-clinical staff providing these specialist interventions
- Embedding a vocational consultant within the clinical program
- The use of psychotropic medications and the impact of potential side-effects on functional recovery

Enablers are:

- Functional recovery is part of the service ethos
- It is guided by the young person's goals and with a collaborative approach supported by the case managers and the medical staff
- Addressing any physical health needs that may be a barrier
- Employing a vocational consultant within the service to bring the specialist expertise and knowledge of employment services
- A vocational consultant to sit within the clinical program for ease of access from young people and case managers
- A designated education support consultant, and developing a partnership with state education departments
- Having a functional recovery coordinator
- The group program can also facilitate social recovery for young people
- Having flexibility within the hours of operation of the service with some after-hours work, particularly for the vocational consultant
- All staff to be given education regarding the respective roles of the non-clinical staff and the value of these positions
- A collaborative approach between the medical staff, case manager, the young person and their family
- Training and orientation of the non-clinical staff to early psychosis and youth mental health settings
- Program manuals and protocol development
- Utilising the experience of the multidisciplinary team, in particular occupational therapy knowledge and skills

Introduction

There is a high risk and incidence of functional decline associated not only with the onset of psychosis (Menezes et al., 2009; Karow et al., 2012)but also in the preceding at risk mental state phase of illness (Crumlish et al., 2009; Fowler et al., 2010). This occurs at a crucial stage of life when young people are embarking on their chosen educational and employment pathways as well as developing their own identity, social relationships and independence. A deviation from this normal trajectory can have a long-lasting impact on their future lives and everyday functioning. Alvarez-Jimenez et al. (2012) conducted a study that looked at the relationships between full functional recovery and symptom remission in FEP over 7.5 years and conclude that 'early functional and vocational recovery plays a pivotal role in preventing the development of chronic negative symptoms and disability'. In order to achieve all the aspects of functional and social recovery, there are key aspects of the service which need to be in place.

Functional Recovery as a Core Component

The focus of functional recovery should be a part of the Early Psychosis team ethos, be guided by the young person's individual goals and collaboratively supported by both case managers and the medical staff. The case management role is ideally placed to coordinate interventions that promote functional recovery. This role may involve individual interventions, such as developing social skills on a one-to-one basis, and/or providing pyschoeducation to schools or employers to maintain education or employment for the young person. It may also involve referring to other specialist services, such as external employment agencies, or to specialist vocational or educational consultancy embedded within the EPPIC service as part of the continuing care team, depending on the needs of the young person. For medical staff, consideration of the use of psychotropic medication and its impact on functional recovery is imperative, with a need to balance symptomatic recovery with the need of the young person to carry on with life's normal activities. Addressing any physical health issues that present as a barrier to functional recovery is important and may be done internally if possible, or externally by referring on for specialist medical advice or to the young person's GP. All of this is providing a holistic service to young people.

A vocational consultant who provides a specialist level of intervention to those young people who need it is employed within the EPPIC service and is an important resource to optimise vocational recovery. Utilising a vocational consultant employed within a mental health service is a relatively new concept. The evidence around this suggests that those young people with a first episode of psychosis have difficulty engaging with the usual sources of employment support such as government funded NGO employment services, or face stigma from employers (Killackey, 2010). Engagement and access problems may relate to a whole host of clinical factors including acuity of illness, cognitive difficulties associated with the onset of psychosis or the negative symptom profile. Traditional employment services who may take referrals from mental health services may not be trained or experienced in working with young people with a first episode of a psychotic disorder and may not understand the issues at hand, or be able to meet their needs. A vocational consultant working in the youth mental health system has a greater understanding of these issues and by virtue of working in the system reduces the layers of service referral that can impede engagement, particularly by young people. For further in-depth information on this see the *Working it Out: Vocational Recovery in First Episode Psychosis* manual.

The person recruited to this role should be from an employment consultancy background rather than being a health professional. This is important due to the fact that this specialist position requires an in-depth knowledge and experience of how to help young people get jobs as well as having a greater understanding of the employment and welfare benefit systems. The person will need to have the ability to work autonomously and the skills to develop good working relationships with internal and external stakeholders. They will also need access to the usual infrastructure, such as their own office and computer, so they can work on a one-to-one basis with young people onsite, and access to a car and mobile phone to provide more community-based support. They may also need to see young people after hours or have later in the day appointments.

The risk of falling away from the young person's expected educational pathways can have a lasting impact on not only their educational achievement, but also on their employment and social trajectory. Therefore, the EPPIC model requires that there be access to an educational support consultant who works as part of the functional recovery component. The main aims of this role are three-fold: to support young people in their usual educational environment (most often schools); to provide ongoing learning opportunities in an out-of-school setting, which provides a greater level and different kind of support and assistance; and to assist the young person find educational or vocational training direction when this is unclear to the young person.

Depending on their individual needs, many young people can remain at school with an extra level of support provided to both the student and school staff. With their knowledge of the educational system and school processes, as well as their knowledge of mental health issues, the educational support consultant is in an ideal position to act as the liaison between schools and the mental health service (in collaboration with the case manager) with a view to working towards the young person's educational goals. If the usual learning environment is no longer tenable, then the educational support consultant can provide individual teaching or other support to find a new educational pathway. For further in-depth information on this see the *School's In: A Focus on Education during First Episode Psychosis* manual.

The person recruited for this position should be from a teaching background, with extensive knowledge of the local educational system, and in particular special needs.

This is crucial due to the importance of this role in not only liaising with local schools regarding a young person's educational goals and plans but also for working one-on-one with those young people who need extra classroom support outside of their usual school environment. The person in this role requires an excellent knowledge of educational options available in the area. The resource modelling of this may vary from site to site, but is unlikely to be resourced from within the clinical program. Existing models utilise a partnership with local special needs schools with the onsite education staff being seen as being part of a campus of the school and funded via the state educational system. Services are advised to approach the State Education Department to develop a partnership agreement to enable this crucial aspect of functional recovery to materialise.

Although there is a key role for case managers to do some individualised therapeutic interventions with young people to promote social recovery, the EPPIC services group program will play an important role. Group programs have the unique capacity to re-enact group social interactions in a safe, supportive and therapeutic environment. Various group modules may not have social recovery as their primary goal but the setting in which they occur provides the necessary milieu to optimise social recovery. An example of this is a group such as a horticulture group, which is aimed at assisting a young person to develop some specific interest or vocational certificate that may be the primary motivator for the young person, but may offer the secondary gain of developing their social skills. For further information, see the component on group programs and the *All Together Now: Therapeutic Group Work for First Episode Psychosis* manual.

It is suggested that the coordination of the functional recovery component is managed by a functional recovery coordinator who has clinical and operational governance responsibilities for this aspect of the overall service. The vocational and educational consultants and group program staff would report to the functional recovery coordinator, as would the youth participation coordinator and the family peer support workers.

Challenges and Enablers for Functional Recovery

One of the main challenges that may occur in developing the functional recovery component of this model is that of the cultural changes that may be associated with employing specialist vocational and educational consultants. As employing non-clinical staff to provide a specific intervention is a step outside of the traditional approach, getting clinicians on board with this may prove to be a challenge. Educating staff in the experience of other services that have utilised this approach and the available evidence related to the associated positive outcomes will help to mitigate this, although normal change management strategies should be used to address potential barriers.

Another potential source of conflict may be in relation to psychotropic medications and the impact of potential side effect profiles on functional recovery. This balance between symptomatic recovery and a negative impact on functional recovery may be difficult to achieve, particularly in services where medication has been used as the dominant intervention, and this may cause therapeutic relationship and engagement problems as well as being a source of intra-team conflict. A collaborative approach between the young person, their family, the case manager and the treating doctor that is mindful of the young person's recovery goals is crucial in addressing this issue. Access to, and knowledge of the latest Australian clinical guidelines and evidence, as well as the EPPIC minimum standards, is also important.

As the specialist vocational and educational consultants are non-clinical staff, there will need to be a level of training and orientation to working in an early psychosis and youth mental health clinical setting. Specific issues related to clinical knowledge such as diagnoses, clinical presentations and the impact of medication on young people will need to be the usual orientation that a new employee requires when joining a new health service. Supervision from a senior clinician from the functional recovery program, access to relevant program manuals and ongoing training will be imperative.

The EPPIC model is explicit in identifying the requirement for there to be a functional recovery component as part of its overall service. The advent of a new service brings with it the opportunity to create a new culture, and the new EPPIC services with the appropriate level of support will be in a position to orientate or re-orientate clinical staff to functional recovery being one of its prime foci. Most services will not be a stranger to a recovery-focused approach. Having multidisciplinary teams with occupational therapy expertise in particular, as well as building on an existing collective knowledge and experience, will be useful strategies to further develop and embed functional recovery into the ethos of an EPPIC service and apply it to early psychosis interventions for young people.

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1.3.11
Intensive Mobile Outreach

Summary

Mobile outreach is associated with intensive case management for young people who have difficulties engaging with the service, have complex needs, including high risk issues (for example, violence, offending behaviours, homicidal and suicidal ideation, sexual abuse, homelessness, high self-harm) and who may have ongoing positive or negative symptoms or a prolonged recovery period.

Two models for intensive mobile outreach presented are:

i. An identified intensive mobile outreach team

ii. A model of intensive mobile outreach work provided by designated case managers in the continuing care team called EPPIC-I.

Whichever model is used, it needs to include intensive mobile outreach as part of the clinical program to provide a comprehensive early intervention service for young people. Early Psychosis centres will need to decide which model may suit them best. This is likely to depend on the geographic size, the population serviced, the number of cases and an estimate of the likely number of young people who may need intensive outreach. Based on the EPPIC clinical experience it is likely that up to 20% of young people will drop out of case management and will then need assertive intensive mobile outreach.

Intensive Mobile Outreach Challenges and Enablers

Challenges are:

- Provision of a proactive approach and philosophy
- Early identification of those young people who may need intensive mobile outreach
- The impact of the EPPIC size and geographic area
- A team-based approach requires sufficient staff
- Clear criteria for acceptance and discharge from intensive mobile outreach
- Some senior clinicians experienced in FEP and engaging with complex/risky young people
- A manageable capped caseload, allowing contact with the young person daily or at least three times per week
- Consultant psychiatrist and registrar cover is essential
- Throughput of the clinical cases
- Appropriate risk management, planning and expert consultation
- Infrastructure and resourcing for assertive home-based and community care

1.3.11
Intensive Mobile Outreach

Intensive Mobile Outreach Challenges and Enablers

Enablers are:

- A proactive approach to the young person, based on collaboration
- Infrastructure supports, such as vehicle access, mobile phones and so forth
- Clear criteria for referral and intensive case management provision via a process such as regular clinical review meetings. This should include a demonstration of strategies case managers have used prior to referral
- Clear documentation of criteria for acceptance and discharge or transfer, standards, referral forms, and all operational procedures
- Designated senior positions
- Access to a consultant psychiatrist experienced in intensive work and available to provide regular and frequent medical reviews and participate in any clinical review processes
- Designated capped caseloads
- Clear process for coverage of staff absences and crisis management
- After hours coverage by the EPACT team
- Processes for regular review, risk management and throughput of young people, including discharge criteria from intensive work
- Strong supervision, training and clinical support
- Process for identifying early, such as from three months, those young people who may need intensive mobile outreach

Description

Intensive mobile outreach provides an assertive approach to a young person regarding engagement and treatment, with the aim of keeping a young person engaged in the service and to still receive a comprehensive approach that deals with all facets of the young person's life.

While mobile outreach usually encompasses a community treatment approach where it is not just providing an assessment, crisis response or short-term treatment, such as may be provided by the EPACT team, it is seen as more **intensive** case management both in its nature and delivery.

Within adult psychiatry there have been models of intensive outreach mental health care, particularly for those adults with severe or chronic mental health disorders, that have been providing a service for some time. While there has been quite a reasonable amount of research and documentation of various models of mobile outreach in adult mental health services, there has been much less regarding youth mental health and community-based treatment models (Schley et al., 2011).

It appears that many of the studies conducted, particularly in adult mental health services, have been comparing community- or home–based treatment with inpatient care and the focus of assertive or mobile treatment teams has been to reduce the admission rate of adults with serious or chronic mental illness. As such, the emphasis at times has been on reducing symptoms, maintaining medication compliance and crisis response, with different models of care described. Within the UK models developed in adult mental health care included Assertive Community Treatment (ACT), Crisis Resolution Teams (CRT) and home treatment in order to provide different models of acute and intensive care and as a way to reduce inpatient care. Lamb (2009) systematically reviewed the evidence on alternatives to inpatient care for children and adolescents requiring intensive treatment for severe and complex mental health issues and concluded that 'intensive treatment models such as ACT and CRT improve patient satisfaction and hospital use in some circumstances...studies support the use of alternatives to inpatient admission for particular groups of young people and suggest a need for a combination of complementary models of specialist intensive provision. There is insufficient evidence on which to base decisions on which model is best...'

Within the EPPIC centre at Orygen Youth Health there have been two main types of intensive mobile outreach service delivery. Originally EPPIC established a team called Intensive Case Management (ICM), which was an outreach service for EPPIC young people aged between 15–24 years. This team was established after an internal review in 2002 found some gaps in the service provision for young people, where there was a subgroup found to be at risk due to suicide/homicide risk, comorbidities (substance dependence/personality disorder), persistent psychotic symptoms and poor engagement.

The ICM team provided assertive case management, covering assessment, treatment and support to young people and their families where the young person was experiencing FEP and was at high risk due to poor engagement, high acuity of risk to self and/or others and had suboptimal recovery. In more recent times EPPIC has continued with intensive mobile outreach; however, the model has changed to have designated case management staff to provide intensive mobile outreach as part of the case management role of the continuing care team.

Whichever model is used, it needs to include intensive mobile outreach as part of the clinical program to provide a comprehensive early intervention service for young people. Early Psychosis centres will need to decide which model may suit them best. This is likely to depend on the geographic size, the population they service, the number of cases and an estimate of the likely number of young people who may need intensive outreach. Based on the EPPIC clinical experience it is likely that up to 20% of young people will drop out of case management and will then need assertive intensive mobile outreach.

Prior to a referral from the continuing care team for intensive mobile outreach the case manager should demonstrate that the following strategies have been employed to re-engage or re-assess a young person where there has been no face-to-face contact with a young person in the first 12 weeks (unplanned) and that they have missed two or more appointments:

- Phone contact with the young person
- Offering home visit or meeting in a community setting
- Contact with the family to request assistance with seeing the young person
- A home visit, without notice, with at least two clinicians
- Send a letter to the young person requesting contact to arrange appointment to review treatment and offer a consultant psychiatrist review
- Consider referral to EPACT for after hours assessment (document rationale)
- Present the case at clinical review meeting

Rationale and Description of Models for Intensive Mobile Outreach

What is the rationale for an intensive mobile outreach team and how can it be of use for an EPPIC service as one of the core components? Is it necessary to be seen as an alternative to inpatient care?

As stated, the ICM team in the EPPIC program arose from the identification of a group of young people in the service who were not engaging or were not attending the service, yet still seemed to be very unwell. These young people also presented with significant risk issues and complex problems, with some having a background of complex needs or a history of poor functioning, drug use, forensic and family relationship difficulties. There was also a high caseload for case managers that did not allow the intensity of input that was required for recovery not only from psychotic symptoms but also in all areas of the young person's life. An assertive intensive mobile outreach team was able to assist in the engagement and management of these more disengaged and complex young people.

Engagement is seen as one of the crucial factors in working with young people, and the strength of the therapeutic alliance is a moderate-to-strong predictor of outcome.

Prior to ICM, within the EPPIC program the Treatment Resistant Early Assessment Team (TREAT) had already been established to assist in the early identification of young people experiencing persisting positive or negative symptoms after their first or a subsequent acute episode, and to facilitate assertive and systematic intervention. This team was a consultation group of senior EPPIC clinicians who came together to discuss and provide treatment recommendations to case managers who wished to present young people who were experiencing continuing positive and negative symptoms after their initial psychotic episode. The need for an assertive intensive mobile outreach team also arose from clinical presentations in this group, as well as the internal review of gaps in service provision.

One of the major aims of an intensive mobile outreach is for clinicians to be able to go out from the service and actively engage young people. Engagement is seen as one of the crucial factors in working with young people, and the strength of the therapeutic alliance is a moderate-to-strong predictor of outcome. The Australian Clinical Guidelines for Early Psychosis (Early Psychosis Writing Group, 2010) recommend that engagement should be prioritised as the foundation of treatment. If a young person cannot be engaged in the service then they will be lost to treatment, they can become even more unwell and run the risk of losing family and social supports, vocational or educational opportunities, an increased risk of heightened drug use, forensic issues and other comorbid problems. As Spencer and Birchwood (Spencer et al., 2001) stated: ‘In the face of the failure of clients with FEP to attend outpatient appointments or to take antipsychotic medication, the temptation to “wait and see” is considerable. However, this approach often ends in a crisis and preventative opportunities are lost.’ Young people may then be admitted to hospital under the Mental Health Act, which can lead to higher distress for all concerned and further erode any engagement prospects. It is really at the point of failure of a young person to attend outpatient appointments or not comply with treatment that assertive outreach needs to occur.

Intensive Mobile Outreach also allows clinicians to work with young people in the least restrictive manner, which again is a core principle of early psychosis work, as the young person can be seen at home, in a park, coffee shop or anywhere that is convenient for them, and allows for the clinician to have more time to provide a more intensive service that really engages and meet the needs of the young person.

Intensive treatment may result in fewer hospital admissions; however, this is not the major goal of the program although it can be an important benefit. The aim of intensive outreach is to engage a young person in the service, commence treatment and to be able to see if they can utilise the other EPPIC programs with the aim of minimising the chance of incomplete recovery and reducing risks to self and others.

Depending on the location and size of an EPPIC area, there are a range of intensive mobile outreach models that can be considered. The following are two possible models where the opportunities and challenges are considered when implementing:

An Identified Intensive Mobile Outreach Team

This consists of a distinct team or team program within the EPPIC clinical program. Staffing consists of the multidisciplinary team with consultant and registrar cover (Entry into ICM from EPPIC also occurred through the TREAT panel with the consultant psychiatrist or senior clinician in attendance). All staff must be available to provide a mobile outreach service in whatever setting is best for the young person.

There are criteria for acceptance into the program, such as a registered EPPIC young person, high risk (including suicidality and/or deliberate self-harm, risk of harm to others, drug and alcohol issues, criminal or offending behaviours, risk or vulnerability due to other causes), difficult to engage (continuing care team case manager has documented attempts offering a number of appointments, home visits or meeting at an alternative environment, phone or mail contact and secondary consultation with family or other services), and issues of psychosocial complexity (including multiple systems, frequent inpatient admissions, history of abuse and trauma, problems with occupational, leisure or self-care activities, social isolation and/or lack of social supports).

There is a formulation-based approach to the young person’s treatment plan, a smaller caseload of 8–10 young people for a full-time clinician and adequate infrastructure support for community-based work such as cars, phones, and so forth.

Once accepted into the intensive mobile outreach service the young person will have a comprehensive review every three months and case discussion within the weekly clinical review team meetings, with the view that all intensive mobile outreach staff are familiar with the young people being treated by the team and are able to respond appropriately to their needs in crises. A young person would need to be seen by the case manager at least 2–3 times per week, and to also have input from other parts of the program to include functional recovery aspects. However, if daily contact was needed then this should occur.

The young person can continue to be managed within the intensive mobile outreach service during their EPPIC tenure of care. The continuing care case manager does not usually remain involved in working with the young person when the intensive mobile outreach team accepts their entry; however, at times agreements can be reached, such as the case manager and specialist worker providing continued family work if this had been occurring and to help with maintaining relationships and continuity of care. There needs to be clear exit procedures and linkage back to the continuing care team case manager who will pick up the ongoing work with the young person once they have exited the intensive mobile outreach program and while they are still within the EPPIC tenure of care.

The intensive mobile outreach program will work business hours weekdays, with after hours coverage being provided by the EPACT team. There should be strong links with the other programs within the EPPIC, and young people should be encouraged to use these, as well as links with other community resources that may assist in meeting the needs of the young person, such as schools. There needs to be a clear philosophy and rationale for the service with good clinical supervision and team meetings.

Intensive work means not only direct work with the young person, but also includes looking at all areas of a young person's life, so may include family work, liaison and direct meetings with schools and work settings, assistance with accommodation, financial or legal issues, taking out a registrar or consultant psychiatrist for a medical review or helping a young person with catching public transport. Basically, 'intensive' can mean whatever assistance or therapeutic skills are required to engage a young person in the appropriate treatment plan based on their needs.

It is also worth considering with this model that prior to acceptance into the intensive mobile outreach team there is a 4–6 week period of comprehensive assessment with the young person to ensure there is a thorough understanding of the young person and their surrounding systems with an identified treatment plan and that they meet the entry criteria. During this period the case manager will remain involved and respond to crises or urgent issues. This provides opportunities for engagement plus an in-depth understanding and clarification with the young person and others what the goals of treatment are, and that there is a solid basis for the intensity of support required.

Intensive Mobile Outreach Work Provided by Designated Case Managers in the Continuing Care Team

In this model there is no separate mobile outreach team; rather, case managers in the continuing care team are designated as the intensive mobile staff to pick up young people who meet criteria of high risk, complex needs and not engaging with the service who are flagged as needing allocation via the continuing care team clinical review meeting. The resourcing and size of the service and catchment area would determine staffing levels. This model of mobile outreach may be best suited for an Early Psychosis centre servicing a smaller population with the aim of scaling up to become a separate team in the future.

If an EPPIC young person requires intensive mobile outreach the continuing care case manager and/or doctor will attend a meeting with the intensive clinician and/or doctor and complete an intensive mobile outreach referral form to check against the criteria and complete any measures required. At the next clinical review meeting a decision is made to transfer the young person fully to the intensive mobile outreach case manager or offer a model of shared care for a limited period.

Shared care should be contracted with the continuing care team in three month blocks with clear treatment goals, clear delineation of the roles and responsibilities of both the continuing care team and the intensive mobile outreach case managers and doctors, such as who responds to crisis management and what specifically the intensive worker would focus on.

The intensive mobile outreach case manager is responsible for feeding back the outcome of the referral after the clinical review meeting, communicating any expected wait time and managing the allocation of young people after consultation with the clinical review chairperson.

Intensive case managers can be designated as EPPIC-I staff who have a reduced caseload of perhaps five intensive cases requiring mobile outreach and another 3–5 cases requiring shared care with another case manager. A system would need to be established that allowed for 'weighting' of intensive cases so that clinicians have an equally comparative load.

As an adjunct to either of the above models there can also be a designated senior psychiatric nurse as part of the continuing care team who has a reduced caseload and capacity to do mobile outreach in a more limited form to young people who may not fit the criteria for such intensive work, but who may need some assistance with engagement, risk management or follow-up regarding medication or treatment compliance. This role is not part of the intensive mobile outreach service but may assist at times.

Opportunities and Challenges with these Models

Critical Factors, Philosophy and Reporting

Whichever model of intensive mobile outreach is chosen by an EPPIC the critical factors for success are still the governance, leadership, culture and resources. There also needs to be a shared understanding of the work and the philosophical basis behind it, along with common reporting and accountability lines. The approach for intensive mobile outreach treatment needs to be proactive rather than reactive and advocacy for young people can be an important part of the process.

EPPIC Size and Geographic Coverage

For a team-based approach to be effectively operational there needs to be sufficient staff. For instance, two clinicians are not sufficient for a team approach. There need to be three or four clinicians to be a team within an EPPIC service that has an area that is not too large in terms of geographic distance. A team-based approach can be difficult for mobile outreach if it covers an extensive and remote geographic area where staff cannot actually get together as a team or the EPPIC service does not have sufficient staff to comprise a team. An intensive clinician as part of a case management continuing care service is more appropriate in these situations.

Criteria for Acceptance and Discharge for Intensive Mobile Outreach

Either model requires clear definition of what is meant by intensive mobile outreach and clear criteria for referral. This is as defined above in the intensive mobile outreach team model. This needs to be closely monitored, as one of the challenges that can arise is dealing with case managers and organisational anxiety about risky psychotic young people. This needs to be contained in an organisation and it can be easy for case managers, due to their level of concerns and good intentions, to think mobile outreach is necessary for a broad spectrum of early psychosis young people. However, within the defined resources of an EPPIC, clear and strict criteria should clarify the role and expectations of an intensive mobile outreach to be servicing those young people who really do need enhanced intensive care. Team leaders can also play an active role in ongoing clarification and description of the role of intensive mobile work, which then assists all staff in understanding this. There needs to be clear documentation standards covering referral forms, decision-making forums and clear procedures for both entry and exit.

Staff Coverage, Caseload and Skill Level

Either model needs to have some senior staff that are experienced in managing psychotic young people with a range of difficulties and risk-driven behaviour. The caseload for any staff needs to be manageable in order to provide the intensity of service required and to develop therapeutic relationships. The caseload level needs to be adhered to. For this model, the expectation for a full-time case manager would be a reduced caseload with no more than five intensive mobile outreach young people. Depending on whether there is an option of shared care with another case manager there should still be a reduced caseload.

Medical coverage is crucial and not to be redeployed into other parts of the program. Of most benefit is having an experienced consultant psychiatrist who can understand the diagnostic issues, provide containment for the team and be clear regarding young peoples' treatment plans. Adequate medical coverage also provides good clinical governance.

Either model needs to be able to manage coverage for staff leave and other absences. This can be a problem for a small team, for instance if one staff member is on leave, then another is on sick leave, with a team of four this can leave only two staff left to cover and manage crises or other situations arising. However, the advantage of the clinicians on the team knowing the young person and/or their particular situation can assist in managing these issues. This can also be addressed by all clinicians on the team being introduced to the young person upon initial entry.

The case management intensive model can more easily address these issues when there is shared care, a duty worker system or the previous case manager can cover at these times of staff leave or vacancy. Arrangements may need to be agreed to with the EPACT team for after hours community work or crisis response.

An EPPIC-I can be a real advantage for peer learning for all case managers in the continuing care teams as they gain greater understanding of the nature of intensive mobile outreach and the skills required. Opportunities for joint work and shared care can also enhance clinical learning.

Throughput

As community awareness increases, referrals may increase and there can be an ongoing issue of 'throughput' of young people, with particular programs such as mobile outreach experiencing difficulties being available to young people as caseloads are full.

This is particularly the case with a designated mobile outreach team approach, and barriers to entry can start to appear. Ongoing relationship-building with the continuing care team can be one way to address this, as well as there being clear processes within the team for reviewing and throughput of young people. One of the ultimate longer term aims with engagement is to get the young person to attend the service on an outpatient basis and to not need such intensive input. Regularly reviewing the goals of the treatment plan enables the team to remain mindful of whether the need for intensive input is required.

A mobile outreach service such as an EPPIC-I tends to have fewer barriers to entry and exit, as the issues are more easily resolved by the continuing care team clinical review process that all clinicians attend. The flowthrough of young people can be greater as far fewer transfer issues tend to arise. However, there has to be a consistent emphasis on, and built into, the clinical review process that ensures the focus on these cases within the larger case management team so that the intensity of the service provision is understood and not lost.

A factor to consider with throughput is the need for young people to be referred early for intensive mobile outreach work, not for instance at the 18-month period of care. This does not mean that referrals should occur at the point of entry into the service; however, from three months after entry into an EPPIC there can be a reasonably clear picture of whether engagement is occurring, whether prolonged recovery may be an issue and whether heightened risk and complexity are present.

It is also highly likely that a small group of young people will require intensive mobile outreach for their entire EPPIC tenure of care; however, this needs careful review and consideration as to the nature of this care.

Clinician Functioning and Risk Management

As the word ‘intensive’ suggests, and given the nature of the needs of the young people requiring intensive work, the clinical work can be quite demanding and stressful, particularly for new or inexperienced staff. This can then impact on the functioning of either model of mobile outreach. Whatever model is used, it will require excellent supervision, consultation and staff support, along with strong leadership, for clinicians to function well. Having some designated senior positions assists with providing best practice and day-to-day management of the workload.

Within a designated intensive mobile outreach approach, a clearly defined team allows for formal group supervision and ad hoc discussion between staff around clinical issues and drawing on the experience of fellow clinicians. A process for expert consultation can be provided, which will allow for reflective practice and promote team building. Discussions regarding evidence-based practices in the area of youth mental health can also help the team with having a shared understanding of the presenting issues of young people who need intensive mobile outreach and promote the development of the theoretical practice so that responses and interventions are effective current and consistent.

Within the case management model there is also a strong need for supervision and for the designated intensive clinicians to have a forum apart from the clinical review process where they can meet together to discuss their practices and the issues arising. Case consultation or presentations is one way to achieve this. EPPIC services need to be flexible and adaptive as to how to arrange the necessary supervision and support to intensive mobile outreach staff and to acknowledge their unique needs at times.

Managing high risk young people can also be very challenging for the clinicians and the organisation. Everyone needs to feel safe for any interventions to occur and to be successful. Whichever model is used, there needs to be a clear articulation of the criteria for intensive work, the expectations, plus clearly defined risk and safety management plans that are agreed to in collaboration with the young person, at the commencement of entry into the intensive mobile outreach team. These must be strictly adhered to. Where possible, and based on need, two clinical staff may attend home or community visits, while safety and risk issues are assessed and engagement occurs. Consultant psychiatrist input is also essential.

The team-based approach can provide an improved way of managing risk for suicidal and homicidal young people and it can be easier for the team to support each other and provide back-up when needed. It may also provide higher levels of oversight and interventions where clinical governance can be more easily managed.

Inpatient Care

One of the benefits of intensive mobile outreach can be reduced inpatient admission rates, or in some instances, no admissions occurring. Intensive mobile outreach is not necessarily an alternative to inpatient care, but it can be useful in managing young people in a less restricted environment with greater community treatment, and if inpatient care is seen as required these can often occur as a planned admission for a shorter duration and with a greater chance of maintaining engagement.

Whatever model of mobile outreach chosen there will be both opportunities and challenges where an EPPIC service needs to consider would best suit the organisation and meet the needs of young people. Intensive mobile outreach gives greater capacity to fully engage and assist those identified young people who may not have received a service and to still provide early intervention and improved recovery for early psychosis.

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1.3.12
Group Programs

Summary

Group interventions are a developmentally appropriate treatment option for young people with serious mental illness and can be used in conjunction with individual treatments. Group programs can reduce isolation and instil hope, lower the levels of clinical depression and improve self-concept and social functioning. They can prevent deterioration and the development of disability after the onset of illness and help to restore a young person's normal developmental trajectory. Group work varies widely, both in the setting in which it is practised and the type of approach used. A group program within an EPPIC will aid in achieving a comprehensive approach to the treatment and recovery of young people with early psychosis or FEP.

Group programs can be divided into streams:

- Social and recreational
- Vocational and educational
- Psychoeducational and personal development
- Creative and expressive

Group Programs Challenges and Enablers

Challenges are:

- Making groups relevant to a young person
- A major task is focusing on engagement and attendance, which requires skilled clinical staff to achieve
- Time is required for the planning and writing of modules, the individual work, the actual running of the groups, and for travelling and coordinating groups held in the community
- There can be a time delay between the referral and the young person's attendance at a group. This needs to be managed well with a focus on continued engagement so that they will attend the group and find it a positive experience
- The case manager's reasons for referral may not match the young person's reasons for attendance, so this may need to be worked on between the young person, case manager and key worker when setting goals. However, not all the reasons need to match
- Financial: some groups can be very cost effective and others more costly. An EPPIC service may need to seek philanthropic funding and run the more expensive groups, such as outdoor adventure, on a once a year basis
- To maintain attendance of young people at groups there needs to be activity-based groups combined with a social focus and a very flexible, adaptable approach to young people
- Partnerships need to be made with other services that are on the same 'page' and have the same philosophy for working with young people, such as a positive strengths-based approach, to run inter-agency groups. This can also provide improved access for young people
- Keeping young people safe. Setting the scene for this with youth-friendly rules and explanations regarding expectations within the group, and individually, is necessary at the commencement of a young person's attendance at groups.
- Flexibility regarding age ranges and having suitable groups

1.3.12 Group Programs

Group Programs Challenges and Enablers

Enablers are:

- Offering a broad range of groups with a strong focus on social, occupational and vocational functioning
- Focus on empowerment and a strengths-based approach with the young person and having collaboratively defined goals
- The format of group program is organised into streams that match the young people's goals
- Flexibility so the program can be modified to meet a young person's needs and also to be run both in the EPPIC centre and in the community
- Continuous evaluation of whether the group's aims and goals are being achieved, with flexibility to change as needed
- Group sizes of between 6 and 8 young people
- Group program clinicians sit within the EPPIC clinical program and fulfil both case management and group program roles
- A youth-friendly and positive culture
- Two staff assigned to each group
- No referral is rejected
- All young people have a key worker with a clear role description
- Planning and module development is well documented
- Training, supervision and role modelling by experienced staff
- Partnerships with other organisations to run joint groups in the community
- Allocation of a key worker to undertake both individual and group work with the young person
- Excellent liaison between the key worker, the case manager and the young person

History and Description

The onset of a serious mental illness mainly occurs during adolescence and young adulthood, and results in low self-esteem and reduced social and occupational functioning. Achievement of developmental tasks, such as identity formation, individuation from family and transition to work or tertiary education may also be interrupted.

During the establishment of the EPPIC program in Melbourne in the early 1990s the group program had a different focus and culture to the traditional day programs of the rehabilitation services and to adolescent programs that were often only a part of inpatient care. It was argued at that time that young people recovering from a first episode of psychosis wanted the same social experiences as other young people. They wanted friendships and support and to participate in age-appropriate activities and roles. At EPPIC it was seen that participating in a recovery group program offered young people these opportunities, as well as a transition phase of going back to school or work.

In one of the evaluations of the EPPIC group psychosocial programs in 1998 that compared a group of young people with FEP who had attended the group program with those who had not, it was found that the young people who had attended the program had a lower level of premorbid adjustment and showed a trend towards higher levels of negative symptoms at admission. However, there were no significant differences between the groups at the 6-month period. It was argued that involvement in the group program may have had a positive impact on this vulnerable EPPIC subgroup by preventing deterioration and the development of disabilities in the critical period following a FEP (Woodhead, 1999). EPPIC further argued that young people recovering from a FEP represent a population with specific needs. It was seen that therapeutic group programs with an emphasis on utilising peer support, encouraging social confidence and reinforcing desirable social skills were ideal treatments to assist with psychosocial recovery. As well, group interventions offered opportunities to address individual goals and needs, as well as mastering developmental tasks. Groups were able to provide psychoeducation through peer sharing, and group work helped young people to develop and foster their independence in many life skills such as in education, vocation and independent living skills.

A further quality assurance project of the group program conducted at EPPIC in 2004 (Cotton et al., 2011) found that 70% of respondents said that while opportunities to participate in fun and interesting activities gave the initial impetus for attending, the development of relationships with other young people going through similar issues maintained their involvement. EPPIC also considered what young people wanted in groups and reviewed self-referral forms over an extended period. It was found that the large majority of young people were identifying goals related to social relationships and the development of self confidence. Half of the young people nominated a vocational or educational goal and the same number identified a desire to increase their independence and develop new skills. Approximately one third wanted information on physical health, level of motivation and also wanted structure and routine in their lives. Young people wished to learn new skills, develop new interests and find ways to express their feelings. Music, art and creative writing were the most common activities requested.

The EPPIC recovery group program also audited those attending and found that the young people attending were predominantly poorly educated, unemployed males, with poor social and occupational functioning and that a significant proportion of them were substance users. A group program with a strong focus on improving social, occupational and vocational functioning was strongly indicated.

The EPPIC Recovery Group Program

The group program provides a range of groups (at least 12 per week, and up to 16 per week) designed to meet young people's goals and interests. The group program aims at empowering these recovering young people while focusing on their strengths and collaboratively defined goals. As these are young people, opportunities to complete developmental tasks are given priority. Treatment plans are developed collaboratively with individual young people to ensure that the selection of groups is meaningful and that they felt empowered by the experience. The group programme format is organised into streams, described below, that matched the goals identified by the young people.

Social and Recreational

The social and recreational stream is in keeping with the high proportion of goals related to social and communication issues. This stream includes the drop-in group, outings, outdoor adventure and sports groups. The groups in this stream encourage and provide opportunities for peer support, to increase confidence, share experiences, develop interests and assist with accessing community interests. Activities are fun and age-appropriate. Social skills are modelled, encouraged, positively reinforced and emphasis is placed on increasing the young person's knowledge of psychosis through informal psychoeducational discussions.

Vocational and Educational

The vocational and educational stream offers interested young people an age-appropriate vocational and educational pathway and is facilitated collaboratively between group program workers and teachers trained in special education from the local Travancore School, a local government special school catering for the needs of young people in the mental health service. Activities in these groups are carefully graded and specifically tailored to meet the individual participant's needs. The groups are designed to help young people return to school, further their education, choose a career pathway, develop work skills and find a job. Examples of these groups are the horticulture and catering groups. These groups are now linked to local educational facilities and allow participants to enrol in a course and complete modules of accredited educational certificates. An addition has also been the Victorian Certificate of Applied Learning, a senior secondary education certificate that has a focus on applied learning and is widely used in the education sector in Victoria. It also offers a pathway to further vocational training or employment. An example of a group is 'Work IT Out', which explores work and training options so that young people can develop resumes and practice job interview and work skills.

The issues in this group were seen as so important to young people that for the past eight years EPPIC has employed a vocational worker, discussed separately under the functional recovery core component.

Psychoeducation and Personal Development

The psychoeducation and personal development stream is in keeping with the overall objectives of the EPPIC service. This stream complements the work offered by outpatient case managers. Groups included 'Get in the Know', which offers psychoeducation for psychosis, 'CHILL', a combination of stress management, relaxation techniques and CBT for managing anxiety symptoms, 'Straight Up', for communication skills and assertiveness training, 'Pound Dog', a relaxation, CBT and graduated exposure utilising dog walking to assist with social anxiety. The emphasis in these groups is on peer learning and sharing, as experience had shown that discussion-type groups have greater attendance than activity-based groups.

Creative and Expressive

The creative and expressive stream provides group members with opportunities to learn new skills and to have outlets for expression other than by verbalising. Young people are encouraged to redevelop interests that they may have had before they became unwell and the groups offered include music, art and creative writing.

Current Group Program and Key Areas of Work

The EPPIC group program still offers these streams and runs up to 16 groups per week. Over time the group program has found that the streams that are the most popular and valued by young people are the social, vocational/functional, personal, and creative (art and music). All these streams cover psychoeducational elements and the coordinator ensures that the groups and programs consistently cover these streams. However, a program can be modified for a young person to suit their needs.

Current groups offered include O-Zone, Music Jam, School's In, Catering, Choir, Horticulture, Finding Your Feet, Freestyle, Drop-In Room, Mind Muscles, iVenture, Gym, Safe and an Introduction to the Group Program.

The ideal group sizes are between 6–8 young people, with no fewer than four young people. There needs to be reasonable attendance to build the group around. Groups are held both on and offsite, and some are run in partnership with other agencies such as MIND and **headspace**. Having groups running offsite and as part of the community setting is encouraged, as this allows for easy attendance by young people and can be less stigmatising. **headspace** is already very active in this way and can further develop their expertise for FEP young people in group programs.

The key themes in all the group programs are to cater to the developmental stages of young people. There is a collaborative approach to goal-setting with the young person. The language and the experience must be youth-friendly, so often goals are spoken about in a variety of ways. The approach is to work on building on a young person's strengths rather than a focus on what are the problems, illness or deficits. It is about the growth of the young person. It is also necessary to be mindful of the phase of illness and recovery stage. What is an appropriate group for a young person in the acute phase can be quite different to what they may need as their recovery progresses. Flexibility and adaptability is required in any group program. A variety of modules are offered to engage young people via a strong activity base which helps get them 'through the door'.

Referrals

Referrals are made by the outpatient case manager on a referral form; however, if a case manager talks to a group program staff member in passing the referral will be followed up. No referral is ever rejected, and which group might suit the young person and which ones they would like to attend is actively worked out with them.

Every opportunity is used in the groups to focus on social skills, positive reinforcement, psychoeducation and building up the confidence of a young person. Role modelling occurs and thought is given to the 'framing' and voicing of comments to a young person. Language is used that is youth-friendly and appropriate to the setting. The focus for groups is also on hope, optimism and recovery. Clinicians become skilled at engaging and adapting how a group will assist a young person. For instance, in the catering group there may be two different young people that have been referred by their case manager. One may not be interested to come initially; however, the worker can reframe the group to still be helpful for them. As the young person is wanting to get work, then the catering group can give them experience in having a 'boss' and this can be added to their resume; which they would also have assistance in preparing. The other young person is interested to attend; however, is worried about others in the group.
It is framed for them that the group could focus on gradually building up friendships, so while being able to work as a team member they could, if they felt more comfortable, just focus on tasks at hand, such as cutting up fruit. After individual discussions with both young people about their concerns and their goals, then both could attend the same group despite their very different goals.

The ages of participants tend to be defined by the type of group provided. For instance, young people in an age range of 15–25 years do not usually mix socially, so it can be best to have groups for the age ranges of 15–18 years and then 18–25 years. However, some groups, such as catering, can meet the full age range.

Two staff members are usually involved in running a group. Staffing levels need to allow for this, as well as including a coordinator role. Staff can be multidisciplinary, and often include occupational therapists and social workers. Group program clinicians sit in the EPPIC clinical team and work in both group program and case management roles.

This assists in mutual understanding of programs, aids in promoting the group program and offers avenues for discussion with the clinical team on issues and ideas, as well as engagement with young people. Staff must receive regular individual supervision, as well as monthly peer supervision.

Key Worker

At referral all young people are provided with a key worker clinician from the group program who facilitates the collaborative work. Extensive work is provided on an individual basis as well as in the actual running of groups. The key worker liaises with the case manager, school or employer and provides any needed one-on-one activity with the young person to help bridge the group sessions. They will make reminder phone calls, any travel training and conduct an overall needs analysis. Key workers must be very skilled clinicians, flexible and able to work from the CBT case management principles while creating a safe environment for young people to attend the group program. They need to develop and build on the relationship with the young person and be able to understand their needs. They also need to be aware of signs of relapse and be able to manage this in the group setting, and individually, if this starts to occur.

Planning

Planning is crucial in developing group programs and modules are developed that cover aspects including:

- The title of the group
- Statement of philosophy
- Aims and specific objectives
- Description of content and format
- Time and length of sessions
- Venue
- Referral process
- Specific selection criteria
- Staffing, staff time per week and names of group leaders
- Materials and equipment
- Evaluation and evaluation tools to be used
- Publicity for the group and the dates it will run

Evaluation and Needs Assessment

Evaluation processes are built into the group program covering the individual and groups. Individual goals and attendance at groups is also evaluated with the young person every three months. It is also important to undertake a needs assessment so that relevant groups are established and there is flexibility to change the nature of the groups offered based on these assessments.

The factors needed for a successful group program

- Services who are already adept at running a range of groups within the community may be used, and will be able to draw on and develop this expertise for FEP work
- To meet the developmental needs of young people at a crucial time in their life within a first episode of psychosis
- Conduct regular needs assessments to determine the type of groups, with evaluation to be ongoing
- Aim to improve the overall functioning of the young person within a strengths-based focus during this critical time
- Focus on what is relevant for young people, such as social relationships with peers, vocational and educational aspects, and be activity-based. Allow for a wide range of groups, and for groups to be provided in the community
- Allows the engagement and assessment of those at risk of dropping out and then addressing this with the young person
- Allows the young person can practice social and coping strategies learned in individual sessions
- Offers an efficient method for providing information to many young people
- Helps address social exclusion
- There is flexibility to change and establish new groups based on need
- Psychoeducation can be provided in an informal manner
- Provides an environment that allows a young person to cope with the effects of psychosis and gain peer support
- Provides for a diversity of groups and allows for partnerships with other services and groups run in different environments
- Costs can be low depending on group activity; e.g., table tennis is cost effective
- Complements the work of case managers and the overall EPPIC model of care, which aims to get young people back to their school, work or career trajectory.

A group program can be a support to young people (and their families) by providing a developmentally appropriate focus and a positive experience for recovery by promoting hope and optimism so they do not feel alone, burdened and stigmatised.

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1.3.13
Family Programs and Family Peer Support

Summary

The onset of early psychosis often occurs in late adolescence and early adulthood. This is often a time of change for young people as they work through the different developmental stages of life. Young people are usually still living in families or having close contact with them, and friends and peers are an important part of the young person's social network. It therefore makes sense that when a young person develops early psychosis this will impact not only them, but on those who are close to them, and that consideration must be given to not only the impact of psychosis on families, but also to collaborating with them in a supportive treatment process. Families are often the key scaffolding for a young person's recovery and for returning to the normal developmental trajectory, so there must be full support and assistance for them.

Family work approach and model:

- Is based on a set of principles (see description) and consists of a flexible phase-based approach with a spectrum of supports model (see pyramid in description)
- The philosophy of family work is that families are seen as doing their best given the current resources and challenges they have to face, with a no-blame view

Note: The term 'family' in this document refers to all family members, relatives, friends, or any significant others to the young person.

Family Programs and Family Peer Support Challengers and Enablers

Challenges are:

- The theoretical approach is eclectic, drawing on a range of models such as crisis theory, coping strategy enhancement, supportive therapy, systemic, narrative, solution-focused and CBT approaches
- The overarching approach is one of flexibility, engagement and collaboration with not only the young person, but with their family, with the aim of working towards recovery
- Hope and optimism are imparted to families, and the impact of having a young person with early psychosis in the family is considered for each family member
- Engaging and collaborating with families is an ongoing process
- Having a specialist family worker role but promoting that all case managers need to regularly see families and provide family work
- Clinicians understanding the needs of families, being able to ‘hear their story’, use a phase-based approach and able to provide psychoeducation and debrief as necessary
- Clinicians understanding the role and referral processes of the family peer support workers and utilising them
- Family peer support workers require ongoing support and a designated coordinator
- Clinicians understanding when families may need more support or more specialist family work for specific interventions
- Establishing and continually providing psychoeducational forums, such as ‘Family and Friends’ information sessions
- Regular review of families as part of the clinical review meetings
- Establishing criteria and a system of referral to the specialist family worker
- Keeping the specialist family worker as part of the clinical team, but ensuring that they do not become a part-time case manager
- Time for the specialist family worker to be available to oversee the program, provide support, consultation, training and education
- For family work culture to be embedded in the service
- Developing up-to-date family resources

1.3.13
Family Programs and Family Peer Support

Family Programs and Family Peer Support Challengers and Enablers

Challenges *continued* are:

- Confidentiality issues
- Clinicians managing the stress and distress of families for each of the individual family members
- Family peer support workers being able to contact families early in the service provision and in settings, such as an inpatient unit

Enablers are:

- A particular family work model of collaboration, a phase-based approach focused on under-standing, rapport building and looking at the families' explanatory model with a 'no blame' attitude
- Proactive and supportive leadership and governance that helps develop and embed the culture of family involvement and the work required
- Sufficient specialist and senior family work staff
- Embed the specialist family worker in the continuing care program where they can also be utilised across the whole service
- Employ family peer support staff who have had the 'lived experience' of a young person within the EPPIC service and promote their role with position descriptions
- Family work is promoted as part of every clinician's role and provision of training and education on the model and interventions
- The full 'menu' of family work services is provided, such as psychoeducational forums with appropriate resource materials

Family Programs and Family Peer Support Challengers and Enablers

Enablers *continued* are:

- The role of the family work specialists is clear and includes promotion, consultation, training; as well as shared work, overseeing of the model and establishing psychoeducational forums and family work interest groups
- For the specialist family worker not to become a case manager
- Supervision and support to family peer support workers via a designated coordinator (can be the group program coordinator)
- A system of flagging new families so that referral to peer support workers can occur early
- Built in process for family review as part of the regular clinical review meetings
- As part of any service level agreements, for instance with an inpatient unit, that family work occurs and clinicians and family peer support workers can be involved early
- Promoting that all clinicians have an empathic and understanding approach with families and work with the family explanatory model
- Family work to commence as soon as possible, to be part of the culture and interaction of triage and the EPACT team
- To ‘set the scene early’ and give a clear rationale about information sharing to address any confidentiality issues

Family work must be given status and importance in EPPIC service provision.

Description

The onset of early psychosis and FEP can be a very distressing time, not only for the young person, but for the family as a whole. There can be a range of difficult feelings for all concerned and particularly in the initial stages of an acute episode there can be much distress and trauma for all concerned.

Family work is an integral part of the clinical approach to assist in the recovery of a young person during a psychotic episode. Since the commencement of the EPPIC outpatient programme at Orygen Youth Health in Melbourne, family work has been an essential component of the clinical service.

Family work also incorporates an introductory group-based psychoeducational programme for families, specialist family work and a family peer support programme. As Crisp and Gleeson (2009) have stated, the principles of family work in the EPPIC programme cover:

- Family work needs to be developed within a collaborative framework
- Family work should empower the family to cope and adjust to the crisis of the psychotic illness
- The overall goals of intervention are to minimise the disruption to the life of the family and to maximise the adaptive functioning of the family after the acute episode
- The specific needs of the family should be acknowledged because the family environment may impact on the young person's experience and recovery but also because the family needs support through a distressing period
- The approach to pre-existing problems within the family should be guided by general crisis intervention principles

A flexible phase- or staged-based approach is taken and the philosophy of family work is that families are seen as doing their best given the current resources and challenges they have to face, with a no blame view. The theoretical approach is eclectic, drawing on a range of models such as crisis theory, coping strategy enhancement, supportive therapy, systemic, narrative, solution focused and CBT approaches. The overarching approach is one of flexibility, engagement and collaboration with not only the young person, but with their family, with the aim of working towards recovery. Hope and optimism are imparted to families and the impact of having a young person with early psychosis in the family is considered for each family member.

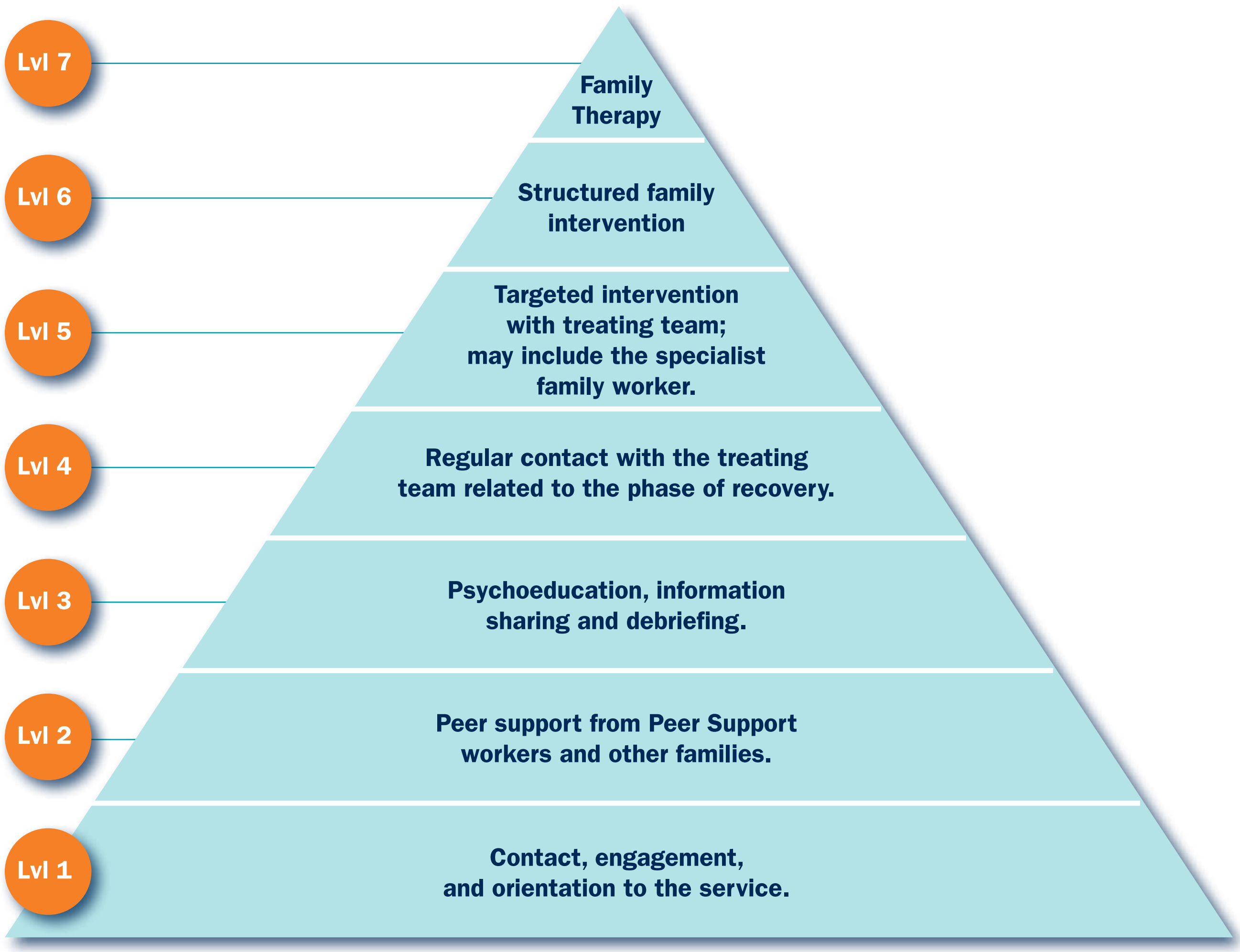
Family work is to be provided by all clinicians within the service, ranging from at the acute phase of the psychotic episode to also being an integral function of the case management role. Specialist family workers are employed as senior staff to oversee the family work model, to help in the direct treatment approach with families, particularly with more complex cases; to provide consultation and training for clinicians and to maintain the family work service-wide approach for a collaborative and phase-based approach with families.

As with young people, a no blame approach is taken with families and that is why the term 'family work' is used. Families can be sensitive to the term family therapy and feel they are being targeted as having many family problems requiring therapy, rather than it being viewed that usually their reactions are very understandable in the context of what is happening to the young person. Families are often in crisis in the initial stages, and each member will have a range of many different feelings, such as shock, loss and grief.

The role of the case manager and doctor is to engage with, and maintain regular contact with families, to provide psychoeducation and facilitate access to the group 'family and friends' psychoeducation sessions and family peer support workers. As well, all clinicians have a flexible and collaborative approach in their work to accommodate the needs of the individual families, depending on the specific phase of the episode.

Families' needs are influenced by factors such as their pre-existing coping skills, the urgency of their issues and the pace of the young person's recovery. Debriefing can be an essential task, including hearing the family story of what has been occurring, plus understanding the family theory as to what they believe may have led to the episode.

It is widely recognised within the clinical service that not only does early psychosis impact on the young person, but it also impacts on the whole family and there needs to be time given to families to hear and respond to them. This can be done through engagement within the psychoeducational framework. The following figure demonstrates the spectrum of support that an EPPIC service needs to have available for the young person and their family:



Family Therapy

Structured family intervention

Targeted intervention with treating team; may include the specialist family worker.

Regular contact with the treating team related to the phase of recovery.

Psychoeducation, information sharing and debriefing.

Peer support from Peer Support workers and other families.

Contact, engagement, and orientation to the service.

Engagement and Psychoeducation

Engagement with not only the young person, but also with families, is a crucial aspect of work by all clinicians and its importance cannot be underestimated. The aim of engagement with families is to establish a trusting working relationship, to acknowledge the impact of psychosis on the family, to acknowledge the part the family may play in the recovery process, to establish a collaborative partnership with the treating team, to optimise the flow of information and to reach agreement as to how to manage further contact. Engagement is also an ongoing process, not ceasing after the first few contacts.

Often initial meetings with families involve the acute care part of the EPPIC clinical service, such as the EPACT team or the inpatient unit staff. For some families the pathway for referral and treatment into the EPPIC service may not have been a straightforward process and usually involves a range of heightened concerns and distress. Providing appropriate practical information at this stage on the nature of the service, contact numbers and psychoeducation regarding psychosis is important. Of equal importance is the sharing of information and early meetings, which are often debriefing sessions where family members' experiences can be discussed, along with their explanatory model of why they believe the psychosis has occurred.

Further family assessment and debriefing will occur during the treatment process with the case manager and doctor. Assessment can give some increased understanding of the effect early psychosis has on the young person and the family, the families' coping resources, their usual pattern of communication and problem-solving, and their level of support. Psychoeducation is also an ongoing process, as during times of heightened stress it is difficult for families to retain all the information.

Peer Support Workers

Family peer support workers are employed to provide basic information and support to families. It is well understood that families who can talk to another family or parent who have gone through the experience of having a young person with FEP find that this can help in explaining the nature of the service, but more importantly, they can really relate to the emotional experiences that occur. Therefore, family peer support workers are employed in the organisation to offer another form of support to families in addition to that provided by the treating team.

There needs to be a system in place to flag families who are new to the service and to alert the treating clinicians involved to see if the family would like to have contact with a family peer support worker. Once consent has been obtained from the family, the family peer support worker will telephone to speak directly to them. If at any stage the family state that they do not want any further contact then this is respected. If agreed in a service level agreement, the family peer support workers can also attend the inpatient unit on a regular basis to assist families in that setting, as often this is a very stressful time for all concerned. Case managers must be familiar with the process for family peer support, and it is an expectation that they will discuss with families whether they would like contact from a family peer support worker. The ideal, and what is most effective to have, are family peer support workers who have experienced having a family member who has been through the service directly themselves. This gives more credence to their experiences and first-hand understanding of the service, which other families can relate to.

Family peer support workers need a designated coordinator and to have initial training and regular supervision and support.

The Treating Team and the Specialist Family Worker

It is understood and promoted within the service that family work is everyone's business and that a collaborative relationship with not only the young person, but also the family, is required. Clinicians need to understand when a family may need more support and to be mindful of the phase or stage of the illness for the young person, and how this will also impact on the family. They also need to be able to work with the young person and family on early warning signs of relapse and specific management strategies for this. Families themselves can often go through phases or stages as the young person becomes unwell and then commences recovery. As for the young person, the acute care phase can also be a very acute and worrying time for the family, who also need special care, understanding and support themselves.

As described, there is a menu of services for families covering the individual meetings with the treating team, psychoeducational forums, the family peer support workers and the specialist family worker. In the individual work with families, clinicians such as the case manager need to know when to highlight those families that may need more targeted intervention. Family considerations should also be raised at the regular clinical review meetings at any time the progress of the young person is being discussed. The specialist family worker also attends the continuing care team clinical reviews, and can keep the team mindful of the needs of families, provide consultation, and decisions can be made about whether there is a need for direct work with the family worker. This work may be done either separately to the case manager or jointly, depending on the clinical issues involved. The family worker is also embedded within the continuing care team.

Clinicians, or the case managers, can have a case consultation with the family worker at any time. The specialist family worker tends to become involved in direct work with families when the needs are high, there are complex issues, recovery is problematic or it is not beneficial for the case manager's relationship with the young person to be also treating the family.

Specific interventions or more structured family work may be required when, in agreement with the young person and their family, there is assistance needed for work on communication issues, problem-solving, coping strategies, stress management or any other behavioural issues. If it is believed that families need specific family therapy, this can be provided by referral out to an appropriate therapeutic service, but not usually as a first step, or it can be offered within the EPPIC service if there are suitably skilled staff.

Opportunities and Challenges with the Family Work Program and Family Peer Support Workers

Opportunities

There are many benefits and opportunities in having a family work program within an EPPIC service. By having the philosophy embedded in the clinical care of the young person, such as engagement and collaboration with families being seen as an absolutely essential task of all clinicians, families are not forgotten and become an important part of the recovery process. If families' needs can be met during this difficult time, they are more likely to be available to assist and support their young person. Having designated family workers can keep the awareness of family support high within the service. They can be available to offer consultation, training, supervision and direct work with families, which also supports the work of the treating team.

The menu or 'pyramid' of services available to families, such as the psychoeducation forums and family peer support workers, allows greater flexibility with meeting the needs of the individual families and helps to identify which staff are best to be involved at particular phases. This is assisted when having multidisciplinary teams, training, consultation and co-working with the family worker. The family worker is therefore part of the continuing care team and highly involved clinically.

Challenges

As has been often demonstrated in services, the opportunities and successes within a service can also be the challenges. While there has been much evidence-based research on working within a psychoeducation framework for people with schizophrenia, there is less specific evidence on working with families in early psychosis or on service challenges. Burbach and Stanbridge (2009) describe a review of the literature that discusses barriers to training such as 'particularly difficulties relating to clinicians' inability to prioritise family work due to the service environment. Specific issues included not having sufficient time for family interventions, difficulties in integrating it with other responsibilities, lack of support from colleagues and a lack of appropriate supervision.' However, it is believed that these types of challenges can be overcome within an EPPIC service by having supportive leadership and using the flexible family work model described so far.

Culture

Not only do clinicians need to be trained in working with young people with early psychosis, family work needs to be embedded in the service philosophy as an essential task for clinicians, who must see families and provide psychoeducation, as well as engage with them and to listen to their story by developing a collaborative relationship. There should be a no blame approach to families and the leadership team needs to promote this within the service. The role of designated specialist family workers and family peer support staff gives added status to these tasks and keeps awareness up. Embedding the family workers as part of the continuing care team provides the avenue for them to be seen as part of the treating team, allows these staff to attend clinical reviews and to work directly with other case managers. If this occurs, case managers are keen to seek consultation from the family worker and to see them as a really helpful resource in not only developing their own skills, but as an ally in assisting with families. Development and maintenance of this culture is an ongoing process that cannot be left aside.

Case Management

For an early psychosis service with high demand and high case manager workloads, it can be tempting for a service to request the family worker to also pick up a specific case management workload. This is to be avoided, as it runs the risk that the family worker will not have sufficient time to be spent on direct work with families, or be available for any training, professional development, consultation or supervision, or overseeing the family work model.

Referral Pathways and Criteria for Referral to the Family Worker

It can be helpful for all clinicians' clarity to have a clear referral pathway and criteria for referral to the family worker. This is not to exclude the informal discussions that co workers can have with each other, but assists in everyone's understanding of what is meant by complex families and so on. It also addresses the issue at times of the family worker being the only person to take all family referrals and continues the culture that it is also clinician's responsibility to work with families.

The common factors in referral to the specialist family worker can be high levels of family distress, persisting positive symptoms, comorbid personality issues, to assist with engagement, relapse prevention, incomplete recovery, or when other complex factors such as drug and alcohol issues are involved.

Psychoeducation Forums

So that all families have the possibility of access to information it is best to have a psychoeducational group called the 'Family and Friends Information Sessions'. These sessions run continuously so that families can attend at any time, such as a repeating four week group that has four distinct sessions that cover the following:

- What is psychosis?
- Treatment approaches, including the medical approach
- What is involved in recovery?
- How families can help with the recovery process

At least two dedicated clinicians need to be given sufficient time within the organisation and supported with resources to provide this service. It needs to be at a time when all families are most likely to attend, such as a 6.30–7.30 pm or later timeslot. It is also helpful for staff education and commitment to rotate the roles of the designated staff among the clinicians in the continuing care team. It can be tempting for services, often due to resourcing and time, not to run this type of group continuously; however, for a service to really have a flexible approach and a menu of family work services then the psychoeducational group needs to be embedded and run continuously as part of the overall family work service provision. In the initial stages of setting up the family and friends information sessions the family worker can be of great assistance.

Family Work Staffing

The designated family work staff need to have the time to oversee the family work model within the service. They also need to develop, or update with the treating team, a family work manual, to have available family work resources and be able to up-skill other staff. Training in structured behavioural family work can be used along with setting up a family work interest group for interested staff.

Attendance by the family worker at the continuing care team clinical review meeting needs to be mandatory and will encourage discussion and education to staff as well as being one of the referral pathways.

Often the family work staff member is from the social work discipline, as they tend to have a systemic understanding; they tend to work with families in their approaches and they may have had further specific family work training.

Confidentiality

Concerns about confidentiality can be one of the challenges that clinicians, family peer support workers, families and young people can face. Family work is based on the assumption that information will be shared, it is about 'how' to do the sharing rather than 'if' it will be shared. Young people and their families need to be given a clear rationale and understanding for sharing information, what is shared and what needs to be kept confidential. Any reluctance can be explored and negotiated. Based on over 20 years of clinical experience at the EPPIC service, the issue of confidentiality is usually not a major one for the young person or their family. Often a young person is agreeable for their family to be informed and to be assisted by the treating team. At times young people are relieved to have a family worker meet separately with the family to try to alleviate the distress and concerns and provide an understanding of the recovery approach. There can even be situations where a young person, who despite having high conflict with the family, or having moved out of home, will still agree for their family to meet alone with a family worker, with noted restrictions on information that can be given to them. This allows for family work to be done regarding communication issues, support and debriefing work.

Confidentiality and knowing the boundaries of their role can be an issue at times for family peer support workers. Therefore they need a supportive coordinator, clear guidelines regarding their role, good liaison with the case manager and ongoing supervision.

Crisp and Gleeson, in their work at EPPIC at Orygen Youth Health describe several issues or challenges when working with families with a young person with FEP to prevent relapse (Crisp & Gleeson, 2009). These need to be noted and can cover not just relapse prevention work. The case manager and family worker need to be very mindful of these types of challenges and address them. They include the following issues.

Engagement and Motivation

This is often high in the early stage of the psychotic episode, however can wane over time. These can be addressed by continued engagement with the family and acknowledgement of the family motivation, possible ambivalence, plus addressing some of the practical issues of attending.

Explanatory Models of Psychosis

Forming an explanation for what has happened to their family member can be difficult in the initial stages and not everyone will have a shared understanding.

Illness and Non-Illness

It can be difficult for families to differentiate what is illness-related and what is related to the young person's developmental stage.

The Challenge of Balancing Anxiety and Optimism

This is how to strike the balance between remaining optimistic regarding the future, but also for the family to be equipped for possible challenges ahead.

Detecting Early Warning Signs

In FEP the degree of vulnerability to relapse can be difficult to predict or detect. However, all families need to be aware of these.

Information Needs

The majority of families have had no previous experience or prior knowledge of FEP, so it can be very confusing time trying to come to an understanding of what has happened, let alone deal with their own feelings about it all. They need understanding, empathy and time to adjust to the situation.

It is for all the above issues that family work must be given status and importance in EPPIC service provision. The challenges for the development of the service can only be met with strong leadership and a specific model, with a flexible phase-based approach, supported by all clinicians in the service.

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1.3.14
Youth Participation and Peer Support

Summary

The benefits of youth participation are many and wide-ranging. As a starting point, youth participation is seen as a fundamental right of young people within an early psychosis service. It embeds young people in the decision-making processes of a service and provides them with a formal avenue for feedback and evaluation that contributes to meaningful quality improvement in service delivery. The experience of being a young person in an early psychosis service provides a unique insight and perspective into identifying the strengths, weaknesses and gaps in service delivery from which a service can build upon.

1.3.14
Youth Participation and Peer Support

Youth Participation and Peer Support Challenges and Enablers

Challenges of youth participation and peer support:

- An accurate understanding and perception of the youth participation and peer support
- The development of positive interface relationships with the clinical team
- Not just having a tokenistic program and poor uptake of youth participation activities
- Recruiting and maintaining peer support workers with the lived experience of early psychosis
- Having sufficient peer support workers
- Providing appropriate and adequate support to peer support workers
- Recruiting a motivated, creative and experienced youth participation coordinator who can actively develop the program
- Having wide-ranging youth consultation approach and processes
- Understanding and deciding what are top-down and bottom-up activities for youth participation
- Holding meaningful and responsive peer support worker meetings

Youth Participation and Peer Support Challenges and Enablers

Enablers are:

- Mental health promotion and reducing stigma
- Promotion of a shared understanding of the need and rationale for the youth participation and peer support program to all in the EPPIC service
- Development of a clear mission statement
- Staff education
- Designated youth participation coordinator with an advocate role as part of the psychosocial team
- Aligning the personal goals of the peer support workers with the goals of the youth participation program and providing support from the clinical team
- Good support, supervision and debriefing processes for peer support workers via the coordinator or senior clinicians
- Having a fair and reasonable reimbursement or similar system for youth support workers
- Holding regular peer support worker meetings and pre-planning agenda items
- Consideration of peer support workers having a wellness plan
- Professional development
- Strong governance and leadership that support youth participation and peers support roles and is part of strategic planning

Youth Participation

There has been a long standing level of commitment to genuine service user participation at a national policy level, with the Australian Commonwealth Government's National Mental Health Plan 2003–2008 (Australian Health Ministers, 2003) and later in the Fourth National Mental Health Plan (Commonwealth of Australia, 2009). Monson and Thurley (2011) describe that current policy and practice involves youth participation at three levels: the practice level, where young people participate in their own health care; service level planning, provision and evaluation, where young people are valued stakeholders and consultants; and policy and systems planning and evaluation. Youth participation is now seen as an essential component in early psychosis service provision internationally (Ehmann et al., 2010; Monson & Thurley, 2011; IRIS 2012). In the EPPIC model, youth participation is an essential core component and aims to improve service delivery, improve mental health literacy, promote help-seeking among young people and reduce stigma regarding mental illness. **headspace** centres and **headspace** National are also strong advocates of youth participation.

Rationale

The benefits of youth participation are many and wide-ranging. As a starting point, youth participation is seen as a fundamental right of young people within an early psychosis service. It embeds young people in the decision-making processes of a service and provides them with a formal avenue for feedback and evaluation which contributes to meaningful quality improvement in service delivery (Monson & Thurley, 2011). The experience of being a consumer of an early psychosis service provides a unique insight and perspective into identifying the strengths, weaknesses and gaps in service delivery from which a service can build upon.

One of the crucial aspects of an early psychosis service relates to the youth-friendliness of the service (which is described in detail in the EPPIC Model section). Optimising youth-friendliness will assist in the engagement of young people into a service, which is one of the most critical therapeutic interventions to enable recovery for a first episode of psychosis. Thus, with a youth-centred approach that has been heavily influenced by young people themselves, one would expect a subsequent positive effect on clinical outcomes. Youth participation activities play a vital part in determining the youth-friendliness of a service because of the meaningful involvement of young people.

There is evidence that service level youth consumer participation activities that are visible and measurable can increase the level of clinical participation of service users (Monson, 2011), resulting in a more collaborative therapeutic relationship between the clinician and the young person. Clinicians encouraging youth participation in itself can be of therapeutic benefit by aiding a sense of self-determination and empowerment, as well as value. Further, a young person's involvement in youth participation activities can develop a number and variety of skills (communication skills, working with media, working in groups etc.) which may be used elsewhere, such as in their career or social life, or by providing a different reason to engage with the service.

One of the most important reasons for a youth participation program relates to peer support. The communicated experience of a young person who has lived through a first episode of psychosis, the involvement of a mental health service in their care and the process of recovery is a powerful tool to provide a message of hope and optimism to other young people and their families. It provides a level of understanding to young people currently receiving care and treatment that is validating and unique to those have experienced a similar journey, as well as enhancing engagement into a service.

Young people who have experienced and recovered from a first episode of psychosis are also the ones who are in the best position to advocate for better access and improved services. Their experiences and stories can assist in addressing stigma within the broader community and in particular help young people to seek help when the need arises. This is being successfully achieved in Canada, where there has not only been a focus on youth engagement but the development of innovative mental health promotion via a system called Youth Net. This is an organisation run by youth, for youth, which offers community-based programming that includes mental health focus groups, youth initiatives and support groups for youth in need (Davidson et al., 2006). Youth Net have also studied youth engagement, such as the young person's most important activity, frequency of involvement, psychological engagement and the subsequent relationship to suicide risk (Ramey et al., 2010).

Structure and Function of a Youth Participation Program

In the EPPIC model, a youth participation coordinator is seen as an essential part of this component of the service. The main function of the youth participation coordinator's role is to coordinate the activities of the youth participation program, which can be broadly split into the two main areas of youth consultation and peer support. The coordinator engages young people into youth participation activities and liaises with the rest of the service, the broader health system and community. The person employed into this role is not necessarily a health professional but may (preferably) be from a background such as community development or youth work where they can bring with them different experiences, culture, attitudes and set of values.

In relation to governance, it is suggested that the youth participation coordinator report to the psychosocial recovery team leader and sit within that part of the team although the actual work necessitates involvement and influence in all parts of the service. Supervision is an important part of the support and development of this position, and should be provided by a senior clinician with a sound understanding, interest in, and experience of, youth participation. Relevant professional development opportunities should be provided to the person in the coordinator position. Young people who are participating in the program should report to the youth participation coordinator and are also provided with supervision and goal-oriented professional development opportunities.

Young people are recompensed for their time, expertise and out of pocket costs incurred as part of their youth participatory activities. There is a debate as to the pros and cons of employment versus simple financial reimbursement. Employing young people to work in the program as peer support workers or consultants has benefits to them, such as holiday and sick leave accrual, having the same rights and responsibilities as any other employee in the service, as well as a formal validation of the role. However, if young people are employed, there comes with it a greater degree of responsibility and pressure to attend work and to conform to the service messaging, which may not be congruent with their own as a mental health advocate. Receiving reimbursement only, as opposed to being employed, allows a greater degree of flexibility for the young person and is non-coercive in relation to the freedom of opinion and expression. Services need to decide on their own strategy to manage this issue. A guide on reimbursement can be obtained from the Health Issues Centre, who have produced a position statement on reimbursement for consumer participants that can be accessed at http://www.healthissuescentre.org.au/documents/items/2008/06/211201-upload-00001.pdf.

Youth Consultation

Youth consultation activities involve past or current service users to provide a consultation and advisory service. This may involve ‘top down’ activities driven by service needs, such as advice on the content and design of resources (e.g., psychoeducation material, service information brochures), research projects, service developments or changes, as well as a number of other activities. Top down activities are referred to the youth participation coordinator who would then consult with the members of the youth consultation team. Bottom-up activities are originated from within the youth consultation team, who may develop their own ideas about service improvements and ways to enact these. These would need to be discussed within team meetings, which are minuted, with the youth participation coordinator supporting these initiatives through agreed service channels. A youth participation steering committee such as that described by Monson and Thurley (2011) may be useful (if not critical) to both formalise youth participation and embed it within the clinical teams and avoid tokenistic concerns.

The type of consultancy work which may be undertaken by the youth participation team is wide-ranging and probably expanding. It may include media work for community education or advocacy purposes (which will involve media training), staff recruitment, the production and dissemination of newsletters and membership of committees to ensure a youth participatory perspective to improve the quality of care throughout the service. Young people may also be employed in research projects and contribute to research design and methodology, interpretation of findings and dissemination activities. Influencing research questions may bring a usefulness and validity to future research.

Peer Support

Peer support is often a bottom-up activity that has been driven by young people in response to identified need for peer support. Peer support workers are employed via an application and interview process and they may work across inpatient and community care team settings. Role definition and agreement to work within in this is important. Their unique perspective can help to facilitate a message of optimism for recovery and support other young people by sharing their experiences of not only service use but also the experience of psychosis, diagnosis, common challenges and what helps. Their experience can describe what a service has to offer the young person and help with engagement into the service, particularly in the early phases of illness. The peer support role may also extend to providing practical assistance with issues that are a barrier to functional recovery, such as assistance with searching for accommodation or with Centrelink applications.

In order to support the peer support worker, a wellness plan that identifies strengths and coping strategies, early warning signs of relapse and an agreed action plan is developed in collaboration with the youth participation coordinator. An agreed process needs to be in place to manage the potential situation of a peer support worker requiring hospitalisation, and how boundary issues are managed. There is a need for the youth participation coordinator to roster peer support workers to provide as much coverage as possible, as well as manage projects and workloads.

Challenges and Solutions

One of the challenges arising for a youth participation program is how the program is perceived in relation to its purpose and benefits. Views on this may vary and many staff within an organisation may be naive to the rationale for a youth participation program. Therefore a common and shared understanding of the program is important to overcome this. Developing a mission statement for the program may be a useful strategy in this instance so that the purpose is clear. Staff education is also important in order to develop an understanding of the rationale and benefits and perhaps reduce any perceived threat that a youth participation program may pose to those clinicians who may be unsure of its role and function. This will also enhance the interface relationships between the clinical teams and the youth participation program, which are crucial to the full functioning of the service.

A lack of understanding of the purpose and benefits of the program may also contribute to tokenism or the uptake of youth participation activities in some parts of the service and not others. The youth participation coordinator and their line manager both have a role to play in developing good working relationships with service managers and being a strong advocate of the program with a view to embedding meaningful youth participation into the fabric of the service.

While experience shows that there may be many young people who want to be part of the youth participation program, recruitment of appropriate candidates may

Their unique perspective can help to facilitate a message of optimism for recovery and support other young people by sharing their experiences of not only service use but also the experience of psychosis, diagnosis, common challenges and what helps.

provide a challenge. One of the key solutions is to discuss with the young person how their own personal goals equate to the overall aims of the program and how their perceptions of youth participation activities match up to the reality of working in the program. For those young people who are currently receiving care from the service, having the support of the clinical team is important. Close working relationships between the youth participation coordinator and the clinical teams again becomes imperative. Maintaining young people in the program may also be a challenge due to expenses incurred through participatory activities, as well as through disillusionment with an inability to see outcomes or by the pace in which change occurs within the system. Any young person participating in the program should not be out of pocket and reimbursement arrangements to address this are important. Travel costs can be minimised by teleconference consultation. The youth participation coordinator also has a role to play in providing regular feedback on outcomes and managing expectations from the outset, including the pace of organisational change.

As participating young people may be at different stages of recovery and have a range of educational and cultural backgrounds, meetings of the youth participants can present a challenge if they are to be meaningful and enjoyable. This can be overcome by the youth participation coordinator meeting with the young person prior to any formal group meetings and assessing what will enable the young person to participate. Peer support work in particular may involve recounting difficult times which may trigger off traumatic memories or relapse. Pre-planning and advance directives in the form of an agreed plan can address this with the young person. All youth consultations should have the back-up of the youth participation coordinator to provide support or debriefing as required.

A youth participation program is an essential component of an early psychosis service and offers a great opportunity for services to develop and improve their service delivery and provide a broad message of optimism and recovery to the wider community. For young people themselves, the program offers a unique, validating and supportive experience that will assist in better outcomes for both young people and their families.

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1.3.15

Workforce Development

Summary

Providing clinical interventions to young people who have experienced a first episode of psychosis and their families requires a knowledge and skill set much of which is unique to this specialist field. Workforce development activities aim to equip services and individual staff members with the knowledge, skills, confidence and competence to provide such interventions.

1.3.15
Workforce Development

Workforce Development Challenges and Enablers

Challenges are:

- It may not be valued by the organisation or only receives ‘lip service’
- Inadequate supervision and resourcing for clinical education
- Developing links with academia and/or clinical schools
- Providing sufficient time and access for clinical training and education
- The demands of the direct clinical work takes priority over the focus on workforce development
- Attitude and motivation of clinical staff for updating their learning and education can be variable
- Willingness and valuing of taking on clinical students for placement experience

Enablers are:

- Strong and advocating leadership so that the workforce development is valued and becomes embedded in the EPPIC service culture
- Development of structures and processes via policies and resourcing that supports education and training for workforce development
- Links and/or partnerships with academia and clinical schools and taking students for clinical placements as one way to promote a current and future youth-focused mental health workforce
- Regular clinical supervision and access to multimedia resource material and systems to promote continued learning
- Adequate resourcing and access for all clinical levels for learning, education and promotion of higher degree learning
- Annual collaborative professional development plans for all staff, which can be part of the performance review process, and reviewed regularly throughout the year
- Managers being knowledgeable of the intrinsic and extrinsic factors for motivation
- Supportive study leave arrangements
- Research endeavours related to the clinical work are viewed as important and given assistance, with close links to the clinical program

Introduction

The concept of workforce development is a multidimensional one and requires individual practitioner motivation, service level processes and structure and culture development to support it. If these are achieved then this will contribute to the success in services delivering quality, evidence-based, best practice interventions. This section looks at the rationale for workforce development as a core component and describes how to achieve it in consideration of the potential challenges for the service.

Rationale for Workforce Development as a Core Component

Workforce development as a core component is essential for a number of reasons. The provision of quality services is a basic right and minimum expectation for young people and their families using any health service. In order to deliver quality interventions, there is a need for knowledgeable, skilled, and competent clinicians and this relies in part on supporting staff with workforce development opportunities and is therefore a key ingredient in developing an early psychosis service. Linked to this is the fact that clinical interventions need to be evidence-based and access to workforce development activities provided by the appropriate and relevant experts are important to achieve this.

Given that the operation of services and the delivery of clinical interventions are expected to have fidelity to the EPPIC model and the latest Australian clinical guidelines, then access to an appropriate level of education, skills training and supportive clinical resources play a crucial role in optimising fidelity. Evidence suggests that bringing about change in clinical practice, for example incorporating clinical guidelines into practice, is a complex process but one which is crucially supported by continuing education (Greenhalgh et al., 2004; Barwick et al., 2005).

Fraser and Brooks (2012) highlight the challenges faced in the supply of the youth mental health workforce in the coming years. Workforce development, in the form of training and education activities, may assist in the promotion of staff job satisfaction (Rambur et al., 2005). Given this, providing staff with access to training and education that supports their clinical and professional development and provides them with the requirements to operate competently in their chosen field is a key to staff recruitment and retention. Investment in this area also clearly demonstrates and acknowledges the value of staff as a key resource in the whole of the service and emphasises their importance in delivering the strategic goals of the service.

Organisational Issues for Workforce Development Component

Given the rationale for workforce development as a core component of a new early psychosis service, it becomes evident that the service itself has a responsibility to provide access to such activities. Similarly, it becomes evident that clinicians also have a responsibility to the young people and families they work with to be informed of up-to-date knowledge and skills regarding the clinical interventions they deliver in order to ensure best practice and safe interventions. For clinicians, the need to maintain professional development hours or points for the professional governing bodies is also a motivator for ongoing learning.

Workforce development activities have three main categories: local professional development activities, broader professional development activities provided by an external agency and postgraduate education. Local professional development activities are coordinated at a clinical service level and often meet mandatory training requirements and identified local, needs-based clinical practice issues. These may also include local journal club activities or ‘Grand Rounds’ where complex cases are presented by the treating team and discussed in order to share clinical knowledge and experience.

Broader professional development may be accessed by the service from external agencies, particularly where local expertise on a certain topic is limited or does not exist or where there are opportunities to hear from leading experts in a particular field. This may involve activities aimed at both the service development and clinical levels and incorporate activities such as developing models of care to be implemented service-wide or clinical workshops in specific therapies or approaches.

Postgraduate education is a category of workforce development that may serve many functions and manifest in many ways. As with other broader professional development activities, it may support staff at a variety of levels within the organisation to develop advanced-level knowledge and skills, in particular in management, administrative or clinical areas requiring expertise. Importantly, it may develop research skills and critical thinking that looks beyond the realm of the individual service and the local context.

Postgraduate education can be enhanced by building relationships with academia, clinical schools and professional colleges or bodies. Providing undergraduate and postgraduate clinical placements within the service will not only help to develop a learning culture within the service but can maintain clinical expertise. Established links with placement students may assist in the recruitment of new staff to the service. The EPPIC service has been very successful in offering clinical placements for students having established networks and relationships with tertiary institutions and been able to employ new graduates in Entry Level Programs.

A research culture embedded within the Early Psychosis service will be attractive to a number of service leads and clinical staff and form part of the workforce development plan for those staff who are interested in such activities.

Two postgraduate courses of note can be accessed:

Postgraduate education in Youth Mental Health (up to Masters level) at the University of Melbourne. Go to http://oyh.org.au/training-resources/graduate-education-distance/graduate-diploma-youth-mental-health.

Master of Science in Early Intervention in Psychosis at Kings College London. Go to http://www.kcl.ac.uk/prospectus/graduate/early-interventions-in-psychosis.

There are a number of other activities that services can provide to support workforce development. One of the main activities is providing access to critical resources such as the latest clinical guidelines, clinical manuals and other multimedia training resources. Although clinical manuals are of use in their own right, their full potential for effectiveness is when they are provided along with other workforce development activities such as education and training, where they serve as ongoing reminders to help embed knowledge into practice (Hoge et al., 2004). Access to computers to search evidence databases and other websites for latest knowledge and resources are important. Computer access will also enhance networking opportunities with a view to sharing knowledge and experience with external agencies who have similar interests and objectives, for example in web-based communities of practice.

One of the standards within the EPPIC model identifies that each service is required to provide access to clinical supervision on a fortnightly basis to all clinical staff. Ideally this should not be a line manager but be provided by a senior clinician with the relevant expertise. Various professional boards have their own guidelines on supervision that service managers and clinicians should be aware of. Clinical staff may also benefit from time-limited, topic-focused group supervision separate to their normal supervision. This may be particularly useful following a training event where the knowledge learned is discussed in real world practical settings to help to embed the knowledge into practice.

Leadership that supports the full range of workforce development activities will go a long way to developing a learning culture within the service. Developing this culture is important as it sets a standard or expectation for both service managers and clinicians to contribute to its maintenance and growth, with obvious benefits to staff and young people and their families accessing the service.

Challenges and Enablers

Workforce development can face many challenges. One of the threats to providing appropriate workforce development activities lies in it not being seen as a valuable concept in itself or that lip service is paid to its provision. It needs to be part of the value system of the service itself, which permeates into a learning culture within the whole organisation. This would need to be reflected by processes and structures put in place by the service to support this value, such as policies and resources around access to education and training, links with academia and clinical schools, structures and processes that support regular clinical supervision or access to relevant resource material to support learning (e.g., computers, clinical manuals).

The issue of providing access to training and education that takes staff away from their core work creates an inherent tension within services. While the need to have a knowledgeable, skilled and competent workforce developed through workforce development activities is crucial to providing quality and best practice, someone has to be available to provide the interventions themselves to young people and their families. The demand for, and busyness of, a service can be a barrier to clinicians being adequately trained when training opportunities are missed due to heavy workloads. A key solution to this problem lies in the provision of adequate resourcing to services to provide both quality care to the community and access to workforce development to all levels of staff.

Resource allocation is a concern of leadership and it requires strong and innovative leaders to advocate for workforce development activities to be continually funded in the presence of high demands on the service. Capping clinical caseloads can be one way of ensuring the capacity to attend relevant training for individual clinicians. The EPPIC model has a capped caseload approach that not only enables capacity for workforce development, but importantly, aims to enhance fidelity to the actual model itself.

The attitude and motivation of individual staff members towards the concept of workforce development may also provide a challenge. Black and Deci (2000) describe extrinsic and intrinsic factors that influence an individual's motivation towards learning and vary from individual to individual. Intrinsic motivating factors tend to lead to more perceived competence, engagement and enjoyment following training uptake. However, where these are limited, then extrinsic factors may come into play. Service managers will have a role to play as an extrinsic motivating factor if this is the case, particularly by acknowledging the role of workforce development in model fidelity and improving quality outcomes. Annual collaborative professional development plans as part of performance appraisal involving line managers, clinical supervisors and the individual staff members can be useful in providing extrinsic motivation where intrinsic motivation is low or lacking.

Workforce development that aims at enhancing fidelity to the model, improving clinical best practice and improving outcomes for young people experiencing a first episode of psychosis and their families is a core component of an EPPIC model early psychosis service. This goes beyond the simple provision of training and education to the workforce into a multidimensional mix of developing a learning culture and building relationships with partner agencies in order to develop a rich environment for learning, knowledge development and innovation.

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1.3.16
Partnerships

Summary

EPPIC services may want, or will need, to utilise partnerships with other organisations to assist in the provision of service to support young people for early intervention, and to have a seamless and appropriate integrated provision of care. It is also an additional way to best meet the needs of young people and their families and to reduce stigma. Partnerships and established links can enhance the quality and breadth of a service and can occur in a variety of forms.

Partnerships Challenges and Enablers

Challenges are:

- Developing partnerships that are more than just information sharing or use of specific facilities
- Finding suitable partners and matching or complementing the organisational mission, goals and resources
- Formalising operational procedures and agreements for service delivery
- Building trusting and respectful relationships
- Providing joint staff training sessions for clinical work and/or administration
- Sustaining the partnership over the long term
- The direct 'on the ground' staff having the commitment to the partnership

Enablers are:

- Comprehensive initial and ongoing planning is essential to cover all potential and current issues and questions
- Clearly documented service level agreements and/or memorandums of understanding with detailed descriptions that are reviewed yearly
- Understanding and learning from organisational theory, behaviour and management practices, including an in-depth understanding of your own organisation
- Finding common links and goals with the partner organisation and focusing on these
- Providing joint training and education sessions that are mutually beneficial and utilise the experience of the partner organisation so as not to just to impose on them
- Have clear and fast conflict resolution processes
- Strong leadership and resources to promote the partnership
- Choose key staff to help build the collaborative processes in all levels of the organisations
- Partner with organisations that have this experience already

Description

One definition of partnerships from the business dictionary states:

‘A type of business organisation in which two or more individual’s pool money, skills, and other resources, and share profit and loss in accordance with terms of the partnership agreement. In absence of such agreement, a partnership is assumed to exist where the participants in an enterprise agree to share the associated risks and rewards proportionately’ (www.businessdictionary.com).

While mental health services are not usually in the business of profit or loss, they are organisations that aim to provide excellent service, which need to work diligently, manage risk, manage financially and allocate resources. One way of achieving this may be to develop partnerships and share resources. The terms integration, seamless service, collaboration, coordination, continuity, linkages and co-location are all words that appear often when discussing partnerships. There can be different levels of partnerships, which need to be clearly planned for, defined, understood and agreed to at the outset. They also need continuous work in sustaining the relationship. EPPIC services may want, or will need, to utilise partnerships with other organisations to assist in the provision of service to support young people for early intervention, and to have a seamless and appropriate integrated provision of care. It is also a way to best meet the needs of young people and their families and to reduce stigma.

Partnerships and established links can enhance the quality and breadth of the service offered and can occur in a variety of forms. Examples may be partnerships with drug and alcohol services, youth services, and organisations supporting young people mental health.

Opportunities and Challenges

The types of partnerships raised here are more than information sharing or use of a specific facility for a short time. They are about more formalised operational procedures, building up trust and having common goals, having written service level agreements or memorandums of understanding that are explicit; plus joint staff training and some shared administrative or joint clinician work. Partnerships provide excellent opportunities to not only provide a seamless service to young people, but to also assist with resource management, for meeting mutual organisational goals and collaboration efforts, and the provision of staff training across the services.

There can be challenges with not only developing partnerships, but also in sustaining them. The planning stage is crucial for any partnership to be successful. There can be a multitude of issues and questions that can arise. These can range from organisations having different philosophies, missions and clinical approaches. The cultures of the organisations can be different. There can be a history of mistrust between services; one service can feel their resources are being used more than the other service. The staff providing the service in the partnership arrangement can have little commitment to the process and identify only with their mother agency. It is not only about the direct service provision, but thought needs to be given to codes of conduct and human resource issues. Staff can feel that they are being imposed on, even in training sessions; feeling like they are being told what to do, rather than understanding what can each service bring to the training and learning from this. Process and system issues can seem unnecessarily complex, so issues arise on how to streamline to suit both organisations. It can be difficult, yet not impossible, to resolve points of conflict or disputes and have proper processes.

headspace Geelong has written about the challenges in forming partnerships in their region and comment that ‘Structural and process considerations are necessary but not sufficient for the successful formation and maintenance of inter-agency partnerships and integrated care provision. Specifically, organisational culture change and staff engagement is a significant challenge and planning for this is essential and often neglected. Although agreeing on common goals and objectives is an essential first step in forming partnerships designed to provide integrated care, goodwill is not enough, and the literature shows that most collaborations fail to meet their objectives. Principles and lessons of organisational behaviour and management practices in the business sector can contribute a great deal to partnership planning’ (Callaly et al., 2011).

As stated in the document regarding the critical factors for the successful establishment and development of an EPPIC, these same factors of governance, culture, leadership and resources are all crucial in successful partnership. In particular, leadership and culture need to be highlighted. Organisations need to understand their own models of care, how ready they are to form partnerships, be prepared to plan and look at issues of power, structure and process at all system levels. The trust, culture and how conflict is managed need to be understood and addressed.

In the **headspace** Geelong (Callaly et al., 2011) model they have acknowledged the following challenges in their service integration:

- Competing agendas of **headspace** National and **headspace** Barwon
- Competing models of service delivery between agencies at the ground level
- Geographic/demographic differences between sites
- Staff impressions that one agency’s processes are being ‘pushed’ onto the other agencies
- Concerns over confidentiality with shared IT
- Anxiety and fear regarding change
- Lack of staff buy-in to the service integration system
- Losing symbols of pre-identity
- Staff feelings of loss
- Confusion or conflict between old and new identities
- Understanding the **headspace** structure/model
- Lack of inter-agency interaction
- Lack of understanding regarding work roles and team structures
- External pressure to implement change and show results quickly.

Some of these types of challenges are not necessarily unique to partnerships as they can be issues that new services or existing services have when faced with change. However, interface issues with another organisation add a further dimension to possible challenges. EPPIC in Melbourne has also faced similar challenges when establishing partnerships and the process at times has been very slow due to the need to build up trust, understand each organisation and to reach agreement.

The ways to address these types of challenges or enable partnerships, which have also been utilised by **headspace** Barwon are:

- Acknowledge from the outset what are the possible issues and be prepared for an ongoing process in not only the establishment of the partnership but also the commitment to continued work involved in sustaining it.
- Be prepared for a significant planning phase and strategic thinking that is clearly defined.
- Have strong, engaged leaderships that can support and progress the joint organisational vision and the development of the partnership, as well as filter this down into the organisations and to the on-the-ground staff. An EPPIC Steering and Implementation Group could facilitate this.
- Principles of organisational change need to be followed (see document titled EPPIC National Support: Developing the Culture).
- Find the common links and goals in the organisations and focus on these. Use these as a way to build up trust and to also build the relationship.
- Have service level agreements or memorandums of understanding that are detailed in description, cover the service and process systems, common policies and procedures, risk management and have built in regular review processes, including how to manage areas of conflict and processes for resolving disputes. Human resource procedures need to be understood and documented.
- Provide joint training sessions for staff that can be mutually beneficial and that look at what each service can bring to these, rather than one service imposing training on the other. This also helps in building relationships and trust with 'on-the-ground' staff, which is crucial in developing and maintaining partnerships.
- Acknowledge and ensure that there is direct day-to-day partnership so that all staff are committed to the tasks at hand and that the developing culture complements this.
- To aim to have seamless referral processes that are as simple as possible so problems do not occur in these types of process issues.
- To understand the unique local service configurations, the key stakeholders and the impact of the particular geographic region. This allows for a more likely and agreeable partnership to form.
- Choose key staff that embody collaborative working relationships and encourage the process of joint work, such as even initially running groups together or attending clinical review meeting and providing consultation. Basically, this involves looking at where the organisations can work well together as an initial starting point and emphasising the common vision and goals.
- Understand and clarify exactly if, how and what resources may be shared.

Partnerships, no matter what specific form they take, can bring many rewards, not only for staff but also for the young people and families involved, and integrate quality care for the community. However, it needs time, planning and ongoing work to build partnerships that can be maintained, trusting and really effective.

Research

Research is a very important part of service development. It provides evidence-based information that can then be applied to clinical work; it allows services to evaluate and review and to see if they are providing useful models of care, informs regarding gaps in service provision and can influence future directions of both clinical work and the overall service development.

Linking to organisations and/or having partnerships with organisations such as tertiary level teaching bodies or universities can provide the skills and knowledge and can facilitate ongoing research work as well as assist in embedding research into the service and clinical programs. An EPPIC service needs to strongly support and promote links to research and partner with those organisations that have the experience in providing this work.

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1.3.17
Ultra High Risk Detection and Care

Summary

The UHR stream of care, which provides stage-appropriate, evidence-based interventions, is an essential core component in the EPPIC model. Interventions provided in this component aim to:

- Minimise disability and the adverse health and social impacts associated with this phase of illness
- Enable recovery before symptoms and poor functioning become entrenched
- Prevent, delay or ameliorate the onset of full threshold psychotic disorders

Tenure of care:

- The current funding model allows for up to seven months of UHR care.

Ultra High Risk Detection and Care Challenges and Enablers

Challenges are:

- Expertise and knowledge in UHR care by clinicians
- Identifying which stage of psychosis young people are at, not only initially, but also throughout the episode of care
- Clinicians being skilled in gaining information and history appropriately to make decisions at both the triage level and in the face-to-face assessment, and expertise in using screening tools
- Identifying those young people who transition to psychosis after entering the UHR program
- Clinicians sitting with the uncertainty of diagnosis and stage of illness at times
- An overloaded service may be tempted to ‘tweak’ referrals so that a young person will receive face-to-face assessment or be taken into the UHR program even if they do not meet the criteria
- There may be face-to-face assessments of young people that do not result in being accepted into the UHR care
- Referring young people as needed to appropriate services once their tenure of care is completed
- Managing the young person’s clinical needs and crisis situations, as well as family needs
- Having streamlined processes for case managers for those UHR young people that transition to FEP

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Ultra High Risk Detection and Care

Ultra High Risk Detection and Care Challenges and Enablers

Enablers are:

- Strong leadership, along with a consultant psychiatrist with early psychosis experience
- A culture of early detection and intervention throughout the EPPIC service
- Promotion of the UHR program via community awareness and education staff
- All triage staff using the PQ-16 as the screening questionnaire to help direct appropriate referrals
- Adherence to the UHR criteria
- All UHR staff trained in using the CAARMS criteria specialist tool and UHR care
- Clinicians able to be flexible and patient enough to manage diagnostic uncertainty and to understand that some young people may not fit the criteria
- Team peer support and robust case-by-case discussions in regular clinical review meetings
- Support for workforce development activities
- Clinicians supported to make appropriate referrals, if needed, of young people after they have had their tenure of care.
- Negotiations may need to occur between community agencies such as **headspace** and the Early Psychosis service regarding referrals after the UHR tenure of care or those young people not accepted into UHR care
- Access to and use of UHR resources and manuals

Introduction

The onset of psychosis is characteristically preceded by symptoms that include depressed mood, anxiety, irritability and aggressive behaviour, suicidal ideation and attempts and substance use, as well as subtle subjective deficits, including cognitive, affective and social disturbances (Yung & McGorry, 1996). Further, there may also be the presence of attenuated or subthreshold psychotic-like symptoms, such as overvalued ideas and perceptual disturbances, as well as deterioration in functioning and behavioural symptoms. However, there is evidence that attenuated psychotic symptoms occur in the general public without a transition to psychosis (Tien & Anthony, 1990; van Os, 2003; Verdoux & Cougnard, 2006)and so developing specific criteria to differentiate between normal human experience and psychopathology with a view to predicting those who will go onto develop a psychosis if left untreated has been a major challenge.

Nevertheless, this challenge has been met with the development of the criteria to identify the subgroup of people who are at risk of developing a psychotic disorder. These UHR criteria (Yung & McGorry, 1996) have made it possible to detect and engage a subset of young people presenting with demonstrable clinical needs who were at incipient risk for frank psychotic disorder. Early research into the rate of transition to full-threshold psychotic disorder within 12 months was approximately 35% (Yung et al., 2003, 2004), a rate 400 times greater than the expected incidence rate for first-episode psychosis in the general population. Although there remains incidence of 'false positives', the criteria have been validated in a number of studies (Yung et al., 2003; Cannon et al., 2008; Woods, et al., 2009).

As well as creating a level of symptomatic distress for young people, emphasising the need to intervene, this UHR stage of psychosis is correlated with functional decline (Crumlish & Whitty, 2009). Meta-analysis has shown that interventions delivered at this stage of illness have been shown to be effective at reducing the risk of transition to full threshold psychosis (Preti & Cella, 2010). For those young people who are help-seeking and are experiencing some psychotic-like symptoms and are assessed as being of high risk of psychosis but as not meeting the diagnostic threshold for a first episode of psychosis, EPPIC facilitates access to a separate, but linked, stream of care.

The UHR Stream of Care

The UHR stream of care provides stage-appropriate, evidence-based interventions and is an essential core component in the EPPIC model. Interventions provided in this component aim to (i) minimise disability and the adverse health and social impacts associated with this phase; (ii) enable recovery before symptoms and poor functioning become entrenched, and (iii) prevent, delay or ameliorate the onset of full-threshold psychotic disorders.

With the development of an Early Psychosis service it will enable a separate stream of care, defined by having separate evidence-based intake criteria than for FEP, access to interventions that have a different focus to those for FEP, a different tenure of care to FEP (such as up to 7 months) and that are delivered by a separate team. (Refer to the intake criteria described earlier.)

For those young people who are engaged in the UHR stream of care and transition to a first episode of psychosis at the 7 month point despite UHR interventions, then a 2 year tenure of care starts with the EPPIC team and a new case manager. Those young people who do not transition to FEP by 7 months, but who still need further care, should be referred to **headspace** centres or other appropriate community services.

Referrals for the UHR stream of care are taken initially by the Early Psychosis triage where all young people will receive a brief screen with the PQ-16 (Leowy RL ea 2005), as this is the best way to highlight potential UHR young people. Referral should then be made to the EPACT team, who will then complete a comprehensive, specialist assessment utilising the validated CAARMS tool (Yung et al., 2005) to determine that the young person is at the UHR stage and meets the criteria for acceptance into the UHR stream. Where there is question over the clarity of the UHR assessment a consultant psychiatrist from the EPACT team should provide a face-to-face review. (See the EPPIC intake flow chart.)

If the criteria for UHR are met the young person is sent to the UHR team leader, who then allocates them within the team. All young people referred to the UHR stream of care are allocated a case manager and psychiatry registrar (with consultant psychiatrist supervision) or consultant psychiatrist for the whole tenure of care. Case managers are from the multidisciplinary team, including clinical psychologists, nurses, social workers and occupational therapists.

Case managers collaboratively plan and coordinate care with young people and their families, as well as provide tailored psychosocial interventions to meet the needs of the young person and their family, based on a case formulation approach. Young people have access to all other appropriate core components of the EPPIC model program, which supports an integrated approach to treatment with a comprehensive range of psychosocial interventions and pharmacotherapy. As evidence points to a functional decline in this stage of illness, individual work with the case manager to address this is important, as is access to other components within the EPPIC model. This may include referral to the vocational or education consultants or group program for more specialist intervention to promote or maintain functional recovery.

CBT is the main psychological intervention approach taken, and has been shown to be effective (Morrison et al., 2004; Bechdolf et al., 2007), with reductions in transition rates and psychiatric symptoms. The EPPIC model uses a stress-vulnerability framework and suggests a modular approach to CBT interventions which have five foci: stress management, positive symptoms, depression/negative symptoms, basic symptoms and other comorbity.

Pharmacological interventions follow the latest Australian Clinical Guidelines for Early Psychosis. Medication is generally restricted to treating comorbid conditions such as anxiety disorders or depression, particularly as these conditions may be the source of attenuated psychotic phenomena. Omega-3 fatty acids have also been shown to be effective in preventing or delaying transition to psychosis in one promising study, which needs replication (Amminger et al., 2010).

For more in-depth information on the full range of interventions for the UHR component, please see The PACE Clinic Manual: A treatment approach for young people at ultra high risk of psychosis, available at http://oyh.org.au/online-store.

Challenges and Solutions

One of the main challenges in developing an UHR of psychosis stream of care for young people relates to the availability of knowledge and expertise in the topic area. Incorporating detection and interventions into a secondary or tertiary mental health service for the UHR population is a relatively new concept. Typically, in traditional existing services, this subgroup of young people will often have missed out on interventions due to a lack of knowledge and understanding of the concept in general. Often, they would be deemed as being ‘too well for service’ with comorbid conditions then left untreated and a number only being picked up by services some time after a transition to full threshold psychosis has occurred. Therefore it is important to have a culture of early detection and intervention embedded throughout the whole service, guided by service leadership who have knowledge and expertise in the field. The role of the community awareness and education staff can also help in education and promoting the UHR stream so that young people are not overlooked.

Another challenge relates to the identification of which stage of psychosis young people are at, not only for the initial assessment, but also throughout the episode of care. Consideration of whether someone is in the UHR stage of psychosis requires a comprehensive biopsychosocial assessment as well as the completion of a validated measure such as the CAARMS (Yung et al., 2005), which is a specialist tool for measurement and requires training beyond the usual health professional education. Further, the assessment and engagement of young people requires particular skills and knowledge in order to gather information and history appropriately. Similarly, challenges may occur in identifying those young people who have transitioned to psychosis while in the UHR stream of care. Maintaining consistency in the determination of what stage of psychosis the young person is at (including the UHR stage or transition to full psychosis) is essential across the whole-of-service and particularly in the UHR stream of care.

The PQ-16 screen at the telephone triage/intake level helps with reducing missed cases (false negatives) and reduces false positives.

Linked to this is the challenge of clinicians sitting with the uncertainty of diagnosis and stage of illness. As this may sometimes take time to establish, a level of patience with this determination is important while still meeting the needs of the young person and providing quality care as the assessment progresses. Team acknowledgement and support around this issue is important, as is the environment to robustly discuss presentations on a case-by-case basis as a team in clinical review meetings.

Access to, and support for, workforce development activities for clinicians are vital in this instance in order to not only develop the necessary knowledge and skills but to assist in embedding knowledge learned into consistent practice. As well as developing the required clinical core competencies in working with young people at risk of psychosis (and those who have experienced a first episode of psychosis) through training and education activities, clinical training in assessment tools such as the CAARMS is vital. Consistency of determination of stage of illness across the service can also be gained by regular clinical review meetings where clinical presentations are discussed with the broader multidisciplinary team and by ensuring that clinicians have access to regular clinical supervision from more experienced and knowledgeable staff members.

The UHR core component has a clear rationale and evidence base for its inclusion as an essential part of an early psychosis service. There is flexibility within the model to deliver a comprehensive range of interventions to meet the needs of young people and their families and fit in with service design. The challenges that arise are surmountable and present an opportunity to provide a quality core component of an early psychosis service which reduces distress of young people, maintains the normal developmental trajectory and potentially minimises the risk of transition to a more serious mental illness. A UHR stream and embedding the EPPIC model within the Early Psychosis service is effectively destigmatising early psychosis as a whole.

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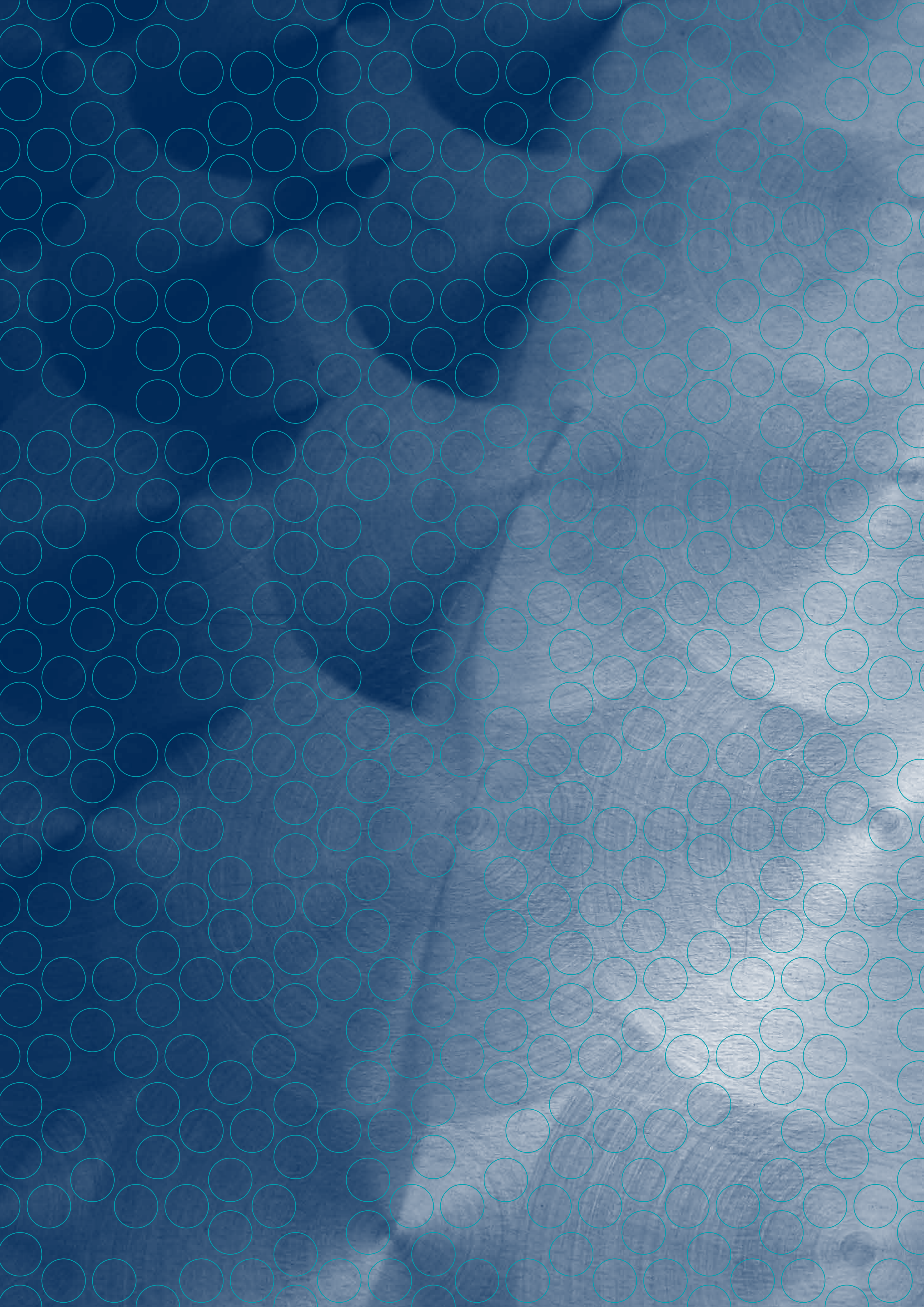


1.4

Clinical Practice Examples of the EPPIC Model by Core Components

Jack and the EPPIC model

Clinical Background Information

Jack is an 18-year-old male, living with his mother and 14-year-old sister. Jack's father was an alcoholic and died from health-related illnesses when Jack was 12 years of age. The father's brother lives next door to the family home.

Jack had a normal birth and met all developmental milestones. He was seen as a shy and quiet child; however, he always got on well with his peers. Jack attended the local high school and was an average student. In Year 11 he started to socialise with a new peer group whom his mother was not happy about, feeling they were not a good influence on him. Jack started intermittent marijuana use and drinking alcohol and started to have poor school attendance on occasions. However, he managed to get through Year 12 and obtain his VCE.

After finishing school Jack commenced labouring work with his uncle, who was in the building trade. He also moved into a bungalow at the back of his mother's home to be more independent. However after six months of working, the uncle's business collapsed due to financial pressures and Jack became unemployed.

Around this time Jack's mother noticed that he was becoming increasingly moody and withdrawn. He rarely socialised with friends, was often alone watching TV, he commenced daily marijuana use and his self-care became poor. Any expression of concern by his mother meant Jack retreated further, taking his evening meal into the bungalow and no longer sharing family meals.

Jack's mother had seen a program on television about young people's mental health which had discussed uncharacteristic changes and she wondered if this might be the same for Jack. Despite initial resistance, Jack agreed to go with his mother to get a check-up from his local general practitioner.

Community Awareness and Education

On presentation the general practitioner noticed that Jack appeared to have blunt affect and poor concentration; he gave vague responses and was making some unusual statements such as 'the news will show it all'. The initial thinking by the doctor was that Jack was suffering some depressive symptoms in the context of drug use and recent stressor of losing his employment.

The community awareness and education worker had recently been to the GP clinic and had left some brochures on the EPPIC service. The worker had also given a presentation on youth mental health at the local GP network meeting which a colleague had attended and spoken to the GP about. So the GP obtained further assessment information from Jack and felt that the EPPIC service may be appropriate for him, as he also seemed to be exhibiting some paranoid ideas and had difficulty with his thinking.

Easy Access to Service

The GP spoke to Jack and his mother about a service that was very youth-friendly and could possibly help them. The GP rang the EPPIC service while Jack and his mother were in the office.

The GP rang the 24 hour 7 days per week contact number and spoke to a triage worker. The triage worker obtained some initial information from the GP and Jack agreed to speak with the worker at that time. The triage worker was able to engage with Jack and give him some information about the EPPIC service. After some initial reluctance Jack agreed to meet with a worker from the EPACT team, particularly as they said they could see him at home. The triage worker made a time for the team to see him at home the next day.

EPACT Home-Based Care and Assessment

Jack had found the triage worker friendly, engaging and reasonable to talk to. The triage worker had obtained sufficient information to decide on the need for further assessment of Jack. The triage worker had also explained the service and the role of the EPACT team and that they could visit him at home. Despite Jack's ambivalence he had agreed when he understood he could be seen at home.

On the home visit by two EPACT clinicians Jack engaged further with the staff, who commenced a biopsychosocial and mental state assessment. Jack eventually felt comfortable enough to disclose to them that he was hearing some voices telling him he was stupid and they were stopping him from sleeping. The EPACT clinicians checked the risks with him, his current concerns and behaviours and his beliefs about why this was happening to him. They also spoke to his mother. From the initial assessment they decided that Jack was likely experiencing FEP and gave his mother and Jack some basic information about this and the service.

The EPACT clinicians also assessed, after discussion with Jack and the family, that he was safe to remain at home as his mother was feeling able to care for him and Jack was willing to engage further with the team feeling that they may be able to assist him; even if it was just to be able to improve his sleeping. The clinicians also felt the risks were low at that point as Jack was denying any suicidal or homicidal ideation and was agreeable to treatment. However, they wanted to closely monitor this. Jack and his mother were given the 24-hour contact number, and together with the EPACT clinicians they discussed the likely issues, but remained optimistic regarding recovery, treatment options and again provided further psychoeducation and explanation of the EPPIC service. It was agreed that Jack and his mother would be visited by the EPACT clinician and psychiatric registrar the following day.

In the initial 24 hour period of review by the EPACT team Jack had a 24 hour period free from antipsychotic medication, but had received some medication for sleep and to relieve some of his anxiety. At further visits with the EPACT clinicians, after discussion of the medication options and side effects, Jack had agreed to commence a low dose antipsychotic and physical health checks had commenced. Jack and the family also received a comprehensive psychoeducation pack and the GP had been informed of the outcome of the initial referral.

Streamed Youth-Friendly Inpatient Care

The EPACT team did not feel that Jack required inpatient care and assessed at that time that he could be successfully treated at home. However, this would be closely monitored and inpatient care would be considered if the situation deteriorated and the risks increased, such as Jack having suicidal or homicidal ideas with plan and intent, or if the family were unable to manage and support him at home, or the florid psychotic symptoms were increasing, along with impaired judgement. These are often complex decisions and involve a consideration of a combination of factors; however, as a first step the EPACT team would look at increasing the intensity of home visiting and support to all, including visiting several times a day, instead of an inpatient unit admission. If an inpatient admission was required, the EPACT team would facilitate this.

Continuing Care Case Management: Medical Treatments and Psychological Interventions

After the involvement of the EPACT team where they worked supportively with him in the home setting, Jack and his family were introduced to a continuing care team case manager by the EPACT clinician. This was ten days after initial contact with the service. Initial meetings covered acknowledgement of their situation, the range of concerns by Jack and his family, plus acknowledgement of the impact on all concerned. Psychoeducation was ongoing, with a focus on recovery and the future.

Jack was seen at least twice weekly by his case manager and doctor in the acute phase and there was weekly family contact with an invitation to the family to attend the Family and Friends Information sessions. There was continued psychoeducation, engagement and collaborative treatment planning. Treatment options, progress and Jack-focused goals were all included.

Jack was complying with treatment and his sleep and self-care was improving. Although still present, the voices were slightly lessening in intensity and he was starting to say he wanted to gain a job. His case manager and doctor felt that Jack was engaged, a good rapport and trusting relationship had developed, and Jack felt the medication was assisting him, so he continued to be compliant with this. He understood the treatment options and plans and was starting to feel hopeful and optimistic regarding the recovery process.

Jack also wanted to understand how to manage his symptoms and felt comfortable enough to ask more questions and to discuss further. There was also a focus by him and his case manager on stress reduction work and the role of drug use in his life. He started to look at his own belief systems, his thinking and was gaining insight. Jack engaged in therapeutic work, such as CBT and started utilising distraction techniques for the voices.

There was also a start at looking at relapse prevention strategies for the future and developing safety plans for him. Jack's mother was feeling more relaxed and overall the family were able to continue their support of him, feeling more settled after the initial crisis. Jack was back eating family meals again.

Functional Recovery Programs

Jack's case manager introduced him to the vocational worker as he had a goal to return to work again where he wanted to gain a trade qualification. The vocational worker engaged with Jack, completed an assessment of his goals and needs and began to look at looks at options for him. The vocational worker liaised with his previous employer, his uncle and contacted a trade school. Jack was pleased to find out that he could commence part-time at trade school in a few months when an opening became available. There was continued liaison between Jack, his case manager and the vocational worker about his goals and working towards these.

Intensive Mobile Outreach

Jack would be referred for intensive mobile outreach if he had not been engaging with the service, had not been seeing his case manager or doctor or had not been involved in any of the EPPIC programs, or if the risks had increased for him along with an increase in positive or negative symptoms. Referral would also be made if the families' ability to cope and manage was being placed at risk and there were threats to his living situation being maintained. If this situation occurred there would be a need for assertive engagement and follow-up by an intensive mobile outreach clinician. Jack did not need this service.

Group Program

The case manager felt that Jack was recovering; however, in order to continue to support this and to help with the transition to work in the future they suggested to Jack that he look at the group program. The case manager introduced Jack to the program and he attended an introduction session and met a key worker. Together they reviewed his goals and strengths and the range of groups available. Jack decided to start with attending the catering group and this meets his goals of socialising and a future work focus. His family are very keen and supportive of this. The key worker supports Jack throughout his time in the group program and reviews his progress or changes in his needs or goals. There is good liaison between Jack, the case manager and the key worker.

Family Work and Family Peer Support

Initially the EPACT team met with Jack's family, which included his mother, sister and uncle, and this also occurred when the case manager and doctor became involved. Particular support was offered to his mother who needed to debrief and discuss her worries, as well as understand better what was occurring and how the service could assist. She also wanted to understand how to best assist Jack herself. The family also attended the Family and Friends Information sessions.

Of particular benefit to Jack's mother was when she was contacted by a family peer support worker as she found it very helpful and a great relief to talk to another parent who had been through a similar experience. She could discuss everything that had happened and her worries about the future, along with her concern over the impact of Jack's illness on his sister.

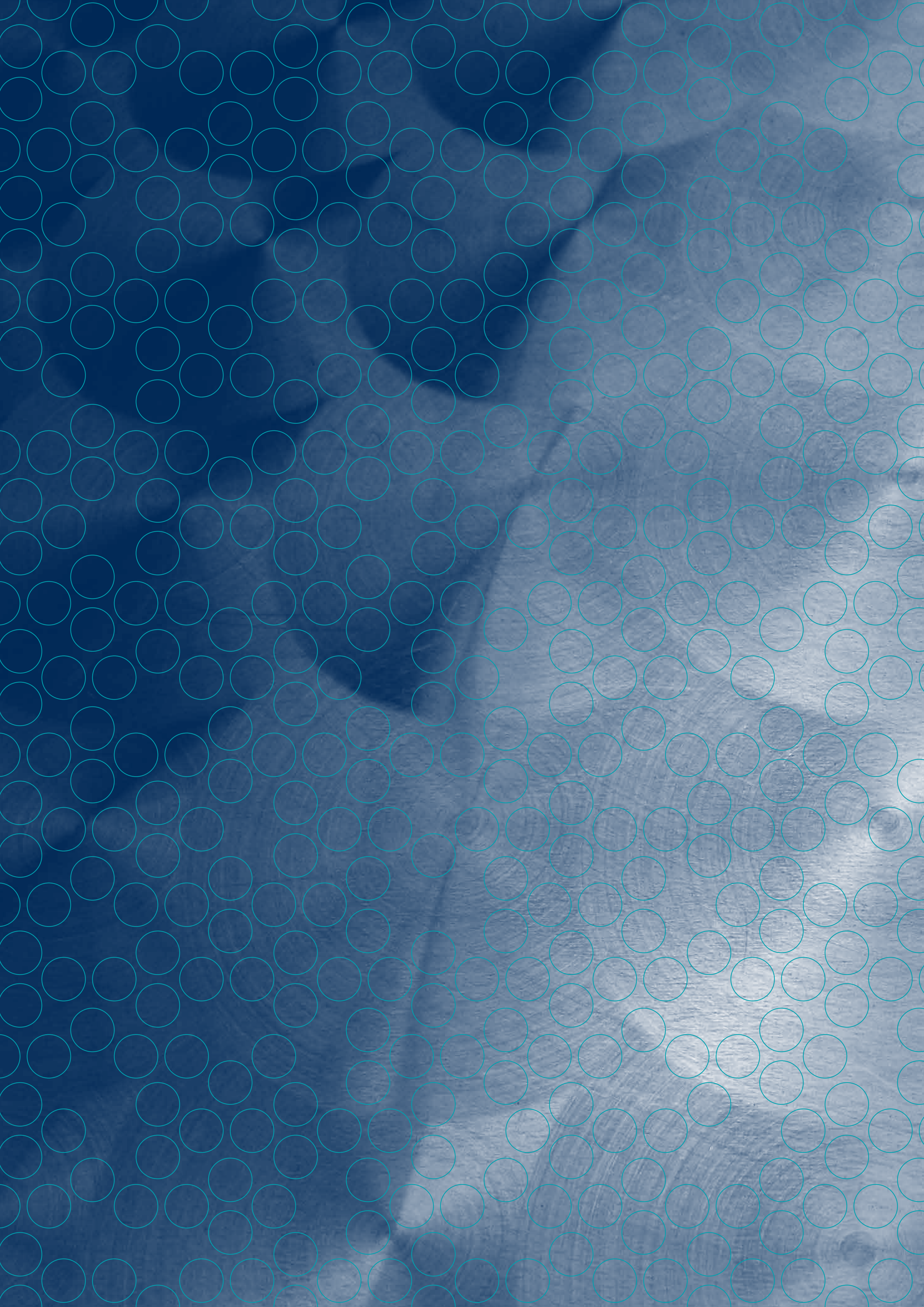
Despite Jack and the family feeling that everything was improving it became clear to the case manager that there were some communication issues between them and fears about Jack continuing his drug use. The case manager spoke with the EPPIC family worker to consult about the situation and it was seen that the family may benefit from some brief family work sessions to 'clear the air' and discuss issues in a contained manner. All agreed to this, so the family worker and case manager met with all the family members together to clarify work on the issues. Despite initial reluctance by the family, due to feeling it could make everything worse, after a couple of sessions, they felt more supported and united, with a greater sense of hope for the future and improved understanding and communication with each other. The family worker involvement ceased at this time and the case manager and family continued with working on maintaining the improvements. The case manager was also focusing on working with Jack around issues of drug use.

Youth Participation and Peer Support

While waiting in the reception area to see his case manager Jack noticed a poster about youth participation and peer support workers available in the service. His case manager also has spoken to him about the peer support worker and he felt it would be good to talk to someone about their experiences when experiencing a psychotic episode. Subsequent discussions with a peer support worker allowed Jack to feel he was not as alone, as he understood that other young people have had similar experiences and have recovered, so it gave him an increased sense of hope and motivation about his future and recovery overall.

The Future

While Jack's EPPIC journey is to continue and he may have some ups and downs along the way, he had begun to have an increased sense of hope and belief that recovery can occur. The intensity of the service provision to him and his family and the comprehensive range of programs available to him also allowed him to think further about his own needs and future in a very supportive environment.



1.5

Clinical Practice Example of Ultra High Risk Detection and Care

Krista and Ultra High Risk

Clinical Background

Krista is a 15-year-old female living with her mother, father and 25-year-old sister. Her mother has had a past diagnosis of schizophrenia and treatment for several years from the local Area Mental Health Service, including several hospitalisations when she was in her early 20s; however, she has remained stable for many years with ongoing medication and support initially from a private psychiatrist and then from the local general practitioner.

Krista is in Year 9 at the local state high school. Over the past three months her grades have dropped significantly where she was previously a straight A student and now regularly misses 2–3 days per week, which she says is due to fatigue. She has also started being more isolative and only on rare occasions seeing her friends. Krista has been encouraged by her teachers and family to see the school counsellor, which she has complied with. She had informed the school counsellor that she had heard voices recently on a couple of occasions.

Ultra High Risk Referral

The school counsellor became concerned about the information that Krista was providing to her and her presentation, where she seemed depressed. The school counsellor spoke to Krista about a service that may be able to help her further and Krista agreed for the school counsellor to call the service while she was present. The school counsellor rang the 24 hour, 7 days per week triage contact number and spoke to a triage worker at headspace about her concerns regarding Krista.

After speaking initially to the school counsellor, the triage worker spoke directly to Krista. During the conversation, while developing rapport and engaging with Krista, the triage worker was able to gain further information. Krista's mood did seem to be somewhat depressed and she was finding it difficult to attend school and study. As well, she described hearing voices approximately twice a week for half an hour each time for the past few weeks telling her to hurt herself, such as by cutting herself. She had not acted on these but was fearful she may do so. The triage worker completed a specific screening questionnaire with her, such as the PQ-16, and felt she needed further assessment, with it being likely she would meet criteria for the UHR program. The triage worker also took note of the mother's diagnosis and Krista's apparent recent decline in functioning. An assessment appointment was made with Krista and she gave permission for her family to be contacted about this.

On assessment at the UHR program and utilising the CAARMS scale questionnaire, it became apparent that Krista was very frightened that she would have schizophrenia, just like her mother. She described that while her mother had been stable for a long time, the family still experienced strange behaviour from her at times and the family had adapted to this over the years. Krista also had become conscious of this after her friends made negative comments about her mother and felt embarrassed and fearful of her own future, leading her to remove herself from friends and to be less communicative with her family. She also exhibited some depressive symptoms and felt little hope for her future.

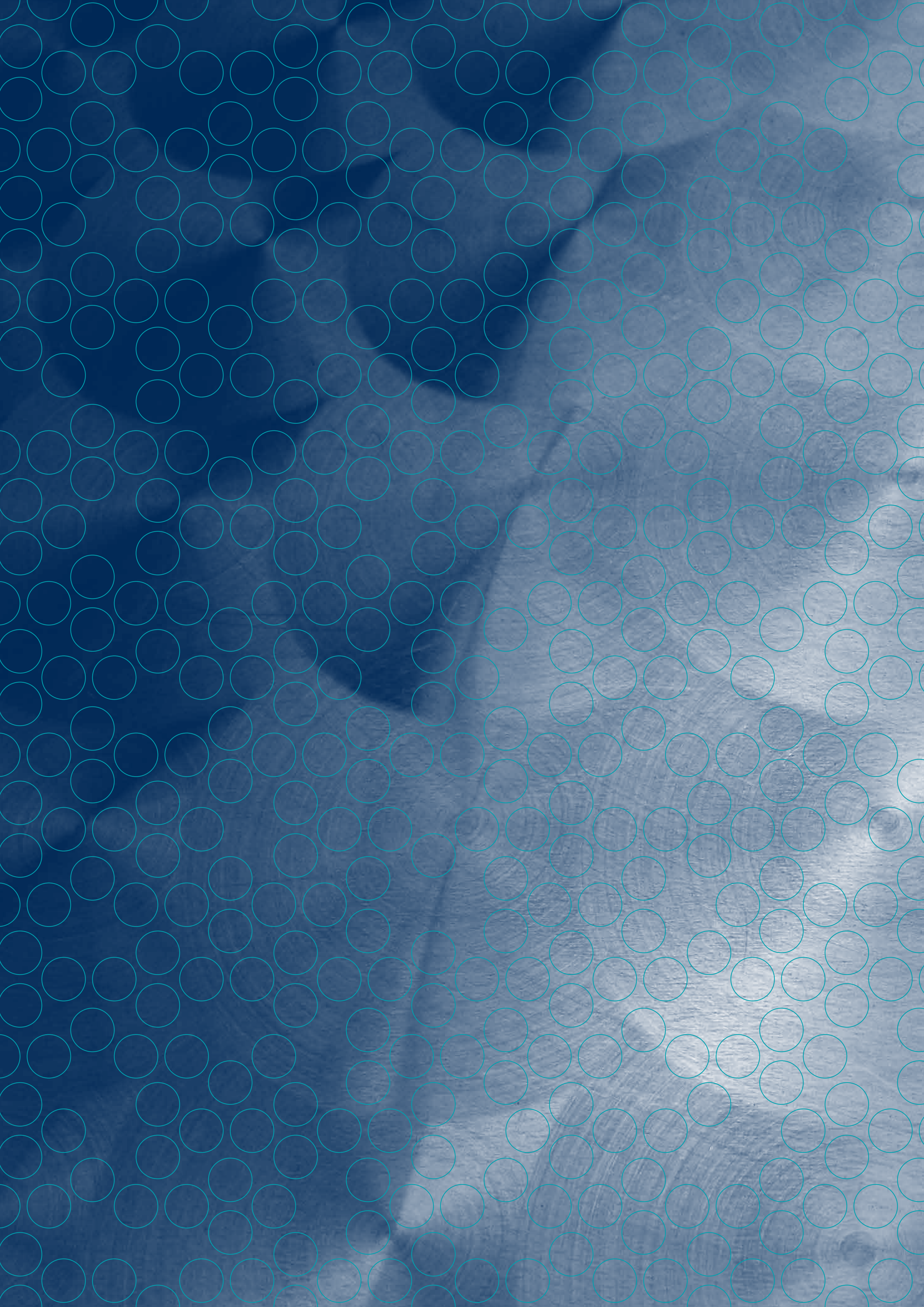
Krista started work with her case manager and in several individual sessions they worked on identifying her fears and beliefs, as well as her current adolescent struggles about her own identity. A cognitive behavioural therapy approach was taken. Through this process it became clear that Krista's sister had always been a strong support to her but this had also recently lessened as her sister was facing her own grief at a relationship break-up.

The family were concerned about Krista and she usually did feel loved and supported in the family. A family session was conducted to clarify the concerns of all members and to look at the family strengths that could be further supported. During this session Krista was able to start to tell the family about some of her worries and the importance of her sister's relationship with her, but also the concern she had that her sister was not coping well. An increase in communication was able to be commenced and some expression of relief was able to be given by all.

The case manager felt that some separate counselling for her sister may be helpful and with her agreement this was arranged for her. Some combined sessions with Krista and her sister were also undertaken where Krista learned about her sister having similar feelings when she was her age and had also been fearful she would have a long-term chronic mental health condition like the mother. They also worked out some ways to manage these concerns. Together, they were able to talk about how they both coped and managed with the situation at home and Krista found her sister was able to be more supportive of her.

Krista attended the UHR program for six months, continuing with individual therapeutic work, including several joint sessions with her sister, and one further family session. During this time she had no further voices, her mood improved, she was able to attend school more regularly and her grades started to improve. She was able to look at her own fears and anxieties, to utilise stress management strategies and found relief in being able to explain her concerns to her family, which resulted in greater support, particularly from her sister. Her sister encouraged her to have her friends visit the home and her sister was at home during these times to be an added support.

Krista ceased her attendance at the UHR group after the six months, but continued to link in with the school counsellor as needed. She displayed no further signs of psychotic symptoms and was back on track for meeting her study and friendship goals, with a more hopeful attitude to the future.



1.6
Standards and Guidelines

The following standards and guidelines are divided into three sections. The first group of standards are the minimum standards; they are the 'givens', which means that they are essential and that without them there can be no EPPIC model. They are the non–negotiable components and hence crucial to the overall service delivery. They cover domains of service delivery and clinical care and there is a strong expectation that these will be adhered to.

The second group of standards are seen as the secondary standards that need to be achieved. These are very important requirements and elements of the EPPIC model that need to be provided in an EPPIC service and will enhance fidelity to the model. Along with the minimum standards, the secondary standards should be monitored to ensure success in the implementation of the EPPIC model and to achieve fidelity to the model.

The third group are a selection of critical guidelines that will further assist in the direct clinical work and service provision. They include guidelines from the Australian Guidelines for Early Psychosis (2nd edition) and it is an expectation that clinicians will work to them.

Introduction

Minimum standards are a useful blueprint on which to develop services and assist in guiding optimal care, quality improvement and evaluation. Further, they inform young people about what to expect from the service as well as providing a tool for meaningful youth and family participation in service improvement processes.

The following standards establish the minimum expectations of all EPPIC services in the delivery of the core components, which are described in detail elsewhere. Delivery of these minimum and secondary standards of care aims to ensure that each EPPIC is a youth-friendly early intervention service that delivers comprehensive, high quality, evidence-based treatment that supports recovery.

Whether an EPPIC service is providing the direct service delivery of core components from within one central site, a 'hub and spoke' model, or from a developed network of partnerships, all EPPIC programs should subscribe to the standards contained in this document. As some EPPIC services may scale up over time it is recommended that each EPPIC service follows these standards during the implementation process as a way to ensure fidelity to the model of core components and achieve the best outcomes for young people. The standards will also be reflected in the EPPIC development of policies, procedures, service development protocols and assist in identifying any program service strengths, gaps or weaknesses.

These standards are not meant to replicate standards for mental health services, but are intended to be more specific to early psychosis and EPPIC services. Therefore some global standards such as services providing care that is sensitive to young people and their families from all cultural and linguistically diverse backgrounds and ensuring that the service provides information in their own language using interpreters as required, are taken as given and not replicated here.

The minimum and secondary standards are listed under each core component. Recommendations from the Australian Clinical Guidelines for Early Psychosis (2nd edition) have also been added to each section where they relate to a core component or adapted to reflect the service at the local level and are noted by Footnote[1]; see the section overleaf on recommended evidence grading.

The standards have been based on a review of the evidence-based literature in early psychosis, localised expert knowledge of the EPPIC service in Melbourne and direct consultation with an expert panel. (See the list of contributors and expert panel members).

Definitions

Please see the Glossary for a detailed explanation of the terms and abbreviations used; however, in brief, for the purpose of this document ‘family’ refers to who the young person views as such and may include parents, siblings, friends or significant others who play a strong role in the young person’s life. ‘Entry to the service’ means after a young person meets the initial criteria for UHR or FEP and following an assessment, acceptance into the EPPIC program will occur in order to commence treatment.

Evidence Grading

Please see the Australian Clinical Guidelines for Early Psychosis (2nd edition) for a detailed explanation of levels of evidence ratings (National Health and Medical Research Council 1998) and the NHMRC (National Health and Medical Research Council) grades of recommendations. These recommendations take into account not only the evidence base (quantity and quality), but also the consistency of findings constituting the evidence base, the clinical impact of findings, the generalisability of findings to all those to whom the guidelines are likely to be applied, and their applicability to the Australian health care context.[1]

Also noted in the Australian Clinical Guidelines Early Psychosis is that evidence does not always exist regarding all domains of treatment in early psychosis, and the absence of this evidence does not necessarily mean that practices or interventions are ineffective. In the absence of any evidence base, guidelines that reflect good practice according to expert consensus are given the designation GPP (Good Practice Point).

References

Early Psychosis Writing Group (2010). Australian Clinical Guidelines for Early Psychosis (2nd edition), Orygen Youth Health, Melbourne, p. 14.

Please note:

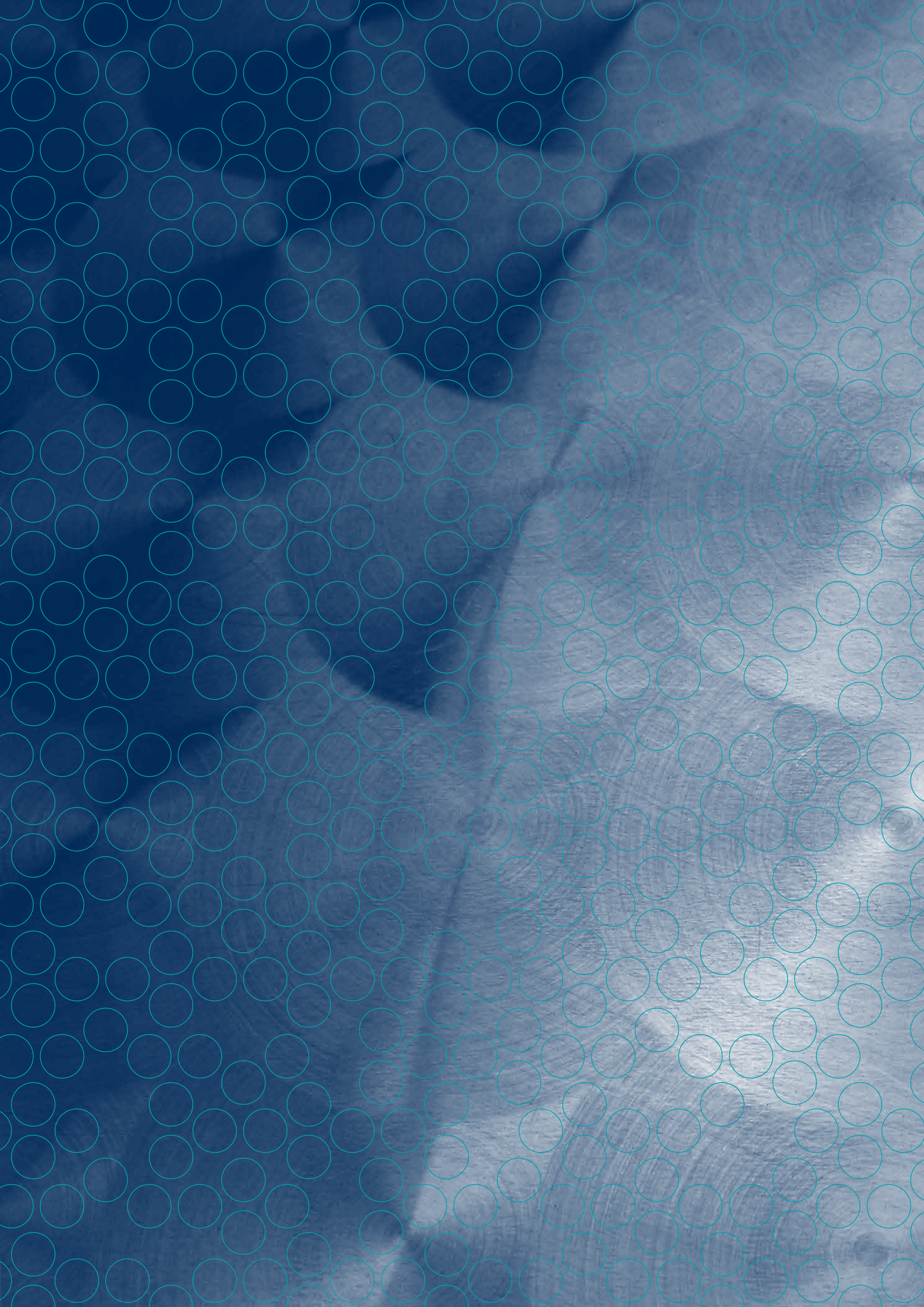
in the Standards Footnote 1 (Footnote 1) refers to:

- Local word adaption of the Australian Clinical Guidelines for Early Psychosis (2nd edition) for the EPPIC service.

Organisational Service-Wide Elements

For an EPPIC service to be established, the following organisational service-wide elements are intrinsically in place. It is important to note these when implementing the EPPIC model:

- There is a distinct and independent operational and clinical leadership team in place that has a track record and expert knowledge of early psychosis service provision.
- There is a setting and a range of activities in place to develop a youth-friendly and early intervention culture within the EPPIC service.
- The required infrastructure is in place, for example, a fully functional physical site, vehicles, mobile phones, access to computers that support best practice.
- The EPPIC service employs clinical staff who are involved in assessment and planning who come from professional backgrounds including psychiatry, psychology, nursing, social work and occupational therapy and who are registered with their professional bodies.
- The EPPIC service is adequately staffed to match caseloads sizes according to the Orygen Youth Health Research Centre modelling tool.
- There are clearly defined clinical pathways in place that support best practice.
- There are clear intake criteria into the EPPIC service.
- There is evidence of each of the essential core components being in place at the point of commencement of the EPPIC service, with the exception of sub–acute beds, family peer support workers and youth peer support workers. At the end of the second year of operation for the EPPIC service all 16 core components are established.



Standards

FIRST GROUP: MINIMUM STANDARDS AS THE ESSENTIAL ELEMENTS OF THE EPPIC SERVICE

The following group of standards are the minimum standards that are the essential elements of the EPPIC service. An EPPIC service must have these standards in place in order to implement the model and provide a service, so they are the minimum essential non-negotiable standards.

Community Education and Awareness

1.1 There is a designated community education and awareness worker.

1.2 The community education and awareness worker provides education about early intervention to primary carers and the wider community to increase knowledge and reduce stigma, with primary care professionals trained in identifying psychosis and given information about how to refer to specialist services. These awareness and education activities should be provided on a regular and frequent basis to staff such as teachers, youth workers, counsellors, general practitioners and police.

Easy Access to Service

2.1 EPPIC services are accessible 24 hours/day, 7 days/week and provide a timely assessment for people experiencing their first episode of psychosis.[GPP Footnote 1]

2.2 Early detection of psychosis is enabled by the EPPIC service receiving referrals from any source and having a clear referral pathway with one clear telephone contact point.

2.3 The EPPIC service is located in a youth-friendly setting, such as close to public transport and contains a welcoming reception area.

2.4 A low threshold for expert assessment is set for any person suspected of developing a psychotic disorder for the first time.[GPP Footnote 1]

Home-Based Care and Assessment (EPACT)

3.1 An EPPIC EPACT team clinician conducts a face-to-face assessment of a young person within 24 hours of an accepted referral, in the least restrictive manner at a place convenient for the young person and their family.

3.2 All young people have a comprehensive biopsychosocial assessment by the acute treating team. This includes developing an understanding of the personal context of their illness and developing a case formulation; a mental state examination; physical examination and investigations; cognitive assessments; assessment for comorbid disorders and a risk assessment.[GPP Footnote 1]

3.3 An EPPIC EPACT team clinician informs the referrer of the outcome of the initial assessment within 48 hours.[GPP Footnote 1]

3.4 An EPPIC EPACT team clinician notifies the young person's general practitioner of their contact with the EPPIC service within 48 hours after entry to the EPPIC program and provides feedback of the assessment to the young person and, with consent, to any other key supports.[GPP Footnote 1]

3.5 An EPPIC EPACT team clinician provides to all young people and their families written and verbal information regarding their rights and responsibilities, and provides access to the feedback and complaint process at the first face-to-face clinical contact and as part of an EPPIC information pack.

3.6 The EPPIC EPACT team provides community treatment as home-based care where young people are not only assessed, but treated and supported in their own environment.

Access to Streamed Youth-Friendly Inpatient Care

4.1 There is access to designated inpatient care for young people in a youth-friendly environment.

4.2 The EPPIC inpatient unit has policies and procedures that optimise clinical practice so that this care is provided in the least restrictive manner.

Access to Youth-Friendly Sub-Acute Beds

5.1 An EPPIC service provides access to a designated youth-friendly sub-acute setting for young people.

Continuing Care Case Management

6.1 The EPPIC service has a designated multidisciplinary continuing care case management team.

6.2 An EPPIC service will designate a senior clinician to allocate new referrals to a case manager and a doctor within 48 hours after referral to the continuing care case management service.

6.3 An EPPIC continuing care case manager and a designated doctor undertake and document risk assessments at each young person's appointment, and this is done in collaboration with the young person and their family.

6.4 The EPPIC continuing care team consultant psychiatrist is informed immediately of any young person identified as being at high risk of suicide or a homicidal risk.

6.5 Both the EPPIC continuing care case manager and doctor meet with the young person and, where possible, the family, and develop an individual treatment plan within four to six weeks after entry to the service, and include collaborative goal-focused treatment.[GPP Footnote 1]

6.6 Treatment response and adherence are regularly reviewed. All young people are seen at least twice weekly in the acute phase and at least weekly by a case manager (or EPACT clinician) and at least fortnightly by a doctor in the early recovery phase.[GPP

6.7 The possibility of relapse is discussed with young people and families along with education regarding early warning signs, and there is development of a relapse action plan.GPP

6.8 Young people with persisting positive or negative symptoms are identified at the three month point of care and on an ongoing basis.GPP

6.9 All EPPIC young people are linked in with a general practitioner on discharge and the GP is sent a discharge summary.GPP Footnote 1

6.10 An EPPIC continuing care team case manager completes a discharge summary prior to a young person's discharge from the service and the discharge summary is sent to the relevant treatment providers and general practitioner.

Medical Treatments

7.1 After entry to the EPPIC service all young people are seen by a doctor within 48 hours, then at least weekly in the acute phase, fortnightly in the early recovery phase and monthly in the late recovery phase. A consultant psychiatrist reviews the young person within one week after entry to the service.

7.2 All young people within the EPPIC service are assigned to a medical doctor (minimum is a psychiatric registrar) and supervised by a consultant psychiatrist.

7.3 Antipsychotic medication is not used in the first 24–48 hours of treatment in young clients with a first episode of psychosis.GPP

7.4 An EPPIC doctor informs and discusses with a young person the medication options and potential side effects prior to commencing pharmacotherapy.

7.5 Second generation antipsychotics (SGAs) are used in preference to first generation antipsychotics (FGAs).GPP

7.6 The EPPIC has a preventative and proactive approach to monitoring and intervening in physical health issues, particularly related to psychotropic medication side effects.

Psychological Interventions

8.1 An EPPIC service employs a designated senior psychologist.

8.2 The EPPIC service provides a range of evidence-based psychological interventions aimed at promoting recovery and providing comprehensive psychological interventions to young people and their families.

Functional Recovery

9.1 Within the EPPIC service there is a designated vocational consultant utilising the individual placement and support model employed as part of the functional recovery program within the continuing care team.

9.2 Within the EPPIC service there is a designated educational and liaison role (with a teaching background).

9.3 All young people have access to specialist assistance from a defined functional recovery program within the EPPIC service.

9.4 Within the EPPIC group program there are group activities aimed at functional recovery.

Mobile Outreach

10.1 The EPPIC service provides mobile outreach intensive case management for those young people with complex needs.

10.2 Within the EPPIC continuing care service there is clearly documented criteria for the identification of young people who require intensive mobile outreach and a designated system of review of each case.

10.3 Within the EPPIC service there is a system in place to monitor caseloads in line with the EPPIC model requirements. This system should take account of the intensity of individual caseloads.

Group Programs

11.1 Young people have access to a comprehensive group program within the EPPIC service.

Family Programs and Family Peer Support

12.1 A designated specialist family worker is employed in the EPPIC.

12.2 Within the EPPIC service, family peer support workers who have experience of a family member experiencing FEP are employed.

12.3 All families are contacted by an EPPIC clinician as soon as possible, or at least within 48 hours following the initial assessment of the young person, unless there are exceptional clinical reasons why this should not be done.

12.4 Family members are accepted as partners in treatment and care strategies and their needs respected and supported.GPP

12.5 Consumers and families who cannot speak English, or who speak limited English, are able to access professional interpreting and translating services where significant decisions are concerned and where essential information is being communicated.

Youth Participation and Peer Support Program

13.1 Within the EPPIC service there is a designated youth participation coordinator employed within the clinical program.

13.2 Peer support workers operate within the EPPIC service.

Partnerships

14.1 There are service level agreements and/or memorandums of understanding detailing the clear purpose, expectations and outcomes of the service with all partner services and the EPPIC. These are reviewed on a yearly basis.

14.2 Partnerships or co-location with other services are reflected in the EPPIC strategic plan.

Workforce Development

15.1 All EPPIC clinical staff are provided with regular clinical supervision on a fortnightly basis at a minimum.

15.2 Every EPPIC clinician has access to the competency and evidence-based clinical training and multimedia resources provided through the EPPIC National Support Program.

UHR Detection and Care

16.1 The UHR group is provided by a separate stream of care to those with full threshold FEP and may be located outside of the central EPPIC service location.

16.2 Young people in the UHR group have access to the full range of service components, even if the setting may be located outside the rest of the EPPIC service.

16.3 Antipsychotic medication is NOT considered as the first treatment option for UHR. However, if rapid worsening of psychotic symptoms occurs together with significant deterioration in functioning related to these symptoms and an elevated risk to self or others, a low dose atypical antipsychotic may be considered as a time-limited trial only, in conjunction with close monitoring and support. Note this is not justified in the majority of such situations.[GPP]

16.4 The UHR care for young people is for a minimum of six months unless there is transition to full threshold psychosis.

16.5 An EPPIC has transfer procedures for those UHR young people who transition to FEP and for those young people who have completed treatment or who may need referral to other community services.

SECONDARY GROUP OF STANDARDS

The following group of standards are built on from the minimum essential set of standards that an EPPIC service will need to adhere to in order to achieve full fidelity to the model. A selection of the minimum and secondary standards can be measured, which will further ensure the fidelity to the model and that best practice is being achieved for young people. Apart from the minimum essential standards described under the first grouping, an Early Psychosis service needs to be able to implement and meet these secondary standards as they will enhance fidelity to the model.

Community Education and Awareness

1.3 The means to access the service and the hours of operation are promoted and advertised to the community using a multimedia approach.[GPP]

1.4 The EPPIC has a community education and awareness strategic plan that designates which communities and community organisations will receive activities, the frequency of these and the way these are provided.

Easy Access to Service

2.5 Acceptance policies are inclusive of individuals with comorbid disorders such as substance misuse.[GPP]

2.6 Young people who are referred to the EPPIC service, who after assessment do not meet criteria for entry, are actively engaged by the EPACT clinician into a more appropriate service; ideally within three days or as soon as possible once that determination is made.[GPP Footnote1]

Home-Based Care and Assessment (EPACT)

3.7 An EPPIC service has processes in place that optimise continuity of care for young people and their families through shared documentation, clinical review and documented treatment plans.

3.8 An EPPIC EPACT team clinician collaborates with the young person and their family to foster active participation in the assessment and treatment process.

3.9 Mental state examination, assessing signs, symptoms and insight, is aided by an antipsychotic–free period of assessment.[GPP]

3.10 Risk assessment takes into account the fluctuating nature of suicidality in young people and requires regular review and monitoring.[GPP]

3.11 Where possible, informants (particularly referrers, but also other key members of a young person's social networks) are drawn upon as valuable sources of information about the trajectory and nature of the young person's difficulties. Assessment also considers the needs of the family, their knowledge of psychosis, the impact of psychosis on the family, and their strengths and coping resources.[GPP]

3.12 Physical examination, including baseline assessment of metabolic functioning and related lifestyle factors (such as diet and exercise) occurs to rule out an organic basis to illness, guide appropriate treatment, and enable monitoring of side effects. Basic metabolic monitoring is ongoing and includes regular weight and waist circumference measurement.[GPP]

3.13 Risk assessment to self and others is undertaken and documented at each visit, and includes routine assessment of depressive symptoms, hopelessness, suicidal or homicidal intent, aggression, the effect of returning insight, and the role of psychotic features on mood.[GPP]

Access to Streamed Youth-Friendly Inpatient Care

4.3 The use of seclusion (if used at all) is kept to the minimum frequency and duration to meet the treatment aims when managing high risk clients.[GPP]

4.4 The EPPIC inpatient unit provides youth-friendly and developmentally appropriate activities such as social, recreational or vocational-related activities for any young person residing in the unit.

4.5 Treatment within the EPPIC inpatient unit is planned in collaboration with the EPPIC community treating team at the commencement and at regular intervals, at a minimum of weekly clinical case reviews and particularly prior to discharge.

4.6 An EPPIC continuing care team case manager or an EPACT team clinician contacts the young person and their family within 24 hours of discharge from inpatient care to assess risk and monitor mental state.

Access to Youth-Friendly Sub-Acute Beds

5.2 There are developmentally appropriate and phase-based functional activities such as social, vocational or recreational that is available for young people within the EPPIC sub-acute setting, provided by the sub-acute care staff.

5.3 Treatment within the EPPIC sub-acute unit is planned in collaboration with the EPPIC community treating team at regular clinical case reviews involving the whole treating team.

5.4 Prior to discharge there is a meeting to plan ongoing community treatment that involves the ongoing community treating team.

Continuing Care Case Management

6.11 A case manager or treating clinician is allocated to coordinate the treatment and care of the young person throughout the episode of care.GPP

6.12 A comprehensive case formulation is completed by the case manager and/or the treating team within six weeks of entry to the service.GPP

6.13 An EPPIC continuing care team case manager and the designated doctor provide all young people and their families information on treatment options within the first four weeks after entry to the service.GPP

6.14 The EPPIC continuing care case manager regularly reviews the individual treatment plan with the young person during their tenure of care and every three months within the formal clinical review meeting.GPP Footnote 1

6.15 Individual treatment plans routinely include additional treatment goals relevant to substance misuse.GPP

6.16 The EPPIC continuing care team case manager or doctor review and document treatment progress in the medical record for each young person or family appointment by the end of the working day.GPP

6.17 Where a young person is identified as at high risk to self or to others, or scores 5 or higher on the BPRS rating scales for hostility or suicidality, the case manager or doctor commences an immediate risk management plan in collaboration with the young person and family (where possible). This is documented by the continuing care team case manager or doctor in a reasonable time period.

6.18 The EPPIC service will designate a senior clinician who coordinates an organisational system approach to identify those young people with an incomplete recovery within three months of them commencing treatment and provide a mechanism of clinical review by senior clinicians, including a consultant psychiatrist.

6.19 Where a young person has been referred to other EPPIC programs the continuing care team case manager liaises and reviews the treatment progress with the identified staff on a regular basis at least monthly, and again at discharge from these programs. GPP

6.20 Where multiple community services are involved, the EPPIC continuing care team case manager coordinates regular case conferences, at least bi-monthly, with the relevant other services and the young person.GPP

6.21 Community treatment orders are used for the minimum duration required to meet specified treatment goals.GPP

6.22 Involvement of the police to enforce treatment is kept to a minimum and used as a last resort in the case of immediate risk.GPP

6.23 All young people are seen at least fortnightly by a case manager and at least monthly by a doctor during the late recovery phase.GPP

6.24 An EPPIC continuing care team case manager develops and documents a plan with the young person and their family to detect and address early warning signs of relapse with the aim to prevent relapse.

6.25 An EPPIC continuing care team case manager discusses discharge planning with the young person and their family at least three months prior to discharge and documents a specific plan with information and contact details of the identified follow-up services to be given to the young person and their family prior to discharge.

6.26 Prior to discharge, the EPPIC continuing care team case manager assists the young person in orientation and engagement with the future treatment provider, including a visit and clinical handover to the designated clinician, such as a general practitioner, or adult mental health service case manager.

6.27 The treating team assertively liaises with ongoing treatment providers and includes a face-to-face handover as part of the discharge process.GPP

Medical Treatments

7.7 The treating doctor coordinates the relevant medical assessments required as part of the initial and ongoing assessment process.

7.8 Potential side effects(including metabolic side–effects, weight gain, extrapyramidal motor symptoms, and sexual side effects) are noted and discussed with clients prior to commencement of pharmacotherapy, monitored, managed and addressed early, with a prevention model if possible (e.g., weight management strategies implemented prior to treatment initiation).GPP

7.9 Side effect profiles guides choice of SGA.GPP

7.10 Pharmacological (antipsychotic) treatment starts with a 'start low, go slow' approach.GPP

7.11 Adherence is monitored and explicitly addressed where necessary.GPP

7.12 Polypharmacy is avoided, specifically the use of multiple antipsychotics.GPP

7.13 Relapse prevention strategies (including more regular review and provision of information about rapid access to care) are particularly indicated if medication dosages are decreased or medication ceased.GPP

Psychological Interventions

8.3 Engagement is prioritised as the foundation of treatment.GPP

8.4 CBTA, supportive therapyB, or befriendingB is provided during the acute phase, with CBT having the most immediate benefit.

8.5 An EPPIC continuing care team case manager refers a young person with significant cognitive deficits or neurodevelopmental disorders for neuropsychological testing.GPP

Functional Recovery

9.5 Case managers facilitate access to educational and vocational services to the FEPB and pre-onsetGPP groups.

9.6 Employment and educational consultants are integrated within FEP services as much as possible. GPP

9.7 An EPPIC vocational consultant conducts and documents a vocational assessment and develops an individual support plan in collaboration with the young person, their family and the case manager.

Mobile Outreach

10.4 For those young people who require intensive mobile outreach there will be a case review conducted by a consultant psychiatrist in consultation with the case manager at least weekly.

10.5 Intensive treatment is provided during high risk phases of illness.GPP

10.6 Services develop and implement appropriate, evidence-based interventions for deliberate self-harm. The LifeSPAN program is likely to be of some benefit for suicidal clients.

Group Programs

11.2 An EPPIC group program clinician reviews and documents with the young person their participation and progress within four weeks of a young person's entry into the group program. Regular reviews of a young person's progress related to the group program are conducted at least every month, and at discharge from the group program, in conjunction with the EPPIC continuing care team case manager (separate to a comprehensive review every three months).

11.3 Where appropriate, group program staff assists young people in finding meaningful psychosocial activities (such as other groups/activities) external to clinical services.GPP Footnote 1

Family Programs and Family Peer Support

12.6 All families with an EPPIC young person are offered contact with a family peer support worker within one week after entry to the service unless there are exceptional clinical reasons not to do so.

12.7 Family work within the EPPIC is provided to young people and their family on a regular basis and consists of, at a minimum, psychoeducation and regular frequent family meetings relevant to the phase of illness (weekly in the acute phase, bi-monthly in the late recovery phase).

12.8 The level of risk (to self and others), the available resources (including community support) and the needs of the client and family are assessed to determine whether the young person can be managed at home.GPP

12.9 Families with more complex needs, such as those with a history of sexual and/or other abuse or long standing emotional conflict, may need to be referred to specialist agencies.GPP

Youth Participation and Peer Support Program

13.3 The culture of the organisation respects consumers and validates their input.GPP

13.4 All EPPIC young people participation initiatives are jointly planned with the EPPIC youth participation coordinator, workers and young people from the outset, based on the needs and interests of young people and with their input into the EPPIC service planning, delivery, evaluation and decision-making processes.GPP Footnote 1

13.5 The EPPIC youth participation coordinator provides training, supervision and support to peer support workers and conducts regular meetings with peer support workers to look at a range of issues.

Partnerships

14.3 Close links are developed between primary and specialist mental health services to facilitate assessment and treatment of emerging mental illness.GPP

14.4 Clinical staff employed in other services and working under the service level agreement or memorandum of understanding have an understanding of, as well as supervision and training for, the direct clinical work with young people with early psychosis or FEP.

14.5 Clinical staff of partner services complies with the clinical standards for each core component they are providing a service for.

Workforce Development

15.3 Each EPPIC service has policies and resources in place that support ongoing professional development.

15.4 All EPPIC clinical staff comply with the clinical standards for each core component they are providing a service for.

UHR Detection and Care

16.6 In the case of the UHR group, information about the nature of symptoms and the level of risk of transition should be carefully provided within a framework of therapeutic optimism, confirming that progression to psychosis is not predetermined, and that effective and well-tolerated treatments are readily available. The person can be reassured that if a more severe disorder were to develop, treatment would be immediately available and is likely to be very effective.

16.7 The EPPIC has criteria for identifying UHR young people and has a triage process for acceptance for an initial assessment. The PQ-16 screening questionnaire is built in at the telephone triage level.

16.8 All young people assessed within the EPPIC service as being in the UHR group are referred to a specific program for allocation to a case manager and psychiatrist.

SELECTED CLINICAL GUIDELINES: THIRD GROUP

The following section is a selection of critical guidelines including ones from or adapted from the Australian Clinical Guidelines for Early Psychosis (2nd edition). It is an expectation that all clinicians work to the the Australian Clinical Guidelines, and to the following guidelines.

Community Education and Awareness

1.5 Primary health care professionals are competent in eliciting and recognising the clinical features of psychotic disorders.GPP

1.6 Mental health services provide education about early intervention to primary carers and the wider community to increase knowledge and reduce stigma, with primary care professionals trained in identifying psychosis and given information about how to refer to specialist services.C Footnote 1

1.7 Mental health services provide tertiary consultation and education services to health practitioners in rural and remote areas along with early psychosis information readily available at key locations, for example in GP's waiting rooms and community centres.GPP Footnote 1

Easy Access to Service

2.7 The EPPIC service accepts potential new referrals from a wide range of individuals, family and friends, and primary care services. A low threshold for expert assessment is set for any person suspected of developing a psychotic disorder for the first time.GPP Footnote 1

2.8 Upon referral to an EPPIC service the triage clinician provides a service response regarding the status of the referral within 24 hours.

Home-Based Care and Assessment (EPACT Team)

3.14 Assessments occur as soon as practicable after referral, and within 48 hours in the case of a suspected FEP. GPP

3.15 Assessment of a young person in an EPPIC service is an ongoing process that establishes therapeutic engagement and treatment, so rapport is a priority. GPP Footnote1

3.16 Assessment of the personal context of illness includes developing an understanding of the longitudinal course of symptoms and how they are regarded by the young person, and the young person's strengths, resources (including family resources) and skills in managing these symptoms specifically and other stressors more broadly.GPP

3.17 Risk assessment also includes assessment of risk to others, risk attributable to neglect and victimisation by others, and risk of non–adherence to treatment (including absconding).GPP

3.18 Involvement of the police to enforce treatment is kept to a minimum and used as a last resort in the case of immediate risk.GPP

3.19 An EPPIC EPACT team clinician actively arranges and manages any transfers of care of a young person to another clinician within EPPIC programs or community agencies.GPP Footnote1

3.20 Where appropriate, clinicians have access to specialist consultation to provide assessment, supervision, advice or co-management for comorbid treatment of substance misuse (including tobacco use).GPP

3.21 The EPPIC service is accessible 24 hours a day, 7 days a week via the EPACT team offering triage, assessment, community treatment and crisis intervention services.

3.22 An EPPIC EPACT team clinician gives appropriate written, verbal or multimedia psychoeducation to all young people and families within one week of the initial assessment.

3.23 An EPPIC EPACT team clinician provides community-based treatment for any young person and their family referred to them by the continuing care team or the inpatient care based on clinical needs.

Access to Streamed Youth-Friendly Inpatient Care

4.7 Where hospitalisation is required, the young person is admitted to a facility that can cater for, and is appropriate to, the young person's age and stage of illness. Where streaming is not possible, a special section may be created in a general acute unit for young recent-onset clients.GPP

Access to Youth-Friendly Sub-Acute Beds

5.5 A range of treatment settings are available to the young person, including home-based support, supported accommodation, rooming in, outpatient services and inpatient care.GPP

5.6 Where the sub-acute unit is not part of the EPPIC service, the sub-acute staff has access to training regarding working with young people with FEP.

Continuing Care Case Management

6.28 The case manager is present at the young person's doctor appointments to ensure continuity of care.GPP Footnote 1

6.29 The case manager facilitates the person's access to necessary accommodation, vocational, recreational, welfare and primary health services.GPP

6.30 The EPPIC continuing care case manager coordinates regular consultation with the young person's general practitioner at least every six months.GPP Footnote1

6.31 The EPPIC continuing care case manager and the treating doctor are responsible for ensuring access to psychoeducation.GPP Footnote 1

6.32 The material (psychoeducation) is appropriate for young people and for early psychosis.GPP

6.33 Psychoeducation and support is provided for the young person and family on an initial, continuing and 'as needed' basis through individual work, group programs or a family participation program.GPP Footnote 1

6.34 Support is provided to young people and their family specifically around the discharge process.GPP

6.35 Where young people are receiving treatment within a drug treatment service, clinicians actively collaborate and communicate about the individual treatment plan.GPP Footnote 1

6.36 Discharge planning includes attention to ongoing treatment of substance misuse.GPP

6.37 An EPPIC continuing care team case manager actively assists young people to engage in planned activities provided by any other parts of the service or external services.GPP

6.38 All EPPIC young people identified as high risk have access to a more intensive and assertive treatment for as long as required.

6.39 For those young people who require extended tenure of care beyond the two years in the EPPIC service there is an organisational system established, such as a formal clinical team review team to identify and review potential extension of care. The review occurs at least three months prior to the end of the two-year tenure of care. A re-entry system is also required for those young people who may have been discharged at the two-year tenure of care but may still be eligible to return for care up to the further three years of care.

6.40 An EPPIC continuing care case manager formally liaises with the EPACT team or the inpatient care clinician within two working days after formal assignment of the young person to them in order to arrange a handover of care.

6.41 An EPPIC continuing care case manager meets with a young person and reviews the comprehensive biopsychosocial assessment within seven days after allocation to the continuing care team.

6.42 An EPPIC continuing care team case manager who has a young person with drug and alcohol use provides appropriate interventions for the young person along with access to specialist staff as required.

Medical Treatments

7.14 All young people are seen by a doctor within 48 hours after entry to service.GPP

7.15 All young people are seen by a consultant psychiatrist within one week after entry to the service.GPP

7.16 Affective and non-affective psychosis is distinguished to enable appropriate treatment (i.e., appropriateness of use of a mood stabiliser).GPP

7.17 Oral treatment is used except in exceptional circumstances where other efforts to improve adherence have been unsuccessful.GPP

7.18 Benzodiazepines may be a useful short-term adjunct in florid psychosis for sedation.A

7.19 Treatment of the primary psychotic disorder is prioritised unless comorbidity leads to high levels of risk to self/others or clinical judgement considers that the comorbidity has a major impact on the primary psychotic disorder (e.g., acute methamphetamine intoxication).GPP

7.20 Medication is recommenced or increased at early signs of relapse.GPP

7.21 The advantages of maintenance antipsychotic therapy in relapse prevention are weighed against any impact of side effects on functioning.GPP

7.22 Early responses to antipsychotic medication are considered as a prognostic sign.GPP

7.23 Clozapine is strongly considered for those who have not responded to adequate trials of two antipsychotic medications, of which one is a SGA.A

7.24 If a satisfactory response occurs, treatment within the EPPIC services is continued for at least two years.GPP

7.25 Atypical antipsychoticsB, especially clozapineA may be useful for suicidality.

7.26 Clinicians are especially alert to side effects of antipsychotics when working with people from Aboriginal and Torres Strait Islander communities.GPP

7.27 All young people within the EPPIC service are assigned to a medical doctor (minimum is a psychiatric registrar) and supervised by a consultant psychiatrist.

Psychological Interventions

8.6 CBT interventions may be indicated in this group (early recovery), speeding up recovery, reducing hospitalisation[D], enhancing short-term adaption to illness[B], reducing positive symptoms[D] and improving personal goal attainment.[D]

8.7 Combined family and individual CBT specifically focusing on prevention relapse is used.[B]

8.8 CBT is considered as an adjunctive therapy during late/problematic recovery.[GPP]

8.9 Psychoeducation and CBT may help reduce substance use in those in the pre-onset phase[GPP] and with FEP[B].

8.10 Milieu therapy[C], supportive psychodynamic therapy[C] and cognitive remediation therapy[D] may be useful in treating symptoms and/or improving functioning in FEP.

Functional Recovery Program

9.8 Employment services for people with FEP are consistent with an individual placement and support model.[B]

9.9 Given the age group of this population, return to education or training is seen as acceptable vocational outcome.[GPP]

9.10 An EPPIC vocational consultant is an advocate for the young person and liaises directly with community services.[GPP]

Mobile Outreach

Nil

Group Programs

11.4 Group programs are offered to those with FEP[B] and UHR.[GPP]

11.5 Group programs are available in a range of clinical and community settings.[GPP]

11.6 Group programs are tailored to the different needs of young people at different phases of illness.[GPP]

11.7 Decisions about participation in any group program are made collaboratively with the individual, based on an understanding of the potential benefits for that person.[GPP]

11.8 Goals are set collaboratively and progress of participants towards these goals is regularly reviewed.[GPP]

11.9 The development of group programs are based on a thorough planning process which includes needs assessment, the setting of objectives; development of content areas and establishment of evaluation strategies.[GPP]

11.10 There is an effective clinical interface between the group program and the case manager (or treating clinician) or multidisciplinary team.[GPP]

Family Programs and Family Peer Support

12.10 The needs of individual family members are recognised and addressed (where appropriate, within clinical services, or alternatively, by referral to external agencies) at all stages of a person's recovery.[GPP]

12.11 The case manager has frequent contact relevant to the phase of illness and the needs of the young person and family.[GPP]

12.12 All families are seen or contacted at least weekly in the acute phase by the acute treating team or case manager.

12.13 Family attendance and involvement is reviewed as part of the of the clinical review process.[GPP]

12.14 Where necessary the clinician prepares the family to deal with crises.[GPP]

12.15 Family interventions alone may be helpful in preventing relapse in FEP.[C]

12.16 All families are seen or contacted at least every two months by the treating team in the late recovery phase.[GPP]

12.17 Families of young people with a slow or difficult recovery or frequent relapses may benefit from more intensive and structured interventions, emphasising problem-solving and communication skills.[GPP]

12.18 Support is offered to family and friends, including psychoeducation on comorbid mental illness and substance misuse.[GPP]

12.19 Family participation needs strong initial support and facilitation by a staff member involved in family support.[GPP]

12.20 Peer family support workers may be a useful resource for information and emotional support, particularly in situations when the young person does not wish the involvement of their family and carers.[GPP]

12.21 Family Peer Support Workers participating in the service receive some payment, and funding is available to allow family Peer Support Workers to acquire any specialist skills that they may need in their role. Family Peer Support workers also receive ongoing supervision and support from a clinical mentor.[GPP Footnote 1]

12.22 The EPPIC service provides a range of appropriate psychoeducation forums for families.

12.23 An EPPIC specialist family worker provides consultation or more specialist family work for young people and their family with more complex clinical presentations.

Youth Participation and Peer Support Program

13.6 Peer Support Workers participating in the service receive some payment, and funding is available to allow Peer Support Workers to acquire any specialist skills that they may need in their role. Peer Support Workers also receive ongoing supervision and support from a clinical mentor.[GPP Footnote 1]

Partnerships

14.6 Integrated specialist services are more effective than standard services in the treatment of people with FEP[A].

14.7 Indigenous health or mental health practitioners are involved in the assessment and treatment of young indigenous people with emerging psychosis, to facilitate and reduce stigma.[GPP]

14.8 Telepsychiatry and other technological facilities are made available to mental health practitioners in rural and remote areas to facilitate links with early psychosis services. These are not, however, be seen as a replacement for visiting specialists.[GPP]

Workforce Development

15.5 Undergraduate and postgraduate medical education is developed to allow for better training in assessment and treatment of emerging mental illness.[GPP]

15.6 Each EPPIC Service ideally has an established link with tertiary educational institutions.

15.7 The comprehensive biopsychosocial assessment is conducted by appropriately skilled mental health EPPIC clinicians, who have a solid understanding of early intervention and recovery frameworks for FEP young people and the UHR group.

UHR Detection and Care

16.9 Omega-3 fatty acids may prevent or delay transition to psychosis.[B]

16.10 Psychological and, where appropriate, pharmacological treatment of comorbidities is prioritised and consistent with guidelines on these comorbidities. Pharmacological treatment of comorbidity is considered before specific pharmacological treatment of attenuated psychotic phenomena since this comorbidity may be the origin of, or contributing to, the prominence of, attenuated psychotic symptoms.[GPP]

16.11 CBT may reduce psychotic symptomatology and prevent or delay transition to psychosis in the pre-onset phase.[B]

16.12 CBT may improve social functioning in the pre-onset phase.[C]

16.13 Supportive counselling alone may improve social functioning in the pre-onset phase.

16.14 CBT may reduce or obviate the need for antipsychotic medication in the pre-onset phase.[B]

16.15 Young people in the UHR group have access to the full range of service components even if the setting may be located outside the rest of the EPPIC service.

Glossary of Terms

Acute Psychosis Phase: The period when a person is experiencing frank psychotic symptoms (positive or negative symptoms.) It begins when active symptoms commence until the start of treatment.

Biopsychosocial Assessment: An assessment of a young person that aims to be comprehensive by looking at all the domains of biological, psychological (thoughts, emotions and behaviour) and social factors that may impact on health.

Case Manager: The main coordinating clinician and point of contact that a young person works with on all aspects of their treatment and recovery once accepted for continuing care.

Clinical Review: A team meeting of designated multi-disciplinary clinicians and consultant psychiatrist where the clinical progress of a UHR or FEP young person is reviewed covering all facets of the comprehensive care approach.

Cognitive Behaviour Therapy: Therapeutic work based on the assumption that a person's cognitive structures (ways of thinking) shape the way they react to and adapt to situations faced in everyday lives.

Community Treatment: The treatment of a young person within a setting that is based in their place of residence or a community setting that they feel comfortable with.

Comorbidity: The co-occurrence of one or more disorders in the same young person either at the same time or following on from a disorder.

Discharge Planning: Specific process that focuses on considering and preparing the young person for discharge from the service, often linking them to other community services for ongoing care but with a focus on the future.

Early Intervention: Interventions targeting young people displaying the early signs and symptoms of a mental health problem or mental disorder. Early intervention also encompasses the early identification of people suffering from a first episode disorder.

Early Psychosis: While there is no single authoritative definition of 'early psychosis', it clearly has an onset focus. It includes the period described as the prodrome and is also considered to include the critical period up to five years from entry into treatment for the FEP.

Early Psychosis Service: A service or centre based on the EPPIC model that provides a comprehensive specilaist youth mental health service for young people being at Ultra High Risk of Psychosis or experiencing a First Episode Psychosis.

Entry to Service: After a young person meets the initial criteria for UHR and FEP and following an assessment, acceptance into the EPPIC program will occur in order to commence treatment.

EPACT: Refers to the Early Psychosis Assessment and community team of a flexible, mobile, home-based assessment and intervention service. It is a 24-hour, 7-day a week service that offers triage, assessment, home-based community treatment and crisis intervention with an oncall-recall component.

Family: Who the young person views as such and may include parents, siblings, friends or significant others who play a strong role in the young person's life.

First Episode Psychosis: The first onset of psychotic disorder in the lifetime of an individual. In this context it represents the first treated episode of psychosis experienced by an individual in their lifetime.

Functional Recovery: A recovery in which there has been improvement in the young person's practical life skills (social and vocational).

Home-based Care: Assessing and/or treating young people with early psychosis or FEP at home or in their own environment, or a community setting that they are comfortable with.

Individual Treatment Plan: A treatment plan, usually goal-directed, completed collaboratively with the case manager and young person specific to them.

Incomplete Recovery Phase: A phase in which active symptoms and/or functional impairment remains.

Intensive Mobile Outreach: A mobile outreach service for intensive case management for young people who have difficulties engaging with the service, have complex needs, including high risk issues (e.g. violence, offending behaviours, homicidal and suicidal ideation, sexual abuse, homelessness, high self-harm) and may have ongoing positive or negative symptoms or a prolonged recovery.

Negative Psychotic Symptoms: The group of symptoms that are 'negative' in the sense that they remove capacity from the individual. They refer to experiences that should be present, but are absent. (e.g., Amotivation, alogia, blunted affect).

Positive Psychotic Symptoms: The group of symptoms that are 'positive' in the sense that they present in the young person's experience but should be absent. (e.g., hallucinations, delusions, thought disorder)

Polypharmacy: Use of multiple medications.

Psychoeducation: A process of providing information and education on psychosis treatment and recovery for young people and families.

Psychosis: A group of disorders in which there is misinterpretation and misapprehension of the nature of reality as reflected in certain symptoms, particularly disturbances in perception (hallucinations), disturbances of belief and interpretation of the environment(delusions), and disorganised speech patterns(thought disorder).

Recovery: A variable and a non-linear process. Generally defined as an outcome that occurs after an illness at a specific time, more complete than remission, when a young person returns to a healthy or healthier state.

Relapse: Having been in a recovered state the young person again experiences psychotic symptoms, either positive or negative, or the same as from a previous episode or a new presentation of symptoms.

Risk Assessment: The assessment of all biopsychosocial risk factors for the young person such as suicide, self-harm, homicide, vulnerability, impaired judgement, neglect of self or others, treatment non-compliance and absconding from care.

Service Level Agreement: The negotiated contract, or agreement, between an EPPIC service and another organisation to provide a service or part of a service to a young person and/or their family.

Tenure of Care: Length of care an EPPIC will provide.

Ultra High Risk Group: A state in which specific predictive criteria are met in which the young person has an increased chance of developing a psychotic illness. A young person meeting the UHR criteria for developing a psychotic disorder include: those with trait risk factors (vulnerability) and a decrease in functioning; subthreshold psychotic symptoms (attenuated psychotic symptoms); or a recent history of psychotic symptoms that spontaneously resolved (brief limited psychotic symptoms).

Young Person: A description of an age range that overlaps the periods of adolescence and young adulthood. Generally defined between the ages of 15 to 25 years.

List of Abbreviations

CBT: Cognitive Behaviour Therapy
EPPIC: Early Psychosis Prevention and Intervention Centre
FEP: First Episode Psychosis
FGA: First Generation Antipsychotic
GP: General Practitioner
SGA: Second Generation Antipsychotic
UHR: Ultra High Risk Group

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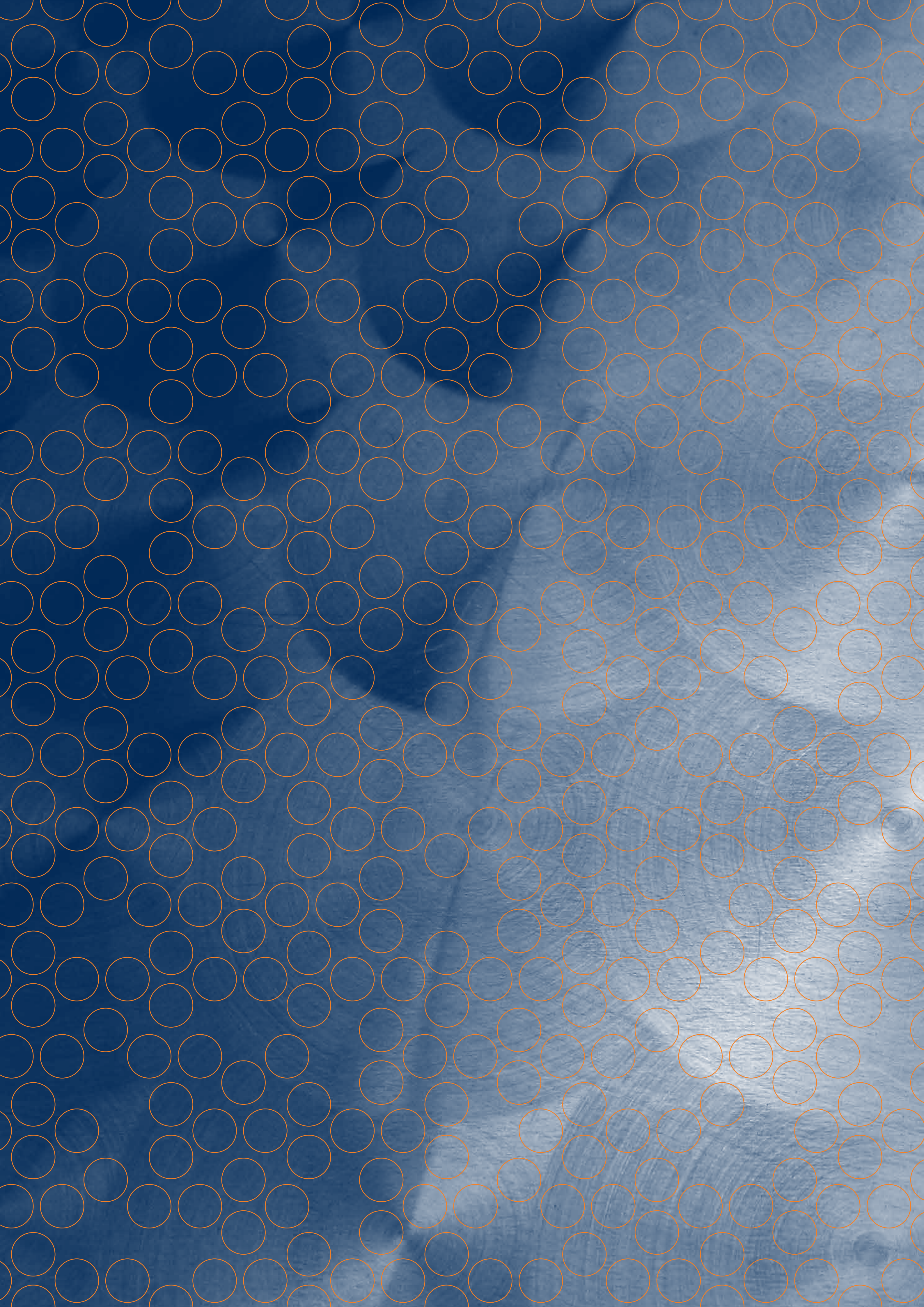


SECTION 2

Establishing and Implementing a New EPPIC Service

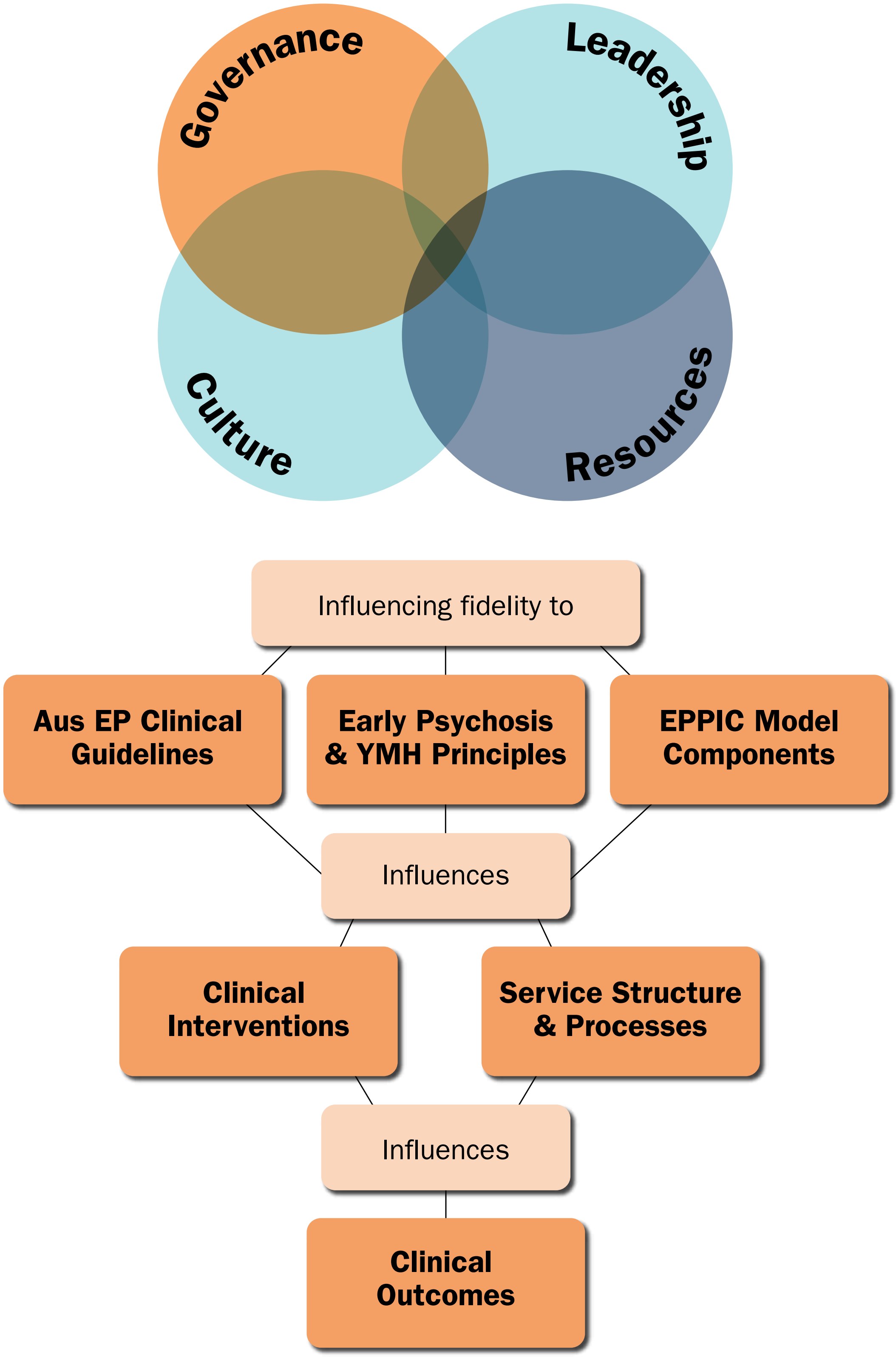
2.1

Critical Factors for Success

Critical Factors in Setting Up and Achieving Success in an EPPIC Service

There are four critical factors that influence transformational change within an organisation. These are **Governance**, **Leadership**, **Culture** and **Resources**. These four critical factors intertwine and are all essential for an EPPIC service to commence and to maintain good quality care (see diagram). The following section describes these critical factors. Further detailed descriptions related to the actual set-up of an EPPIC service and the core components are provided in the other sections.

If an EPPIC service does not pay attention to these four critical factors there will be many challenges to the implementation, sustaining and scaling up of the service. The model of core components will likely end up being quite diffuse and there will be no buffer within the organisation to meet the challenges and retain a comprehensive EPPIC model and service.


Governance
Leadership
Culture
Resources
Influencing fidelity to
Aus EP Clinical Guidelines
Early Psychosis & YMH Principles
EPPIC Model Components
Influences
Clinical Interventions
Service Structure & Processes
Influences
Clinical Outcomes

Clinical governance systems need to be clear and cohesive and can only be supported with good leadership, positive organisational culture and adequate resources.

Governance

In broad terms governance is about building institutions and processes that are accountable, responsive and transparent. Effective governance contributes to achieving developmental goals, it helps with service delivery, helps with partnerships where strengths can be utilised and coherence regarding models of care. Governance allows learning from experience and promotes continuous quality improvement; it focuses on enhancing strategic coherence and is driven by committed leaders. Leadership, the culture of an organisation and resources are all crucial to effective governance.

Both corporate governance and clinical governance are important. The Australian Auditor General has defined corporate governance as 'the processes by which organisations are directed, controlled and held to account. It includes how an organisation is managed, its corporate and administrative structures, its culture, its policies and the way it deals with its various stakeholders. The concept encompasses how public sector organisations acquit their responsibilities of stewardship by being open, accountable and prudent in decision-making, in providing policy advice and in managing and delivery' (Department of Health, 2005).

One of the important issues related to corporate governance for a new EPPIC service will be its independence from other governing structures. Senior management control of financial resourcing is crucial to enable the operationalisation of the service. There have been examples within Australia and internationally where the resources for early psychosis services without clear, independent governance structures have been side-tracked to other parts of an area health network to bolster the status quo.

Within mental health services, governance is often defined as clinical governance yet it is still underpinned by the same strengths as corporate government, such as being rigorous in application, accountable in delivery, developmental and positive. One definition describes clinical governance as a system through which organisations are accountable to continuously improve the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Scally & Donaldson, 1998).

The World Health Organisation (2003) divides quality into four aspects:

- Professional performance (technical quality)
- Resource use (efficient)
- Risk management (the risk of injury or illness associated with the service provided)
- Patients' satisfaction with the service provided

For effective clinical governance, organisations also need the right infrastructure to support the processes of accessing evidence, education and training, time to look at the quality of service provision, review data and to plan improvements. It is also researching and recognising how good practice in one service can be transferred to another service.

The development of clinical governance is to consolidate, pull together and universalise the policies and approaches within an organisation with the final accountability resting with the clinical director or the chief executive officer of the overarching health organisation.

For clinical governance there are therefore systems and structures put in place to address clinical risk management, quality of care and continuous quality improvement, accountability and to have clear roles and responsibilities, along with capacity building. This is often demonstrated by clear clinical pathways. Clinical governance systems need to be clear and cohesive and can only be supported with good leadership, positive organisational culture and adequate resources. A separate clinical governance system will be crucial in the new EPPIC services in order to bring about transformational change and maintain fidelity to the EPPIC model and ultimately improve outcomes for young people experiencing a FEP and their families. This governance structure needs to be separate and clearly defined from the adult and child mental health services; however, with acknowledgement of the linkages to state-run acute care inpatient units or private inpatient facilities.

Leaders of an EPPIC service need to see the opportunities available to them; be able to support the early psychosis philosophy and to 'walk the talk'; to be acknowledged as clinical experts, to inspire confidence and encourage others while having a strong commitment to understanding the structures and tasks that need to be done within the resourcing framework.

Leadership

Leadership is spoken about frequently and there has been much research and articles written about what constitutes a good leader. A 'good' leader can also be each individual's subjective experience and so there can be differences in opinion and perception of what is meant.

Views have also changed over the years and terminology has included charismatic leaders, transactional leaders, transformational leaders and those with the strong quality of having emotional intelligence. There are many different styles and behaviours of leadership that have been identified.

Emotional intelligence covers the components of self-awareness, self-regulation, motivation, empathy, and social skills. Transactional leadership has been more of a traditional approach with power being given to the leader to perform tasks and achieve goals with reward and punishment for the team's performance, so direction is given from the top down. Transformational leadership have often had the same goals, such as to get the job done, however with a more flattened structure and where the leader motivates the team through effective communication strategies to achieve the desired outcomes. There are many and varied definitions and characteristics of leaderships styles.

Whatever the definition of leadership it is also a question of are we talking about just one leader or several or a group that becomes a leadership group? Is it also people being most effective that are both leaders and managers? How does the organisation define the leadership and all areas of governance, culture, and the use of the resources?

There appear to be common traits that leaders need to be effective; these include having good communication skills, have commitment to the tasks, having a vision of what is wanting to be achieved, ability to share the vision and to communicate with others, while obtaining commitment and motivation from them and to be role models.

Leaders of an EPPIC service need to see the opportunities available to them; be able to support the early psychosis philosophy and to 'walk the talk'; to be acknowledged as clinical experts, to inspire confidence and encourage others while having a strong commitment to understanding the structures and tasks that need to be done within the resourcing framework. A clinical director needs to be a strong and caring leader and to inspire hope and confidence in the model and the ability of the clinicians to perform and for recovery to occur for the young people and their families. The strength of leadership and commitment is particularly important given the paradigm shift that may occur in those new EPPIC services that are utilising or recruiting staff from traditional mental health establishments. Flexible thinking needs to occur to achieve easy access to services, guaranteed tenure of care, clinical pathways for integrated services and ability to build on partnerships with a youth focus.

As with the governance structure, there needs to be clearly defined and separate leadership in the EPPIC service that is distinct from the adult and child mental health services with acknowledgement of the linkages to the acute inpatient care facilities. Ideally leaders will have the technical expertise and track record of leading early psychosis services, which will be useful in getting the job done. Most importantly, they need commitment to the vision and an empathic and understanding approach.

Culture

People tend to understand what is meant by culture; however, it can be difficult to define. Often it is seen as the way people behave, think and view the world. It is the accompanying social norms and values that an organisation has and the philosophy behind it all.

For establishing and implementing an EPPIC, the culture that it wants to create can be a crucial factor in ‘setting the scene’ for the service. Basically it is to achieve hope, optimism and be the ‘heart’ of the service where everyone is truly involved in caring about young people and their families. Early Psychosis services need to have an embedded culture of being youth-friendly and an early intervention focus on youth mental health.

Workforce culture needs to be aligned with the EPPIC mission and values of early intervention, recovery, hope, optimism and youth-friendliness, all of which pervade through a comprehensive approach to early psychosis service provision.

When implementing an EPPIC it is crucial to be not only mindful of the type of culture one wants to create but to take active steps in creating or changing the current culture, and for this to be part of the overall strategic planning, leadership role modelling and ongoing training and workforce development processes. A common goal and a framework that allows for flexibility and creativity within it is likely to act as a catalyst for a motivated and passionate workforce.

For a more detailed description of developing the culture please refer to the Appendix for Creating an EPPIC Culture and Change Management processes as these often goes hand-in-hand with creating a culture.

Resources

Nothing can really happen within an organisation without a proper funding arrangement. However, resources can cover a range of things, but also it is not just the initial resourcing that is required; planning needs to be given to managing and sustaining an ongoing service, particularly when scaling up a service. Excellent budget management is required.

The range of resources includes initial and ongoing funding, the source of funding, the agreements tied to the funding, the ongoing nature, if any, the use of any existing funding and resources, the infrastructure needs and the type of workforce required and training needs. How will the funding be rolled out and managed, and by whom? This aligns with the other critical success factor of separate clinical governance in that it is important that the resources attributed to the development of an EPPIC service are managed by the appropriate management team responsible for the EPPIC service.

Infrastructure comprises the necessary physical resources and structures that services need to operate in. These include buildings, office, interview and meeting areas, IT equipment, whiteboards, data projection systems, medical recording systems, reception areas, motor vehicles, pagers, mobiles, phones, faxes, photocopiers, a phone system, a duress system, resource cabinets, desks, chairs etc. These also need to meet occupational health and safety regulations.

A major consideration for resourcing is the workforce and their initial training and ongoing development. What type of workforce is being sought, and what are the professional backgrounds required? There needs to be designated positions of clinical team leaders, senior staff and on-the-ground staff in a variety of different roles. Further, there is a requirement for staff that cover other areas, such as administrative staff, quality assurance staff, professional development, financial management staff or avenues from which these are sought in existing services?

Training is an essential element for clinical staff in early intervention and recovery frameworks. Again this needs resourcing for staff and apart from the cost of time commitment, also requires a range of multimedia information, ranging from leaflets, booklets, videos, online-based material, clinical and operational manuals.

References

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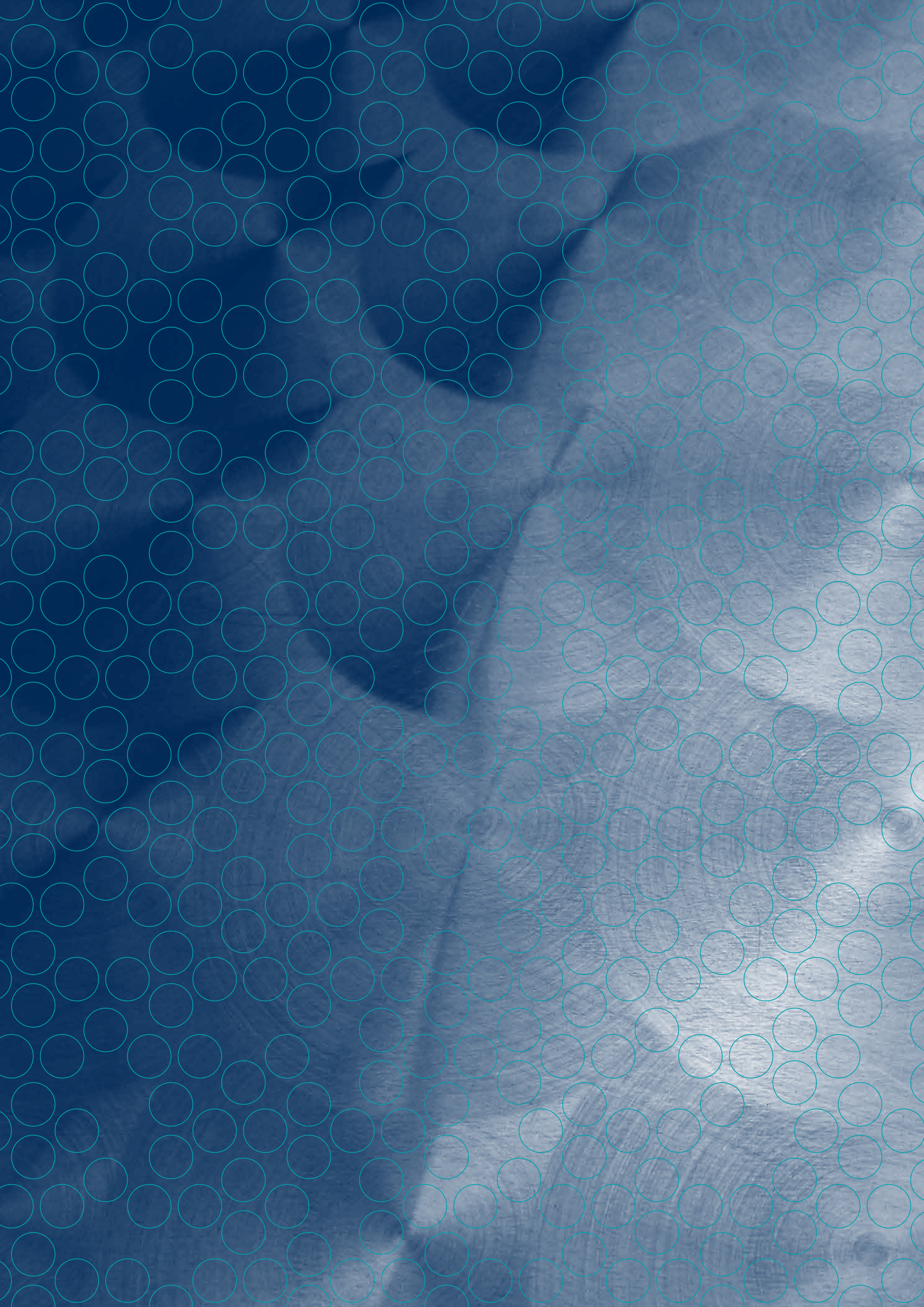


2.2
Establishing an EPPIC Service

When EPPIC commenced in 1992 nine steps were taken when implementing the service (Edwards & McGorry, 2002). These were:

1) Stating the philosophy and principles of early intervention
2) Setting the boundary conditions for FEP and early psychosis (criteria and catchment area)
3) Assessing the population needs and current service use
4) Setting the early psychosis scene
5) Identifying an early psychosis workforce
6) Defining the focus
7) Developing a written plan (strategic)
8) Implement key service components
9) Monitor and review

Early Psychosis services are in a unique and valuable position to implement the EPPIC model. The philosophy and principles of early interventions and youth focus must be embedded along with a strong youth mental health focus. For the new Early Psychosis services the focus is already defined by the EPPIC model, and there are some service systems, governance, leadership and organisational culture and processes in place that can be enhanced, along with the necessary expertise for the further development of collaborations and partnerships.

This implementation package also provides specific information on the core features and core components of the EPPIC model that Early Psychosis services can use when planning and implementing, along with taking note of some of the potential implementation challenges to also plan for.

The following provides a very brief overview of steps involved when implementing the EPPIC model at Early Psychosis services:

- Designating Early Psychosis centres. This can involve a hub and spoke model with a focus on integration with existing youth mental health centres.
- Establishing an EPPIC Implementation and Steering Group including key stakeholders or personnel. May include a project worker role and involvement from EPPIC National Support.
- Planning in all areas, including the four critical factors for success (governance, leadership, culture and resources) and specifics in terms of the implementation of the 16 core components.
- Planning communication strategies for all Early Psychosis centres, community organisations and young people and their families. Utilising the community awareness and education roles for the community prior to commencement. Including change management processes
- Appointing staff.
- Training/workforce development.
- Scaling up of services.
- Monitoring and reviewing of standards, guidelines, self-assessment tools and key performance indicators.

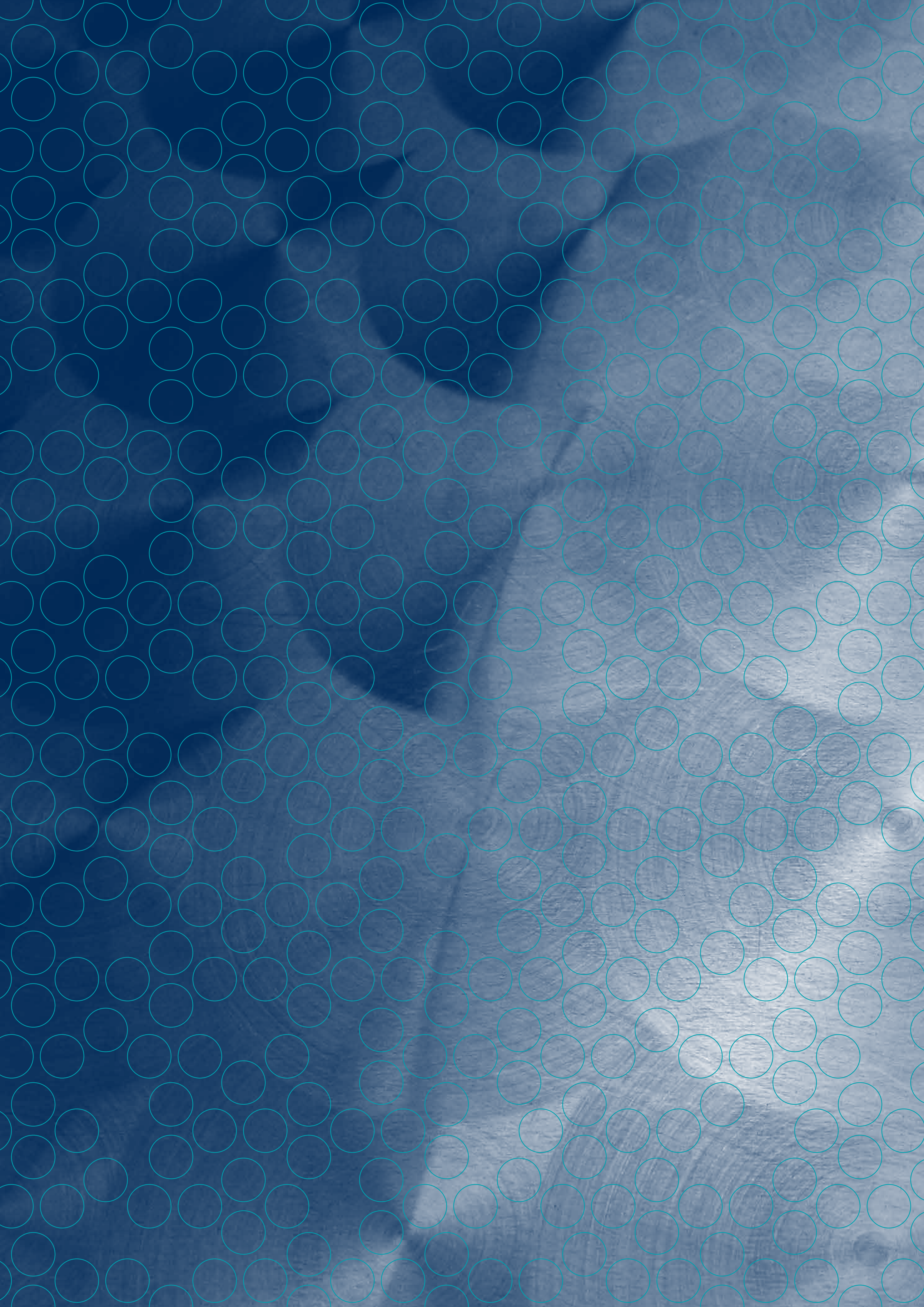
References

Edwards, J., McGorry, P. D. (2002) Implementing early intervention in psychosis: A guide to establishing early psychosis services. Martin Dunitz, London.

Opportunities and Challenges

In the description of the 16 core components there is detail about the opportunities and possible challenges for each, with clear suggestions on how to enable service delivery for the EPPIC model.

See the Appendix for a core component checklist for commencing an EPPIC service.



2.3
Implementing the Core Components and Scaling Up

While it has been stated that the 16 core components must be implemented prior to an Early Psychosis service commencing (excluding the sub-acute unit and the family and peer support workers), there are several of the core components that require particular initial planning and are essential for any service to commence.

For an Early Psychosis service to commence, at a minimum there needs to be a fully functional triage service and an EPACT team for the assessment and home-based treatment; leadership, including a clinical director; case managers, a senior psychologist, a family worker and medical staff must be appointed; there needs to be access to group programs, functional recovery staff and agreements reached with local inpatient unit providers. Community awareness and education activities should have been planned and commenced 1–2 months prior.

For both the FEP and UHR groups there can be some reliability in predicting the referral numbers and the EPPIC modelling tool can be used in terms of likely staffing numbers for the first and subsequent years.

It is not anticipated that an Early Psychosis service will be overwhelmed with referrals initially, so scaling up of the core components can be considered. Basically there are two types of scaling up. One is scaling up at the service level of the core components, and the other is the scaling up of the programs, such as increasing the number of the Early Psychosis centres.

Scaling up services is a complex topic. It can sound simple if just thinking about expansion, yet it requires careful thinking, strategic planning and utilisation of frameworks that may assist. The following is a review of some of the current information written about scaling up and how it may be applicable to Early Psychosis services when implementing and scaling up the EPPIC model.

The World Health Organization (2009) has written a report entitled ‘Practical Guidance for Scaling Up Health Service Innovations’. In this report WHO describes the following lessons that have been learned:

- Interventions backed by locally-generated evidence of programmatic effectiveness and feasibility increase the likelihood of being successfully scaled up.
- Scaling up often involves an institution-building task that requires a variety of special technical, managerial, human resource, leadership and financial inputs, as well as longer timeframes than typical project cycles.
- Scaling up must be concerned with sustainable policy and program development, including both institutional capacity and availability of financial resources.
- When tested interventions involve a large degree of change in the institutions expected to adopt them, scaling up will require extensive technical support and time.
- Adapting health innovations to changing socio-cultural, economic and institutional contexts in the course of the expansion is vital for success.
- Integrating considerations of gender and human rights into scaling up initiatives is essential.
- Special attention to monitoring and evaluation is needed as scaling up proceeds to ensure that results inform strategic adjustments and adaptions.

Scaling up is defined as ‘deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis’.

When looking at scaling up the key features of the new interventions need to remain intact during expansion and the greater the degree of change implied by the innovation then the greater the effort will be for successful scaling up.

The attributes of user organisations that facilitate successful scaling up usually have the following characteristics:

- There is a perceived need
- There is appropriate implementation capacity
- The timing and circumstances are right
- There is effective leadership and internal advocacy
- The resource and user organisations are compatible

A way to enhance the capacity of the organisation to ensure successful scaling up is to:

- Have ‘champions’
- Look at the strengths and weaknesses of the organisation in the areas of resourcing, staffing, technical competence, management and administration, organisational culture, policy and the legal framework for service delivery and leadership
- Make use of existing processes and structures
- Acknowledge scaling up may be an institutional change task of major proportions

Designing and implementing a scaling up strategy involves making strategic choices to be made in the following areas:

- The type of scaling up
- Dissemination and advocacy
- The ways to organise the process
- Assessing costs and mobilising resources
- Monitoring and evaluation

When considering the scaling up of the EPPIC model within an Early Psychosis service, the ideal is to have a smooth scaling up process, where the organisation and community are able to manage incrementally with more resources and activities. There is the initial scaling up of a service taking on and implementing the EPPIC model at designated sites, and then there is the scaling up of the core components with an option for full scaling up to occur at the end of the two-year period. The expansion of a service to include an Early Psychosis centre is seen as scaling up in terms of providing more services, and reaching more young people with specific specialist mental health needs. It can also include a greater geographic area along with a group of new young people requiring the multiprogram and specialist interventions. Clearly, objectives need to be defined at the commencement of implementing the EPPIC model and scaling up. This will involve change and often this will involve unique challenges.

Some of the challenges that can occur with scaling up can include the following:

- The impact of the scaled up or new service on the rest of the service. Is the workload to increase for all, how will this be managed, particularly for the triage service?
- Can the management system be proactive and deal effectively with the practical problems that are likely to arise?
- How to ensure that all staff, young people and the community are well informed and will support the new service and interventions. There is a need for good coordination and communication processes and to ensure that the service maintains its fidelity to the model.
- There can be opposition from a range of quarters, as often change can be resisted. How to prepare and face this challenge?
- Are there sufficient resources for implementation, including the training required?
- Will local ownership occur?
- Can any partnerships support the scaling up, are they on the same page in terms of commitment, policies, philosophy, staffing?
- Will each of the core components be scaled up? How will this occur? How to ensure that if scaling up a core component that it is not just done in isolation without thinking of any broader implications to other components and the service overall?

When discussing the need for strategic planning for scaling up, it needs to include specific planning for these types of challenges; for trouble-shooting along the way for any constraints that start to occur.

Waddington (2012) discusses how scaling up is easier if it has the following factors:

- There is a strong evidence base
- There is demand for scaling up
- The intervention is compatible with the norms and values of the population and its health service
- Quick results are possible and help spread demand
- The interventions are simple and standardised
- Costs are low for consumers

Similar to the World Health Organization, Waddington (2012) discusses the need for 'champions', such as a highly committed group of champions to 'generate support and push it along. Scaling up generally involves multiple organisations working on service delivery, financing and/or stewardship functions (such as coordination and regulation). Responsibility for these functions can be shared out in many different ways, and it is easy to see how scaling up often involves quite complicated coalitions…Championing requires a "can do" positive mentality and a willingness to manage proactively. Any scale up will face political, technical, logistical and administrative obstacles which need to be dealt with in a constructive and timely way. The groups driving scale up thus require a variety of skills, from the ability to win over local support and forge effective coalitions, competence in technical areas, management and training to a talent for resource mobilisation and advocacy.'

Again, monitoring and evaluation is seen as crucial from the commencement of scaling up as there are a constant range of decisions that need to be made. Progress needs to be assessed, problems areas to be identified along with any effect on the rest of the organisation. In developing a framework for the scaling up delivery, consideration should be given to the following areas:

1) Develop a scaling up vision and for this to be shared both within the organisation and supporting or partner organisations.
2) Decide on what type of scaling up is to occur and set the objectives while noting possible constraints.
3) Develop strategic plans at the initial implementation stage. The plans to include information and advocacy, resources involved, including financial, timeframes and sequencing, possible challenges and solutions, training and change management processes and monitoring of progress and evaluation.
4) Designate a group and/or champions who can actively pursue the scaling up purpose and take responsibility for this, along with having the necessary skills and expertise required for a coordinated and communicated approach.

Early Psychosis Service Scaling Up – What to Consider and How to Achieve It

As has been noted already the process and concept of scaling up services, when implementing models, has become a worthwhile way for services to configure and implement major service changes and new models of care. However it is a process that needs careful consideration and planning.

Cooley and Kohl (2006) have developed a framework for scaling up that includes the following ten tasks:

- Create a vision. What is being scaled up, how will it be accomplished, who will perform the key functions, where will it occur?
- Assess scalability. Determine the viability of the model for scaling up, analyse the organisational context and social context
- Fill information gaps
- Prepare a scale up plan
- Legitimise change
- Build a constituency
- Realign and mobilise resources
- Modify organisational structures
- Coordinate action
- Track performance and maintain momentum

In order to begin this process the following gives a range of questions and answers that helps with the Early Psychosis service scaling up planning and implementation. This can be a useful way for services to think about how scaling up may occur.

Developing a Plan

Considerations for creating a vision

What organisational, process and technical factors are critical to success?
These would be the four critical success factors of leadership, governance, culture and resources. These are explained in this EPPIC model implementation package.

Is it necessary to replicate all elements of the model on a large scale?
It will depend on the population that the EPPIC service will be serving and expected referral and transition rates, plus resources. Geographic location will be a factor. The EPPIC National Support modelling tool will give information on budget and EFT required. The scale will be determined by these. The government has set the parameters and expectations regarding funding, timelines and that the EPPIC model with its 16 core components is to be achieved.

Is there a need for intermediary organisations to support the scaling up process?
The EPPIC National Support team can support the process in a detailed manner. Local partnerships would need to be considered, e.g., group work (MIND? CMHC?), functional recovery programs (CRS?), IPU (AMHS? Private?), sub-acute beds (community organisations or PARCS?), EPACT (emergency departments? police?)

How would scaling up take place?
Scaling up can occur in three different ways. However, the timeline is two years for all 16 core components to be in place.

Scaling up can occur via:

- After the 15 components are implemented, then the remaining aspects of two of the core components (family programs and family peer support and youth participation and peer support programs) and the core component of sub-acute beds need to be implemented by the end of the second year. An Early Psychosis service is unlikely to have the family peer support workers and youth peer support staff at the commencement of the service as it can take time to develop people who have the lived experience of participating with an EPPIC service.
- After implementing the 15 core components some of these can also be scaled up over time (e.g., the group program can operate with an increased number of groups, the continuing care team can increase the number of case managers, the number and nature of partnerships can increase).
- Within the Early Psychosis service geographic areas and locations of centres there may need to be a Phase 1, where an initial EPPIC service with the core components is established, and a Phase 2, where other centres have the model established with them and/or linked to the original Early Psychosis service model site. This can be done as a planned hub and spoke model.

How to address the scaling up questions for an Early Psychosis Service

1) Assessing Scalability

Is there a perceived need by all organisations?
There is by the Early Psychosis service, EPPIC National and the Federal government, however will other organisations come on line? It is likely they will perceive a need, but issues may arise regarding partnerships? These will need to be addressed, usually by being mutually beneficial by both organisations (often by sharing resources) and by servicing the young people that both organisations work with. In the case of utilising youth-friendly inpatient care there may need to be service level agreements between state-run inpatient services or private facilities and Early Psychosis services that allows their use, but also can aim to meet the EPPIC model and standards of care.

How easily can the core components meet the outcome to be achieved or replicated?
The four critical factors need to be established, not necessarily replicated. The same with the 16 core components—the essence of these needs to be established as explained in the model. There may be some adaption to the local area and the configuration of local services; however, fidelity to the model must be maintained. Following this EPPIC Implementation Guide, including the EPPIC minimum and secondary standards, will assist with this. Meeting the key performance indicators should also ensure this. EPPIC National Support can provide consultation and help manage the implementation and achieving fidelity to the EPPIC model.

Is there anything special or unique about the social context, the political context, or general circumstances that would need to be present for the model to be replicated successfully?
Early Psychosis services may need to consider resourcing if not having a catchment area and that not all treatment will be able to be provided to all young people. Some young people who live outside of a geographic area may only be able receive care if they can attend the centre. As a major focus of the work is on home-based care, Early Psychosis services will need to designate the geographic areas for attendance by the EPACT team and other EPPIC programs where home-based care is to be provided.

As the model is promoting home-based care and treatment and not just for the EPACT team to be providing this service then a geographic area is likely to be needed for home-based care for continuing care team case managers, or for the intensive mobile outreach component. This may also mean that those young people who may live outside the geographic area may not be able to receive the full EPPIC service, which can impact on the clinical outcomes and hence fidelity to the model. It is anticipated this may be a small number of young people.

Consideration will need to be given to local factors of socio-economic status, cultural groups and access to them, how large the geographic area may be and those areas that include remote access. These will all need to be addressed and included in any scaling up process.

If looking at partnerships, do the partner organisations have the appropriate organisational and implementation capacity or the means to develop the capacity?
It depends on what partnerships are being looked at, as to then to assess for this. Are there already a number of working partnerships that can be utilised, such as with the Commonwealth Rehabilitation Service (CRS) and other local community organisations? It also depends on whom the Early Psychosis centre contract work out to; for example, a local lead agency may well have the means and capacity to help with implementation and it would also be an expectation of the service provision. This needs to be reviewed and decided at the initial implementation phase.

Does the lead agency or partner organisation have the vision, mission, culture and values compatible with the EPPIC model to assist with implementation?
This would need to be assessed by the Early Psychosis service, but it could be assumed this would be compatible and basically it does not seem workable unless there is a good degree of compatibility. There needs to be strong adherence to the EPPIC model so commitment is needed not just for the initial implementation phase, but for the ongoing scaling up process. There needs to be strategic plans and implementation timelines developed to adhere to scaling up to ensure fidelity to the model and that a comprehensive service is provided. Do all the organisations involved understand the model and the requirements?

What additional information or documentation is needed?
The EPPIC model is provided as a package that highlights specifics of each of the components and possible challenges as well as enablers to address these. However, it needs to be looked at specifically for each site regarding the actual implementation and any local adaption. For example, where is the local IPU that they may be using, how accessible, youth-friendly, and what agreements for access are in place?

2) What is Needed in a Scaling Up Plan?

This requires clear planning regarding what is to be scaled up, how it is to be done and by whom, the intended timelines, tasks and role delineation, responsibilities and oversight of the plan (Governance). Trouble-shooting and problem-solving needs to occur when obstacles arise. A major aspect is that planning for scaling up needs to occur from the initial planning and implementation stages. This can be done by an EPPIC implementation and steering group or working group.

3) Establishing the Preconditions for Scaling Up

How to legitimise the change?
This needs to be established during the implementation phase. The implementation phase of the model will also require cultural change and the plan for scaling up needs to be included in this process as well. For instance, culture change processes need to consider staffing factors, new and current staff to consider, staffing of partner organisations, leadership, culture, the resources required and so forth.

Utilisation of evidence-based resources that support the EPPIC model, as already described in this EPPIC model and implementation package, and the cost effectiveness these will assist. Utilisation of the training and content development packages from EPPIC National Support and timelines for providing this can be included in the scale up plan.

Clarity is needed regarding who has the authority and decision-making power to commence the scaling up process. The Early Psychosis service will drive this.
Which organisations are involved?
The Early Psychosis service will drive this along with the EPPIC National Support Program.

Potential challenges and issues will need to be anticipated and assisted by using this EPPIC model and service implementation package.

Clarity regarding which partnership is current or will be required in the future and to commence negotiations early, even if scaling up is not to commence until the second year after implementation.

4) Resource Allocation for Scaling Up

Funding is clear and provided. There is a need to ensure the resources support the process for scaling up. Clear governance and reporting lines are required for this. The EPPIC National Support modelling tool can be utilised for this.

Infrastructure and staffing levels need to meet the anticipated final scaling up outcome. It is necessary to ensure that this has been considered and planned for, and this can be achieved with the EPPIC modelling tool.

5) Implement the Remaining Core Components

Establish a timeline, actions and implement. For example, if considering implementing youth participation in the second year, then employ a youth participation coordinator as first step in the initial implementation stage. This will ensure that there is scaling up and development of the model for youth participation with clear responsibilities; that any current activities already covering youth participation can be incorporated into this component and that young people who may have been in the service over the past year can become future peer support workers.

All partnerships must have clear avenues in place to facilitate scaling up, along with processes for resolving issues or conflicts. Clear documentation and agreements are necessary for this to be successful.

6) Tracking the Progress of Scaling Up

There needs to be adequate procedures for documenting the progress of scaling up, as would have been done in the initial implementation phase. Issues must be noted and how they have been resolved shown. An implementation and steering group should ensure this with regular reporting mechanisms.

While drawing on the current knowledge base and designated positions within youth mental health services, such as youth participation staff, the EPPIC model needs to have its own designated staff and to scale up these programs over the two-year period.

Early Psychosis Service Scaling Up – Planning and Implementation

As discussed, when creating a vision for scaling up there are four critical factors for the successful establishment of the EPPIC model: leadership, governance, culture and resources. As well there are the different ways of scaling up:

- After the 15 components are implemented, then the remaining aspects of two of the core components (family programs and family peer support and youth participation and peer support programs) and the core component of sub-acute beds need to be implemented by the end of the second year. The remaining aspects are the family peer support workers and the youth peer support staff, as it can take time to have people who have the lived experience in the EPPIC service, so it is difficult to have these established in the first year. However, planning for these staff needs to commence in that year.
- After implementing the 15 core components some of these can also be scaled up over time. For instance the group program can operate with increased number of groups, the continuing care team can increase the number of case managers, the number and nature of partnerships can increase. This may mean starting off with each of the core components but in a smaller capacity, then building up proportionally over the two-year implementation period.
- Within the Early Psychosis service geographic areas and locations of centres there may need to be a Phase 1, where an initial EPPIC service with all core components is established, and a Phase 2, where other Early Psychosis services have the model established with them and/or linked to the original Early Psychosis service model site. This can be done as a hub and spoke model or an own model outright, depending on resources.

Scaling Up for Each Core Component of the EPPIC Model

In terms of planning for scaling up and staffing, some of the core components can be linked together under the following headings when thinking about how to scale up. However the 16 core components still need to be established.

The headings can be:
Awareness and partnerships: covering community awareness and education, youth participation, peer support workers and family peer support workers.

Triage and acute: covering allied health and nursing, medical staff, team administration, leadership; hence EPACT and ease of access to service.

Community care teams: covering allied health and nursing, medical staff, administration, leadership; hence continuing care case management, medical treatments, psychological interventions, mobile outreach, family programs, and UHR treatment.

Psychosocial recovery: covering allied health and nursing, vocation and education, administration and leadership; so includes group programs and functional recovery.

Leadership and administration: covering the clinical director, program manager, health information manager, reception and administration, and workforce development.

The following description gives some comments on how scaling up may occur for the areas of awareness and partnerships, and triage and acute. These can be used as examples when contemplating and planning for Early Psychosis service scaling up of the core components.

Awareness and Partnerships

This covers the components of community education and awareness, peer support workers, family peer support workers and youth participation.

Some services may have community education and awareness and corporate affairs staff who are used to promote youth mental health, early intervention and ease of access. The aims of the Early Psychosis service community education and awareness are to reduce stigma, improve mental health literacy, improve knowledge and awareness of how to access care, and to promote mental health support and care for young people and the community. EPPIC also has an overall aim of reducing DUP and providing specialist early psychosis and FEP care. The Early Psychosis service will need to provide understanding and promotion of early psychosis and FEP. While some services do have familiarity with these mental health issues, they will also require more detailed explanation of early psychosis and FEP and the specialist nature of the service provision of an Early Psychosis service. This will include not only the nature of early psychosis and FEP, but also the clinical pathways, referral processes and secondary consultation and training, as well as embedding themselves in the local community.

The EPPIC model needs to have its own designated staff and to scale up these programs over the two-year period. What is essential is having positive and well-functioning working relationships. This can and needs to occur from the initial implementation stage.

What would scaling up look like for the awareness and partnerships core components?

About a month or two prior to the commencement of the Early Psychosis service a community education and awareness worker should be employed so that awareness-raising planning and activities can commence. This would be a senior level allied health position.

The initial functions of this worker would be to commence planning and contacting the local community of referrers, including local mental health providers, to inform about the service, including referral pathways with the aim to increase mental health literacy, knowledge, reduce stigma and provide information on the Early Psychosis service and when it will be commencing, and to provide leaflets and other avenues for multimedia information on accessing the service. A further role would be to review current information and resources available, to develop these further and to perform a needs analysis so that strategic planning can commence for future activities.

A dedicated youth participation coordinator should be appointed at commencement of the Early Psychosis service to develop a mission statement and policies, to establish and coordinate activities of the youth participation program, to consult with young people and to commence the planning for, and recruitment of, future peer support workers.

As an example, utilising the EPPIC National modelling tool, based on a population of 500,000 in the first year, there should be one EFT for community awareness and education, and a 0.67 EFT worker for youth participation, with a 0.33 EFT peer support worker (would need to be built up over time). This is not necessarily the population coverage of an Early Psychosis service, rather an example of what needs to be considered.

As discussed in this EPPIC Model and Service Implementation package the activities of the community awareness and education staff can expand to include accessing the local community, such as local schools, universities, TAFEs, counsellors, health professionals, general practitioners and other health service providers. This is to not only provide information on the service, but to further develop resources, provide education and training, secondary consultation, attendance at local community meetings, identification of gaps in knowledge and services and address these, develop partnerships and to also assist in the education of and liaison with staff. It would be anticipated that all of these activities are occurring by the end of the second year of the service opening.

This team of community awareness and education staff will commence the planning and activities outlined above. However, local centres can configure the EFT arrangement that suits them, plus when and what a full EFT team would consist of.

In terms of scaling up, it is anticipated that within the first year (as well as other tasks) that the youth participation team are working on the development of the peer support worker program and that this commences within the second year of service. This can take some time to build up, due to the need to have young people who have been past users of the service and who are now well enough to manage this role. By the end of the second year, peer support workers for young people would be part of the service and actively supported and involved in peer support activities.

In terms of family peer support workers the same principles apply. It will take time to access and find suitable and willing family members with a young person who has the lived experience of the Early Psychosis service to become family peer support workers.

The oversight and establishment of the coordinator position for these staff is discussed elsewhere, such as being part of the group program or functional recovery coordinator role. It is the coordinator's role to actively seek and promote this part of the service development and to ensure that family peer support workers are employed. The specialist family worker can also assist with the model development.

Scaling up can occur in various ways. This may mean that within the second year there is only one part-time family peer support worker employed; however, once they commence and start providing a service, along with the group program coordinator they can also help with advocating this role to other family service users. Scaling up may mean starting small but continue to build to the required EFT resources with an aim of being established by the end of the second year.

Scaling Up Triage/Intake and Acute Services

Within services may be currently existing triage/intake services. These may be under the function of a team where multidisciplinary staff take referrals either by phone or by 'walk-in' to the centre. Hence there is an existing triage/intake service where clinicians explore the reason for referral, explain the service, check for urgency and risk issues and arrange further assessment or referral to a private provider or referral elsewhere. Having an Early Psychosis service would mean there would be a need to triage/intake for early psychosis and FEP young people using specific criteria. The current triage/intake system could be enhanced to have EFT that provides this service. For instance, based on a population of 1,000,000, within the first year it is anticipated that there would be 1,100 referrals of which 230 would be FEP new cases and 120 would be UHR new cases. The management of the referral numbers will need to be addressed from the start of the Early Psychosis service, and could involve a plan of training up existing and new triage/intake staff so they could expertly triage/intake all referrals and those for UHR and FEP. Appointing further or new senior clinicians as part of the team would assist in workload management, as well as being a point of consultation for other staff and to be involved in up-skilling or training staff in early psychosis work. The position could be either full-time or part-time (0.8 EFT) if there already is a senior triage/intake clinician who has part of their current role to assist in overseeing the triage/intake function. Obviously it would be important to look at the current and anticipated referral rate and EFT in the triage/intake service for Early Psychosis referrals prior to the establishment of the Early Psychosis service.

As part of the funding model the normal scaling up would occur by the second year, where the allied health and nursing clinicians would increase EFT. Consideration would be given based on referral numbers as to whether triage/intake EFT under the team would need to be increased. Current predictions would see referrals for the second year to be at 1,063 with 232 FEP new cases and 121 UHR new cases, hence it would seem the current triage/intake EFT could be maintained for the second year.

The other main functions of the EPACT team are assessment, community treatment and crisis responses, with the aim of the majority of service provision to be via home-based care and to have a flexible, accessible 24 hour, 7 days per week service with triage/intake and on-call functions.

The EPACT Team

The EPACT team is a crucial core component, and aside from the triage/intake contact it is often the first point of face-to-face contact with the young person and their family. Adequate staffing from the commencement of the service is essential to fulfil the EPACT role and to be able to see and engage young people as early as possible.

For a rotating roster with coverage of 7 days per week, with two shifts daily of 8.30 am–5 pm weekdays (or 9.30 am–6 pm weekends) and 1.30 pm–10 pm daily, then 9.67 EFT would allow good staff coverage of two on the AM shift and three on a PM shift. (Eight and a half hour shifts allow for one ADO per month). Coverage could be done with three on an AM shift and four on a PM shift with 9.8 EFT. However there needs to be allowance for all types of leave that occur, so this needs to be taken into consideration. This will also be defined by the hours the EPACT clinicians work and their role in providing afterhours access such as the oncall and recall service.

There is also the issue of on-call work, and coverage allows for one worker on the PM shift to be the designated on-call worker. Clinicians also need to do home-based care where they would be conducting home or community visits in pairs, so the staffing needs to be adequate to cover for this.

The assessment process can also take some time and be spread over several sessions as often it is an ongoing process and the intensity of acute clinical work cannot be underestimated. Having a well-staffed team is essential as clinicians can be out on the road seeing young people at home or wherever needed, and possibly up to three times per day in acute phases. Crisis responses are also required, and these can all vary in type and length of time taken for their management. As well, time is needed to provide the required engagement and to hear the young person's story along with family concerns, whether it is a crisis situation or otherwise.

In terms of scaling up it is essential to have sufficient staff to provide the required programs from the commencement of the Early Psychosis service. Clearly, the EPACT team would need to have a defined geographic or catchment area that they are covering as it is not be possible to do home-based care too broadly. One option that could be considered when commencing, while the service is still becoming known, is the hours of service and whether this might be reduced to start with, so EPACT clinicians may work reduced hours on a PM shift, to possibly 7 pm or 9 pm at night. This would then be scaled up as demand increased. However, this raises the issue of after hours contact, which still needs to be provided so that there is 24/7 coverage.

After Hours Contact

The Early Psychosis service would need capacity to conduct triage/intake, support and provide crisis response for the Early Psychosis service calls and contact the EPACT on-call worker if it seems recall was necessary. Also handover to the EPACT team at the commencement of their morning shift.

These are examples of possible scaling up scenarios. A task that needs to be completed in the planning stage prior to implementation is the choice of which core components will be scaled up over the two-year period and the specific details of how to do this. Almost all of the core components can be scaled up over time; however, the EPPIC service needs to be comprehensive and functional to meet community needs and achieve fidelity. A two-year time period is not a long period of time to achieve scaling up processes.

References

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Waddington, C. (2012) Scaling up health services: challenges and choices. HLSP Institute, London. www.hlsp.org/institute

World Health Organization (2009). Practical guide for scaling up health service innovations. World Health Organization, Geneva. pp I–54.

Evaluation

Evaluation of any service, program or model is seen as an important part of any service development and delivery. There can be many different reasons for why evaluation is important. These can include:

- It is part of the quality assurance process
- It helps to ensure improved services for young people and their families
- It can assist in improving staff performance and management
- It provides for reporting and accountability
- It can help with contributing to evidence-based interventions
- It can explore and inform of gaps in service or problem areas that can then be addressed

The development of standards can 'set up possibilities for the contractual specification of service quality and they are also a way for translating policies into action' (Riordan, 1997. For the EPPIC model the adherence to standards and the accompanying key performance indicators will ensure that fidelity to the model is achieved. There is not only complexity involved in the establishment of the 16 core components of the EPPIC model, but complexity also occurs in the delivery of human and health services, where every young person comes under the influence of a multitude of everyday psychological, social and environmental life factors that can impact on their mental health. Among this complexity is the evaluation of a service that aims to try to extricate the crucial elements involved in the service provision and in meeting the goals with the overall aim of providing best practice and interventions that will improve young people's wellbeing.

For an Early Psychosis service to achieve fidelity to the model it needs to demonstrate not only the existence of the 16 core components but also that they are being provided in the prescribed manner.

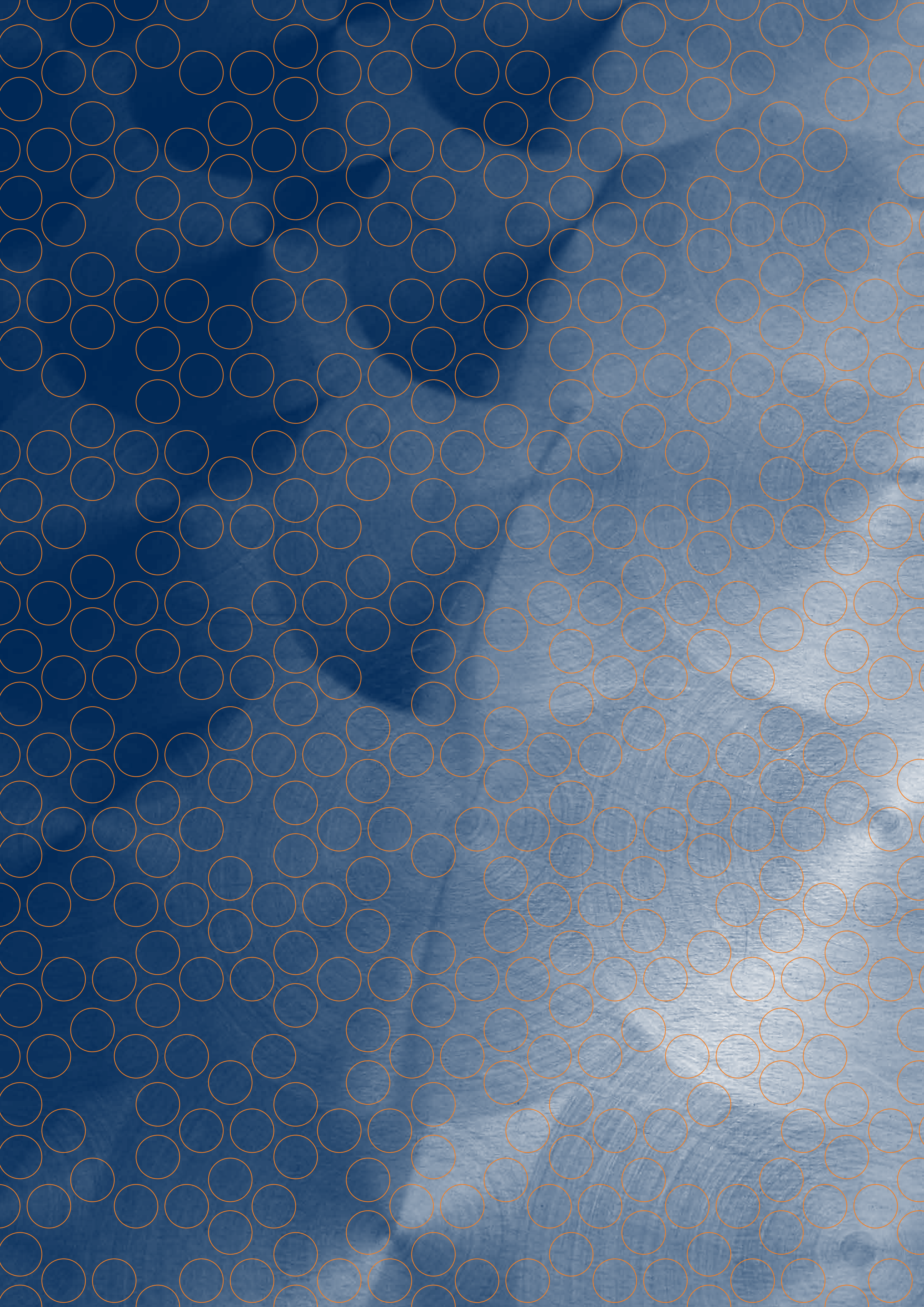
The ultimate goal is to be preventative in approach, provide early intervention and to reduce the ongoing impact of mental health issues on the young person's development and future.

The associated guidelines, and minimum and secondary standards, will assist not only with the implementation of the model but also ongoing best evidence-based practice. Meeting the minimum standards and guidelines can lead to meeting the key performance indicators, which will then ensure fidelity to the EPPIC model. Standards have been chosen, titled Priority Items, where the majority can be directly linked to the KPIs and these can be used to measure how the EPPIC model is operating and whether it is likely to achieve fidelity. (To be discussed at implementation workshops). Clinical audit tools can be developed and are one way to assist in the measurement and hence evaluation of the service. For instance, a standard can state that 'an EPPIC EPACT team clinician conducts a face-to-face assessment of a young person within 24 hours of an accepted referral and in the least restrictive manner at a place convenient to the young person and their family'(Standard 3.1). This is a measurable standard that can be easily audited to see if the service is achieving this. Established data systems can also be revised to include gathering data that informs about outcomes and the deliverables.

Services may have evaluation processes and data systems established which may need to be expanded and extended for use by the local Early Psychosis service for appropriate evaluation to occur.

Reference

Riordan, J., Mockler, D. (1997) Clinical Audit in Mental Health: Towards a Multidisciplinary Approach. John Wiley & Sons, London. pp. 13.



Appendicies

Appendix I

Creating an EPPIC culture

As with the concept of change management the term ‘culture’ is another word that people are familiar with, and it can be spoken about in terms of workplace or organisational culture. Yet what does it mean and how do you create an EPPIC culture?

Culture

Susan Heathfield defines culture as ‘the environment that surrounds you at work…it is made up of values, beliefs, underlying assumptions, attitudes and behaviour shared by a group of people. It is the behaviour that results when a group arrives at a set of generally unspoken and unwritten rules for working together… It is especially influenced by the organisation’s founder, executives, and other management staff because of their role in decision-making and strategic direction.’

Why is this important for an EPPIC?

As with any new service, or redesigning of a service, the aim is to provide the best practice or service possible and along with the notion of change management, it is not just the principles, guidelines or standards that are put in place, it is also the workforce that has to enact these and provide the service that can be the strength or weakness of whether an organisation achieves its goals or not.

A current organisational culture can be difficult to change or creating a culture from the ground up for a new service can also be hard work, yet it is an important task in the successful establishment of and for ongoing work.

The importance of workforce culture is recognised at a national level where as part of the National Mental Health Strategy 2011, there is a National Mental Health Workforce Plan, with objectives of having service cultures that support hope and optimism, support a recovery–oriented culture within mental health services, underpinned by appropriate values and hence promotes workforce ongoing learning, supervision and professional development.

For establishing and implementing an EPPIC, the culture that it wants to create can be a crucial factor in ‘setting the scene’ for the service. Workforce culture needs to be aligned with the EPPIC mission and values of early intervention, recovery, hope, and a comprehensive service for early psychosis, which then allows for motivated and passionate staff.

In the EPPIC service in Melbourne, the core culture and values for the continuing care team are documented and stated as:

- The at risk mental state must be followed up
- Engagement is one of the most crucial aspects
- A recovery focus
- Principles of early intervention, including early diagnosis and treatment, can significantly improve the prospect of recovery and decrease long-term impairment for many individuals
- The phases of psychosis

Individual teams within the service also have their own ‘principles’ or stated ways of working on the team that encompass beliefs and behaviour and help embed a workforce culture that supports the core beliefs. For instance, the EPACT team has the following principles for working on the team:

- EPACT is ONE team and all staff play a crucial role in clinical decisions, workload, management and team dynamics.
- EPACT functions best in a supportive, positive and friendly environment.

- EPACT seniors are crucial in promoting a positive culture and ensuring decision-making and processes are appropriate and enacted.
- EPACT creates an open door policy for all staff on the team in relation to raising issues, suggestions and ideas.
- EPACT creates an environment where clinicians assist each other and actively help in each sub-program where necessary.
- EPACT shows respect for others by following expected processes of punctuality, care for work equipment, general environment and all administrative functions.
- EPACT embraces some diversity of role and particular tasks such as shift senior roles, senior responsibilities.
- EPACT aims to have positive relationships both within the team, external staff and other agencies.
- EPACT focuses on best clinical practice within the framework of young people's mental health.

For Orygen Youth Health, of which EPPIC is part, the following principles have guided the range of services and programs provided:

Principles

Clinical staging
Focus on youth
Early intervention
Functional recovery
Evidence-based practice
Mental health promotion
Family participation
Youth-friendly service provision
Family peer support

Whatever an organisation's vision or the principles that it holds, the culture to be created is to be aligned with them, with the aim of having a workforce that understands, values and behaves in a way that reflects these.

Steps involved

If looking at changing an organisational culture, or establishing a new culture, there can be several steps involved. Heathfield describes three major steps for organisation change of culture:

1. **Understand the current culture.** This may involve trying to be an impartial observer and understand the culture as reflected in staff emotions as the reflections of values, the physical environment and surrounds, the tone of communications and employee interviews on the subject. However, one cannot look at changing a culture unless it is known what the current culture is.

2. **Organisation strategic direction and what the organisation's culture should look like.** This needs to be decided, so what is the vision and how must the culture change to support the vision? What is the culture that the organisation wants to create?

3. **Plan the desired culture.** This needs to be done before any changes are made. Mission, vision and values need to be examined for the strategic and value-based components of the organisation. This then provides a plan for the strategic direction in creating or changing the culture.

The two most important elements in creating organisational culture change are:

- Executive support: As in change management processes, there is a need to 'walk the walk', use all available communication tools and to have strategic conversations.
- Training: The workforce needs to understand what are the expected behaviours and values. Training is crucial for this.

The EPPIC service must have clear leadership that speaks often about the philosophy of early intervention, gives a rationale based on evidence-based practise, sets up the core components of the service based on this philosophy and values, provides extensive staff training; engages staff who demonstrate the values and seeks ongoing feedback and ideas on how to improve the service and the culture. This has been also clearly documented.

Staff who have worked in the service for some time are also seen as the 'culture carriers' and they assist in orienting new staff and sustaining the culture by their beliefs and actions. Clinical leads also discuss and demonstrate the values and beliefs so that the culture becomes embedded in a way of working that best assists young people and the staff feel positive and comfortable with.

All training, professional development and supervision always focuses on the core values of youth mental health: being youth-friendly, engaging, easy access, comprehensive service from a biopsychosocial perspective within a recovery framework. Clinical examples are highlighted, such as simply facilitating engagement with a young person by seeing them in a garden gazebo on the work site, rather than in an office if this best suited the young person. Having position descriptions that state the mission, values, and expectations, as well as the specific work tasks also assists.

What it takes to work in early intervention programs…

> ‘You need someone who is a good communicator and at ease in relationships, with a relaxed, easy-going style and a sense of humour who holds an optimistic, hopeful outlook. It is important to come from a value base that respects individuals and their families and culture, and sees people as people struggling to come to terms with impact of a psychosis’
>
> Dr Jo Smith, NIMHE/Rethink Joint National Early Intervention Program Lead, UK

What are the qualities an EPPIC may want to look for and encourage in their workforce?

Qualities Needed in Clinical Staff who work with First Episode Psychosis Youth

The following points suggest qualities to look for when recruiting staff for the Enhanced **headspace** services.

- Commitment and a thorough understanding of the philosophy of early intervention and recovery concepts for youth
- Good understanding of youth and family development between the ages of 12–25 years
- Excellent mental health clinical skills for engagement, assessment, a holistic care approach, crisis response, case management, therapeutic interventions, advocacy and liaison
- Flexibility to cope with organisational change
- A flexible approach to the young person’s treatment and care
- Good negotiation skills
- A ‘can do’ attitude with a positive, hopeful outlook
- Capacity to learn and create new ideas
- Excellent communication skills and an empathic, ‘good listener’ approach to the young person, family or significant other with an ability to build rapport
- A systemic view of the young person

When implementing an EPPIC it is crucial to be not only mindful of the type of culture one wants to create, but to take active steps in creating or changing the current culture, and for this to be part of the overall strategic planning, leadership role modelling and ongoing training processes.

References

Commonwealth Government (2011). National Mental Health Strategy 2011, (Objectives 1.4, 1.4.1). See www.health.gov.au

Heathfield, S. M. Culture: Your environment for people at work. See www.About.com

Orygen Youth Health. See www.oyh.org.au

Appendix II General Guidelines for Change Management

Change management is a concept that has been written and spoken about since the late 1980s and has incorporated the idea of change leaders to take responsibility for the process and people involved. It is generally seen that the majority of staff are aware of the terminology; however, do not often have knowledge of the processes involved.

This document will draw on some available knowledge and resources to give some general principles, steps and guidance on how EPPIC may think about and manage change within the organisation. Clearly change management has to take into account the nature of the organisation, the history, the type, size, local issues and the nature of the change being anticipated.

Basically, change management needs to be understood in terms of a rationale: why is the organisation doing it, for whom, where and how will it occur?

What is change management?

Since the late 1980s there has been a great deal of literature and models provided about change management for all types of organisations, definitions given and processes articulated, with some institutions providing consultancy and training on all aspects of change management. As the Queensland government describes 'each approach has its pros and cons, however no one framework is the "best" in all situations. Indeed it is not so much the actual model or theory that is important, but more that the approach that is taken is relevant to the circumstances. In fact the best change approaches appear to use and adapt aspects of various models to suit the culture of the organisation and the context of the change. Fundamentally, the basis goal of all change management is to secure buy-in to the change and to align individual behaviour and skills with the change.'

Whatever your views or definition of change management it appears that change and organisational change is an inherent part of life and organisations. The general goal of change management is to achieve a positive benefit to the organisation, to the service providers and to the service recipients.

Why is managing change necessary?

In terms of mental health organisations or systems the performance of the workforce is a most important asset for delivery of service and requires that staff have appropriate and best practice knowledge, skills and motivation.

The workforce, or human resources, need to understand the change, accept and be motivated by it and hence have the capacity to adapt. If the change management process is not managed well then resistance can occur, and misunderstandings, barriers and obstacles arise and change processes get stuck or stop occurring. If change is presented to people in an effective way where all aspects are understood, then change is more likely to occur and be a smoother process causing less disruption to all concerned and the organisation. Basically, it depends on how change is presented.

Frameworks

Dr John Kotter's original eight-step model can still be useful in discussing the change management process and as a way to avoid failure by taking a holistic approach to see the change occur. However there are now many other useful resources. Kotter's model still exemplifies the core stages in any change management process so it is helpful to explain here. (Services can adapt or use any model that suits their local context).

1) **Establishing a sense of urgency.** This helps others to see the importance of change and so will be convinced of the importance of acting. It 'aims for the heart' by connecting to the deepest values of people and inspire them.

2) **Creating a guiding coalition.** To assemble a group with enough power to lead the change effort and encourage the group to work as a team. Team trust, shared goals, enough key players, proven leaders, and all relevant points of view are needed, so that the group has credibility to drive the change process.

3) **Developing a change vision and strategy.** It is necessary to create a vision to help direct the change effort and develop strategies for achieving that vision. Effective visions have six key characteristics:
   - Imaginable: convey a clear picture of what the future will look like
   - Desirable: appeal to the long-term interest of stakeholders
   - Feasible: contain realistic and attainable goals
   - Focused: clear enough to give guidance
   - Flexible: allow individual initiative and alternate responses
   - Communicable: easy to explain quickly

4) **Communicating the vision.** Make sure as many as possible understand the vision and strategy. Must be communicated in all forums, at all levels and even in hour-by-hour activities. Most importantly it includes to 'walk the walk' or 'actions speak louder than words' by leaders and all involved.

5) **Empowering broad based action.** Remove obstacles to change, change systems or structures that seriously undermine the vision, and encourage risk-taking, non-traditional ideas, activities or actions. This may include honest dialogue with managers and staff who are not willing to consider the vision and change process.

6) **Generating short term wins.** Plan for achievements that can easily be made visible, follow through with those achievements and recognise and reward those employees involved. The guiding coalition is a critical force for this.

7) **Never letting up.** Use increased credibility to change systems, structures and policies that do not fit the vision and development of employees. Consolidate gains and produce more change.

8) **Incorporating changes into the culture.** Anchoring new approaches into the culture for sustained change. Culture is composed of norms and shared values. Culture change rules cover:

- Comes last not first in the process
- Must be able to prove that the new way is superior to the old
- Success must be visible and well communicated
- Accept you will lose some people in the process
- Reinforce the culture with every new employee

Kotter's model as briefly described above can be incorporated into an EPPIC service change management process. There can be local adaptions to this original model, but the core concepts should still be used.

Guidelines

Drawing on this framework for change management, the guidelines or steps for an EPPIC to consider in the change management process include:

1) **A sense of urgency.** There are internal and external drivers for change. These include government directions, timelines and funding arrangements, the increased evidence for prevention, early intervention and a recovery focus for youth mental health, cost effectiveness and improving access and quality of life for young people. This can also include a review of organisational gaps and opportunities arising from the innovation.

2) **Creating a guiding coalition.** Create a project leadership team, which could be the EPPIC Steering and Implementation Group (EPPIC SIG) with an appointed project manager, or a project team as part of this group with accountability and hence governance to the EPPIC SIG. Overall governance should be defined. Must have committed leadership and to lead by example.

3) **Develop a vision and strategy.** The EPPIC vision can be to provide young people with emerging psychotic illness timely access to effective, safe and appropriate care delivered through comprehensive and competent expertise within an optimistic, youth-friendly culture that is acceptable to and engages well with young people and their families. The project team develops a project plan that includes consultation within the service and support from the EPPIC National Support team and covers the proposed organisational structure. This can be used to inform stakeholders and look at partnerships. This may be done in forums, working groups and individual consultations about the proposed model of core components and scaling up plan. Strategies can include to restructure or the new development of a service, incorporating the standards and guidelines as guidance in developing the core components, having clear referral pathways, evidence-based treatment and recovery approaches, data collection and measures for evaluation.

4) **Communicating the change vision.** Provide training sessions and workshops to staff. Include different levels in the organisation and different training modalities, such as to managers, clinical leads, young people and families and on-the-ground staff. All communication strategies need to include gaining staff views and feedback, plus the rationale and 'givens' of the proposed service delivery model, such as the core components.

5) **Empower broad based action.** Review obstacles and the change process, look and review partnership processes. Adjust planning as needed. Process mapping for the Enhanced headspace service provision of core components.

6) **Short-term wins.** The project team and/or EPPIC SIG acknowledge the process, including addressing staff feedback, highlighting achievements and stages so far in the process, with particular staff identified as 'champions' or active advocates of youth FEP services who have credibility. Clearly document, distribute at different forums/ways.

7) **Never letting up.** Consolidate the gains. Continue with project manager and team to assist with finalising the clinical model of core components and implementation process.

8) **Anchoring new approaches in the culture.** Use new language of early intervention, recovery, youth, hope, and so forth. Develop operational manuals by clinical leads and teams. Utilise program manuals. This can involve further training for staff regarding progress, to reinforce the vision, information sharing, and problem-solving. Support the clinical staff through the transition phase of psychological realignment or to establish a culture for new staff.

This document conveys general approaches and steps to change management. Clearly, within each Early Psychosis centre there are unique factors that may influence change management and specific details to be worked out, such as particular strategies that will legitimise the local change management process.

References

1) Queensland Government Change Management Best Practices Guide. Five key factors common to success in managing organisational change. See www.health.qld.gov.au/publication

2) Kotter, J. Leading change: Why transformation efforts fail, Harvard business review www.kotteronternational.com

APPENDIX III Core Components Checklist for Commencing an EPPIC Service

The following is a brief checklist of what needs to be in place at commencement and the scaling up of an EPPIC service. It may need to be adapted for the local Early Psychosis service and added to. These are to be read in conjunction with the EPPIC Standards and the Australian Clinical Guidelines for Early Psychosis, (2nd edition).

Community Education and Awareness

- Position descriptions
- Recruited
- Psychoeducational resources, brochures regarding the service, technology platforms are identified and implemented
- External key services within the geographic location of EPPIC service identified for education to improve mental health literacy and referral paths i.e. schools, GPs, counsellors, youth workers, NGOs, headspace, police, hospitals, young people, families/significant others
- Internal key programs and staff identified for education to improve mental health literacy and referral paths, i.e., other clinical program staff, emergency departments
- Program established for education regarding youth mental health, FEP and UHR, at both the initiation of the EPPIC service and for ongoing consultation and training
- Clinical pathway model developed. Education to all regarding central referral process and contact number
- Partnerships with community organisations established and service level agreements made or in process
- Liaison with all services established and to be maintained
- In operation at least 1–2 months prior to EPPIC commencement and potential referrers know the start date and how to contact the service

Easy Access to Service

- All referrals to the EPPIC have a designated clearly identified central contact point, such as one triage/intake phone number
- Service location is close to public transport and well known
- Geographic boundaries or catchment areas for some of the EPPIC service components (e.g., the EPACT team) are designated, age range, intake and acceptance criteria defined (clinical pathway model)
- Policies developed regarding referrals for both FEP and UHR
- Intake criteria defined, documented, available for distribution, along with the PQ-16 screening questionnaire
- Defined management strategy for dealing with either influx of referrals at commencement of service or for slower number of referrals
- EPPIC service has infrastructure in place
- Innovative service delivery, technology platforms established
- Afterhours triage/intake established

Home–Based Care and Assessment (EPACT)

- The EFT established to meet demand in geographic area, including coordinator, senior and base levels, based on EPPIC National Support modelling tool
- Infrastructure administration and financial allocation to support rostering system, penalty rates, after hours work, on-call system and home-based work
- Position descriptions documented and recruitment occurred
- A range of multidisciplinary and skilled clinical staff appointed as per minimum standards. Including adequate staffing levels of medical and psychiatric nurses.
- Orientation of all clinical staff
- Location and staff amenities defined and ready with associated infrastructure – vehicles, phones, computers, medical records

Access to Streamed Youth-Friendly Inpatient Care

Established service level agreements with state or privately run inpatient units or establishment of an EPPIC inpatient unit and to have taken into consideration the following factors:

- If a stand-alone young persons' unit is not available then a defined special FEP section of a general acute unit established with bed numbers agreed
- Clear youth-friendly physical environment, welcoming, relaxed atmosphere, posters/pictures, visiting area that encourages families and friends activities
- Youth-friendly multidisciplinary staff that can provide range of services: consultant, psychiatric registrars, psychiatric nurses, social worker, occupational therapist. Sufficient FTE
- Length of stay aimed to be very short (average 10 days) with option of transfer to home-based community treatment and case management
- All necessary infrastructure addressed: offices, number of beds, meals, medications, group rooms, meeting areas, recreational areas, security
- Group programs to support functional activities suited to young people
- Training structure and timetable established, with initial training having taken place if agreed
- Assessment of how clinical interventions comply with Australian Clinical Guidelines for Early Psychosis (2nd edition) and EPPIC National Support minimum standards, i.e. acute phase of treatment, medication, case manager involvement, engagement and recovery focus, family work and psychoeducation etc.

Access to Youth-Friendly Sub-Acute Beds

If possible, facility located and service level agreement reached with consideration of the following:

- Access and discharge criteria documented
- Bed numbers clear and documented
- Purpose documented with clear policies, and operational procedures
- Clear length of stay documented

- Youth-friendly physical atmosphere
- Continued engagement and phase-based recovery approach with options for home-based community treatment
- Clinical care includes EPPIC team reviews with coordinated and collaborative approach with the young person
- Suitable multiskilled clinical team approach, designated FTE
- Functional and occupational activities and services provided for young people
- Training and ongoing professional development for sub-acute staff provided and timetabled. In line with Australian Clinical Guidelines for Early Psychosis and EPPIC National Support minimum standards

Continuing Care Case Management

- UHR and FEP young people have a designated individual case manager
- Case managers have capped case load of 15–20 FEP young people with a minimum two-year duration of care, allocation system established
- Case managers are multidisciplinary and employed at the appropriate designation, i.e., social worker, clinical psychologists, occupational therapists, psychiatric registrar under the supervision of consultant psychiatrist
- Case managers work with a designated consultant psychiatrist or registrar
- Sufficient case manager EFT provided as per EPPIC National modelling tool
- Case managers provide a coordinated approach to care with an individual phase-specific treatment plan, including a comprehensive linkage to other core components/services such as housing, financial, vocational, legal, drug and alcohol
- Case managers trained, or is in progress, regarding the model of care and clinical pathways, guidelines/standards and required data entry processes
- Case managers document all contact with young people and families/significant others in medical records
- Case managers write individual service plans based on case formulation and in planned collaboration with young person and their family/significant other
- Regular review meetings occur at three-monthly interviews with all EPPIC case managers and leaders
- Case managers provide specific psychological therapeutic interventions, such as CBT aimed at recovery
- Position descriptions
- Recruited
- Suitable office space: youth-friendly, confidential
- Administrative support and equipment established (faxes, photocopy, phones, chairs etc)
- Model of case management documented and operationalised for phase of illness
- Case managers understand referral pathways for other core components, such as group program, EPACT, IPU, family work etc
- All staff team meetings planned and to occur
- Philosophy, procedures and criteria established and documented for those young people with potential for an added three years tenure of care
- Quality and evaluation review procedures in place
- Case managers will receive clinical supervision, training and ongoing professional development. Documented and initiated
- Case managers work in line with Australian Clinical Guidelines for Early Psychosis (2nd edition) and National Support minimum standards
- Infrastructure support in place, such as pagers, mobiles, vehicles, computers, office equipment, interview and meeting rooms and other space requirements (lunch areas), administrative support

Medical Treatments

- Position descriptions
- Recruited
- Sufficient EFT to match the anticipated caseload and to match allocation with a case manager
- All medical staff are trained or being trained in the evidence-based pharmacological interventions which are in line with the Australian Clinical Guidelines for Early Psychosis (2nd edition)
- All medical staff trained in the in the treatment of early psychosis and model of care, understand their role and referral pathways
- All medical staff use pharmacological interventions that are cognisant of the youth- and phase-specific focus for FEP
- Medical records are consistently maintained and all interventions noted, with regular review
- Pharmacological interventions are done in consultation with the young person and their family/carer
- Medical staff work as part of a collaborative team and participate in the regular case review process
- All local prescribing and medical interventions are documented in an operational manual and in accordance with the Australian Clinical Guidelines for Early Psychosis
- The physical health needs and metabolic monitoring of young people are part of the comprehensive treatment approach and documented in the medical record. This is also part of the regular case review with a focus on prevention and treatment options
- Early psychosis nurse practitioners may be employed to assist with the health and metabolic monitoring needs
- Infrastructure in place to support medical interventions
- Supervision and accreditation arrangements in place

Psychological Interventions

- Evidence-based psychological interventions are provided to young people by the case manager or in conjunction with specialist staff
- Evidence-based psychological interventions include individual psychotherapy and cognitive behavioural therapy
- A senior clinical psychologist is employed to provide more specialised psychological interventions to those young people that may be more complex in presentation and to assist in overseeing and training specific interventions to case managers. Position description and recruitment occurred

- Psychological interventions are outlined in an operations manual with a focus on engagement, and managing the recovery process. Treatment strategies will include CBT, suicide and relapse prevention, psychoeducation and substance use reduction
- Psychological interventions, including a cognitive behavioural approach to case management, are aligned with the Australian Clinical Guidelines for Early Psychosis (2nd edition) and EPPIC National Support minimum guidelines
- Group and individual supervision is established and will occur on a regular basis. i.e. weekly/fortnightly/monthly
- Professional development has been planned and commenced to assist all staff knowledge and skill bases
- All new staff oriented or in orientation to the philosophy and rationale of psychological interventions for FEP young people
- Clinical resources, including online, are documented and easily accessed by clinical staff, such as a range of clinical treatment manuals on FEP for youth

Functional Recovery Program

- A vocational and educational program is available for young people to assist their return to, or remain in employment or education
- The vocational and educational workers are either embedded in the program, with position descriptions and recruitment occurred, along the lines of the individual and support model, or there are local arrangements with community employment agencies to provide **comprehensive** youth-specific employment and educational assistance
- Service level agreements completed with community agencies with specific detail regarding functions and a youth-specific focus, along with EPPIC program for training and ongoing support on FEP young people
- Easy accessibility for young people to community agencies, providing the service is evident
- Group programs are established to support, either in the service or the community agencies, the functional recovery and assist in the areas of self-esteem, confidence, depression and anxiety, and to return the young person to their normal developmental trajectory for work or school
- Service access may have a technology platform as part of the functional recovery program. This is described and documented regarding use and availability

Intensive Mobile Outreach

- Intensive mobile outreach case management model is documented and implemented depending on local requirements
- Multidisciplinary team with consultant psychiatrist as per EPPIC National modelling tool
- Position descriptions completed and recruited
- Intake, acceptance and discharge criteria documented with description of clinical pathways
- Case loads are capped so as to enable appropriate intensive outreach
- Operational procedures and policies in place and documented to cover comprehensive case management approach, crisis intervention, individual psychological interventions, family support and/or psychological interventions, systems consultation, liaison and advocacy

Group Programs

- Identified group program embedded within the EPPIC or demonstrated partnership with youth-focused group program providers in the community
- Group programs are comprehensive, offering a range of groups suitable for FEP young people to work on personal issues, such as confidence, self esteem, social skills, anger, anxiety and recovery
- Positions descriptions and adequate EFT recruited for the program as per EPPIC National modelling tool
- Groups programs evident, within a supportive peer group environment, and range in size from 4–8 young people and with designated streams
- Review process evident that focuses on a range of group programs offered, which can include school study, work, improving health, physical fitness, reducing drug use, stress management, social and leisure, music, art, mental health
- If group programs are offered in partnership with other community agencies, service level agreement documented and training provided or will be provided and ongoing support documented
- Group programs to align with the Australian Clinical Guidelines for Early Psychosis (2nd edition) and EPPIC minimum standards
- Group programs provided by multidisciplinary clinical team
- Sufficient resource materials for use of group program and suitable location established
- Easy accessibility for young people, as demonstrated by location and hours of operation
- Referral pathways clear and documented
- Staff receive or training planned and ongoing supervision in early psychosis philosophy, model of care and group work

Family Programs and Family Peer Support

- Model of family work and family peer support planning established
- Family work interventions are provided by case managers, with documentation in medical records
- Position description and specialist family worker recruited to provide specific family interventions for more complex cases and to oversee family work within the EPPIC, plus provide supervision and training on key family interventions, particularly to case managers
- Family work in line with Australian Clinical Guidelines for Early Psychosis (2nd edition), EPPIC National Support minimum standards and associated manuals
- Family work will be reviewed regularly as part of case management review, so processes in place
- Psychoeducation and family support groups being planned and established
- Multimedia family psychoeducational resources available for easy access for staff and families

Youth Participation and Peer Support Program

- Youth participation coordinator position described and recruited
- Youth participation coordinator documents model and there are policies and procedures documented that outlines the involvement of the EPPIC young people involvement in service development, feedback processes, peer support, community educational and advocacy activities. Includes strategic planning
- Youth coordinator is actively developing a youth participation team, as demonstrated by youth contact, inclusion activities, and future peer support workers established with position description and option for employment
- Designated space evident for youth participation activities, such as drop in room with multimedia psychoeducation resources and suitable for meetings
- Peer support workers in the future are shown to be derived from the FEP group of the EPPIC

Partnerships

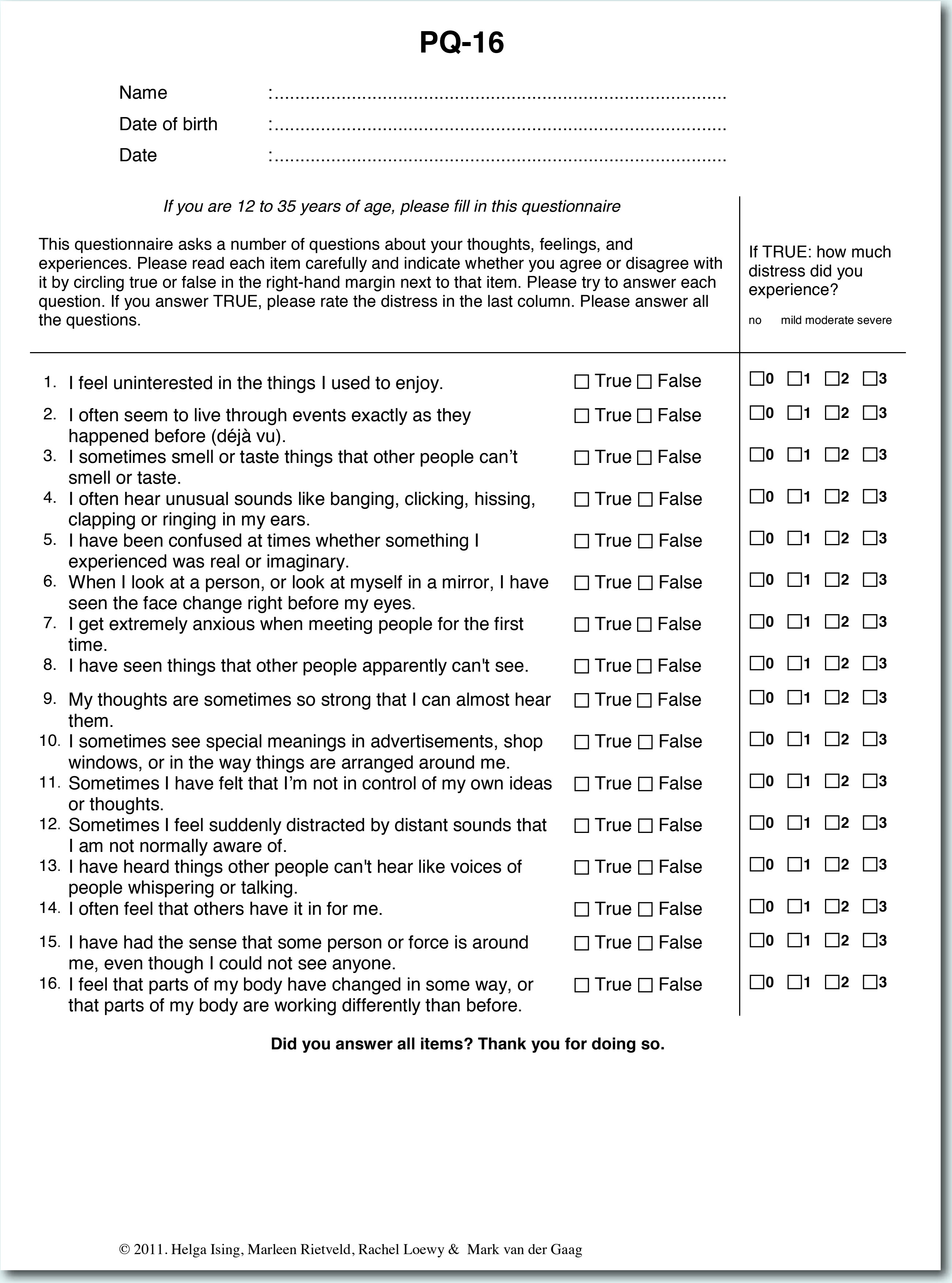
- Documentation of established partnerships in the form of service level agreements or memorandums of understanding
- Clear documentation of purpose, expectations, outcomes and location. May include co-location or integration of services
- Strategic planning documented of future possible partnerships, based on FEP need. Including possible links to facilitate evidence-based research

Workforce Development

- Clearly documented workforce development program as part of strategic planning
- All staff commenced with extensive training, or in progress, on youth UHR and FEP with emphasis on philosophy of early intervention, acute care, recovery, phase-managed illness and core components prior to and at commencement of EPPIC, along with the Australian Clinical Guidelines for Early Psychosis (2nd edition) and EPPIC National Support minimum standards
- Initial training conducted and documented, plus future needs, feedback and gaps reviewed and demonstrated with further training timeline established
- Wide range of resources evident and available for staff use on FEP and UHR young people, including multimedia, clinical manuals, clinical guidelines
- Financial resources available and outlined for ongoing training, professional development and conference attendance with policy and protocols in place
- Documented established links with clinical schools to foster clinical placements and planned commencement of this

UHR for Psychosis Populations

- Positions descriptions and recruitment occurred for clinical staff as per EPPIC National Support modelling tool
- Clear model documented for referrals, intake, acceptance criteria and clinical pathways for UHR young people
- All infrastructure requirements met
- Documented model of UHR care demonstrating adherence to the Australian Clinical Guidelines for Early Psychosis (2nd edition) and EPPIC National Support minimum standards
- Documented policy and procedures for UHR young people not accepted into the program, and for re-referral, plus referral options after the designated period of care
- Tenure of care to be a minimum of six months and documented in intake, screening and acceptance criteria
- Documented training and support for the clinical workforce



PQ-16

Name : ....
Date of birth : ....
Date : ....

If you are 12 to 35 years of age, please fill in this questionnaire

This questionnaire asks a number of questions about your thoughts, feelings, and experiences. Please read each item carefully and indicate whether you agree or disagree with it by circling true or false in the right-hand margin next to that item. Please try to answer each question. If you answer TRUE, please rate the distress in the last column. Please answer all the questions.

If TRUE: how much distress did you experience?

				no	mild	moderate	severe
1.	I feel uninterested in the things I used to enjoy.	☐ True	☐ False	☐0	☐1	☐2	☐3
2.	I often seem to live through events exactly as they happened before (déjà vu).	☐ True	☐ False	☐0	☐1	☐2	☐3
3.	I sometimes smell or taste things that other people can’t smell or taste.	☐ True	☐ False	☐0	☐1	☐2	☐3
4.	I often hear unusual sounds like banging, clicking, hissing, clapping or ringing in my ears.	☐ True	☐ False	☐0	☐1	☐2	☐3
5.	I have been confused at times whether something I experienced was real or imaginary.	☐ True	☐ False	☐0	☐1	☐2	☐3
6.	When I look at a person, or look at myself in a mirror, I have seen the face change right before my eyes.	☐ True	☐ False	☐0	☐1	☐2	☐3
7.	I get extremely anxious when meeting people for the first time.	☐ True	☐ False	☐0	☐1	☐2	☐3
8.	I have seen things that other people apparently can't see.	☐ True	☐ False	☐0	☐1	☐2	☐3
9.	My thoughts are sometimes so strong that I can almost hear them.	☐ True	☐ False	☐0	☐1	☐2	☐3
10.	I sometimes see special meanings in advertisements, shop windows, or in the way things are arranged around me.	☐ True	☐ False	☐0	☐1	☐2	☐3
11.	Sometimes I have felt that I’m not in control of my own ideas or thoughts.	☐ True	☐ False	☐0	☐1	☐2	☐3
12.	Sometimes I feel suddenly distracted by distant sounds that I am not normally aware of.	☐ True	☐ False	☐0	☐1	☐2	☐3
13.	I have heard things other people can't hear like voices of people whispering or talking.	☐ True	☐ False	☐0	☐1	☐2	☐3
14.	I often feel that others have it in for me.	☐ True	☐ False	☐0	☐1	☐2	☐3
15.	I have had the sense that some person or force is around me, even though I could not see anyone.	☐ True	☐ False	☐0	☐1	☐2	☐3
16.	I feel that parts of my body have changed in some way, or that parts of my body are working differently than before.	☐ True	☐ False	☐0	☐1	☐2	☐3

Did you answer all items? Thank you for doing so.

The PQ–16 questionnaire should only be used after referring to the following:

Loewy RL et al. (2005). The Prodromal Questionnaire (PQ): Preliminary validation of a self-report screening measurefor prodromal and psychotic syndromes. Schizophr Res 77(2-3): 141–9.

Notes

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