

Youth Early Psychosis Status Report

**Mental Health Branch
March 2007**

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Youth Early Psychosis Status Report

Foreword

Youth Early Psychosis (YEP) services have been funded to provide specialist treatment and care to young people who are experiencing, or at high risk of, a first episode of psychosis. Many of these young people also have drug and alcohol problems that require concurrent treatment in light of the interactive nature of drug and alcohol use and mental illness (dual diagnosis). Monitoring and early treatment may be provided in partnership with other health service providers such as GPs in the early stages of the illness. Services have also demonstrated the value of such collaborative practices following discharge.

The initiative has drawn upon promising research that has shown that by providing timely treatment, specific to the phase of illness and in accord with the evidence, the duration and severity of illness and associated disability can be reduced and outcomes improved for these young people.

The YEP funding specifically enables smaller caseloads for an increased number of YEP clinicians, enabling them to work more intensively with young people and their families, providing assistance, if required, throughout the critical three-year timeframe following the first episode, when relapse is most likely.

More generally, YEP services also promote the development of a youth-specific focus within specialist mental health services. They provide another option for treating the older adolescent and young adult cohort known for its developmental diversity. The youth model bridges existing programs for children and adolescents (0-18) currently provided by CAMHS and those for older adolescents and adults (16-64). As such the YEP services broaden the range of options for engaging a diverse client group and those who care for them. In particular, YEP services offer opportunities in the assessment and treatment of dual diagnosis given that it is common rather than exceptional among this group of young people.

Since its introduction in 2003 the YEP program has progressively expanded, and a YEP service has now been funded in 17 out of the 21 Area Mental Health Services covering the State. Because of the growing investment in this new model, it was decided in 2006 to undertake a status report examining the implementation and functioning of YEP services to date.

Although this status report is not a formal or independent evaluation of the initiative, the findings and recommendations contained herein are expected to inform quality improvement activities in YEP services and guide ongoing service development. The important linkages between these clinical programs and Psychiatric Disability Rehabilitation and Support Services will become an increasing focus as YEP services become more established.

On behalf of the Department of Human Services I thank all those who contributed to the development of this report.



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Acting Executive Director
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March 2007

Executive Summary

The purpose of this Status Report is to provide managers, planners, clinical leaders and interested professionals in the mental health sector in Victoria with an overview of the implementation to date of the Youth Early Psychosis (YEP) program. It examines Youth Early Psychosis services from three perspectives: how they were implemented, how these relatively new services are currently operating, and how well they are currently positioned for a more comprehensive evaluation.

The first wave of funding for regional Youth Early Psychosis services in Victoria was rolled out in 2003-2004, and service provision commenced in 2004. As YEP services aim to assist young people aged 16 to 25 years of age experiencing first-episode psychosis for a period of up to three years, the first notional 'cohort' of clients will not be discharged until some time in 2007. With clinical outcomes as yet unascertainable, it would have been premature to embark upon a comprehensive service evaluation initiative. This Status Report therefore sets out to document progress in implementing this new model, to identify challenges services have encountered in establishing their YEP service and local approaches to circumvent any obstacles. It is hoped that, in the short term, the experience of these 'early adopters' will be of use to area mental health services that are yet to implement (or be funded for) a local Youth Early Psychosis service. In the long term, the findings in this report can provide a point of reference for future service improvement and evaluation activities.

DHS provides service enhancement funding for YEP services, premised on the fact that all tertiary public mental health services have already been providing a level of service to the target population, albeit at a later stage of the illness. Services are expected to identify the extent of resources being used to address early psychosis with young people aged between 16 and 25, and to consolidate these resources with designated YEP funding into a cohesive new service.

Two distinct YEP service models have evolved. The first is centred around a clearly identifiable team within adult mental health services. In the second approach, YEP clinicians are spread across adult teams but unified by their focus on youth early psychosis issues. Each approach carries both benefits and risks. Because of its clear physical presence, the 'team-based' model may be easier to implement, but in the long-term this approach may lead to the creation of an additional service boundary and militate against the development of an early psychosis focus across the continuum of services. The 'function-based' model may facilitate the development of precisely such a focus, provided the YEP effort does not become diluted and mainstreamed before the service gets to that point.

Implementing a YEP service requires more than adding just another component to the existing network of mental health services. As the YEP service is underpinned by an early intervention framework, clinicians are being asked to work in a different way: to intervene more proactively at an earlier stage of the illness, in ways that are specifically targeted at the phase of the illness, and to work longer and more intensively with a smaller group of clients many of whom experience dual diagnosis (both mental health and drug and alcohol problems). Implementing this extent of change to local service culture means that a coherent change management process needs to be developed. This process needs to engage, firstly, with clinical leaders in order to gain their support and their willingness to act as an advocate for the new service.

Some YEP services experienced a significant lag time between funding being provided and the commencement of clinical service provision. The primary external constraints that have delayed service establishment include recruitment difficulties, problems in securing appropriate accommodation; and the need to clarify or resolve governance issues in a multi-provider service. YEP services also commented on the significant community development workload in the implementation phase, as effective linkages have to be established with a broad range of service providers.

There was, across all YEP services, a strong commitment to the early intervention model underpinning the program, and a belief that the YEP model really 'works'. Key factors

contributing to the perceived service effectiveness were the lower caseloads, the capacity to engage the young person, and the effective linkages with other service providers. Examples of positive outcomes cited included improved, and more consistent, clinical care, greater continuity of care, high levels of consumer satisfaction; and positive feedback from families about psycho-education sessions.

While these comments are positive, most positive feedback about YEP services to date is based upon clinician or manager perception and is yet to be substantiated independently. YEP services were generally not able to access key data in order to critically reflect upon the effectiveness of their service and identify areas for improvement. The Mental Health Branch will work with YEP services to strengthen and unify data collection practices through the introduction of a shared Minimum Data Set in order to provide the program with a solid evidence base that can support and inform monitoring and quality assurance processes.

In terms of operation, the picture that emerges from the template responses and the site visits is that the new YEP services generally 'deliver' on their primary role of providing intensive case management for young people aged 16 to 25 years with early psychosis. The care they deliver appears to be guideline-based and phase-specific. In keeping with the YEP service focus on early intervention, a lower threshold for intake is in place and is supported by effective linkages with triage and CAT teams.

YEP service feedback indicates that, collectively, YEP services have made significant headway in delivering the core dimensions of the program but have further to go in fully implementing early intervention approaches, in optimising continuity of care and in further developing effective linkages with stakeholders, including families and primary care providers. More work is also required in developing linkages with services for clients from culturally and linguistically diverse (CALD) and indigenous communities.

Recruitment and retention cause a range of problems for most YEP services, but in particular for those in rural areas. Firstly, recruitment problems and staff turnover compromise a service's capacity to meet its targets. When young people's needs cannot be met by the YEP service, demand upon other components of the service system increases. A period of reduced staffing is likely to result in more restrictive clinical practice. The service can become more inward-looking, focusing on the key priorities of providing safe care to clients and avoiding their relapse; but service development ceases until capacity is restored.

The report recommends that the statewide rollout of the Youth Early Psychosis program be continued to extend service coverage across the State.

The recommendations developed in the course of this Status Report can be found on page 33.

Introduction

There has been a significant expansion of the Youth Early Psychosis (YEP) program since the first regional services were established in 2003-2004. The purpose of this Status Report is to provide managers, planners, clinical leaders and interested professionals in the mental health sector in Victoria with an overview and appraisal of YEP implementation to date.

After a brief introduction outlining the expansion of the YEP program, the Status Report examines Youth Early Psychosis services from three perspectives: what factors impacted on service implementation, how these relatively new services are currently operating, and how well they are currently positioned to reflect upon their own practice and to lay the groundwork for a more comprehensive evaluation down the track.

This report is not a formal service evaluation activity; it is too early for such an endeavour. It was conceptualised by the Mental Health Branch of DHS as a contained initiative that aims to identify, in consultation with the sector, a range of service development issues associated with the implementation of a Youth Early Psychosis service.

It is hoped that this report will:

- bring a renewed focus to early psychosis service implementation and practice-based evaluation;
- assist services that are still in the service planning or implementation phase;
- improve the knowledge base for further expansion and evaluation of the program as funding becomes available; and
- assist in identifying issues that need to be taken up by DHS centrally.

The Mental Health Branch would like to commend all those involved with YEP implementation on their efforts and achievement to date; and to thank all those who contributed to this Status Report (see Appendix 6) for their time, which was given so freely.

The Expansion of YEP Services in Victoria

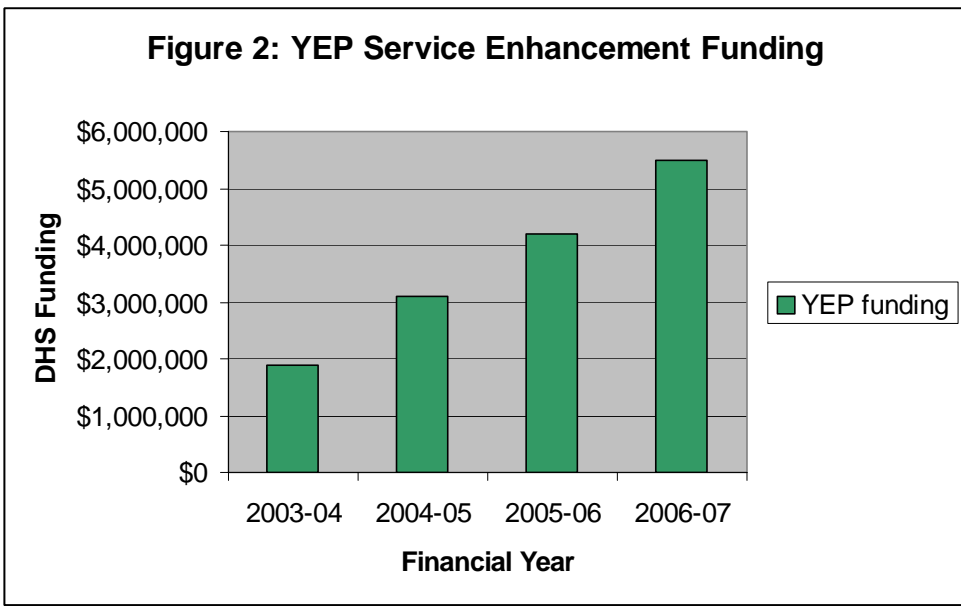
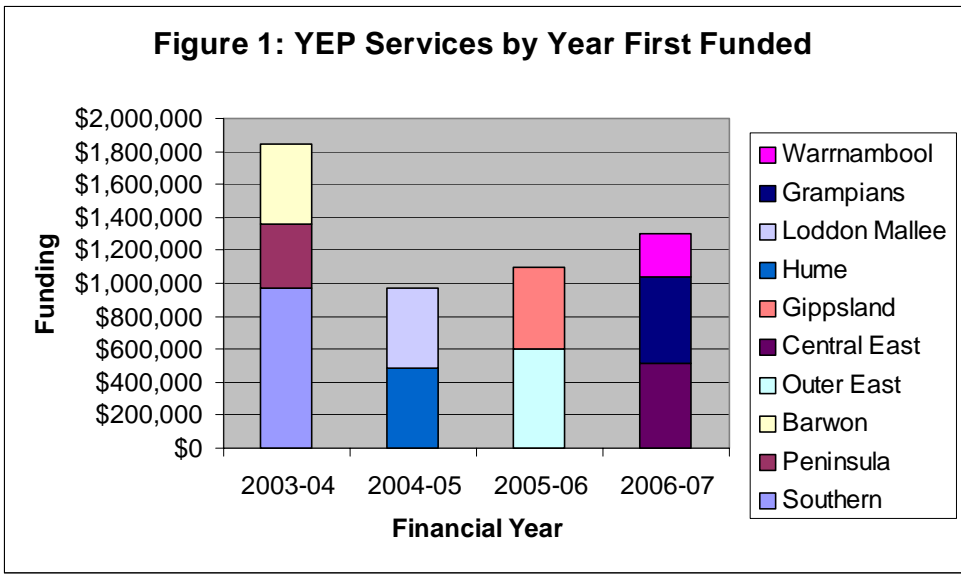
The rate of first onset of mental health disorders is highest among the older adolescent and young adult age group: up to one in four.

Early intervention in first-onset psychosis, a serious low prevalence mental disorder, indicative in some cases of the onset of schizophrenia and often accompanied by problematic drug and alcohol use, has been a priority for government. A growing body of research suggests that early intervention using appropriate treatments can improve short and longer-term outcomes for these young people, including increased rates of recovery, reduced rates of relapse and lower levels of disability.

The Early Psychosis Prevention and Intervention Centre (EPPIC) was established in 1992 and has gained national and international acclaim for its work in the area of first-onset psychosis. EPPIC is now part of ORYGEN Youth Health and provides a local early psychosis service through its Continuing Care Team (EPPIC CCT) to four Area Mental Health Services (AMHS). In addition, EPPIC Statewide provides education and training support to regional Youth Early Psychosis services across Victoria.

Since 2003-04 the Victorian State Government has invested in the systematic rollout of regional Youth Early Psychosis (YEP) services to 16–25 year olds as a subspecialty program within the Adult Area Mental Health Service with close links to Child and Adolescent Mental Health Services, primary care services and other community services and organizations.

Figure 1 below shows when each regional YEP service was first funded; figure 2 shows the steady build-up of recurrent funding since 2003-04.



The first YEP funding allocations in 2003-04 were determined on the basis of an expression of interest process. Funding was provided to establish a YEP service in Barwon Health as well as a joint program across Southern Health and Peninsula Health which has now developed into two separate programs that are separately funded.

Since 2003-04 a primary concern in rolling out YEP services across the State has been to establish a YEP service presence in all rural areas in the first instance.

By 31 March 2007, all young people aged between 16 and 25 living in rural areas of Victoria and experiencing, or at risk of, first episode psychosis, will have a Youth Early Psychosis service within their region. In Melbourne metropolitan areas, 73% of the youth population will have access to a YEP service by that date, and across the state, 80% of the youth population. An overview of regional YEP services can be found in Appendix 2.

In *Future Directions. An Action Agenda for Young Victorians* (2006) the expansion of YEP services is identified as one of the 'Top 40' actions aimed at improving outcomes for young people.

Four metropolitan areas have to date not received dedicated funding from DHS to establish a YEP service. These are:

- Inner South Area Mental Health Service (The Alfred Hospital)
- North Eastern Area Mental Health Service (Austin Health)
- Inner East Area Mental Health Service (St. Vincent's Health)
- Northern Area Mental Health Service (Melbourne Health)

It should be noted that St. Vincent's Health has recently established a YEP service. This service started operating in part of the catchment in October 2006 and is not included in this Status Report.

Dedicated funding for the new regional YEP services shown in figure 1 totalled \$5,502,607 in 2006-2007, providing 56 EFT. While the chart reflects the steady rollout of the YEP service model over the past four years, it also understates the overall level of funding spent on early psychosis services in Victoria. Firstly, EPPIC funding (which provides a further 31.2 EFT across EPPIC CCT and EPPIC Statewide) is not included in the chart. Secondly, a key requirement of the YEP funding model is that services identify, prior to the YEP service agreement being finalised, the extent of resources that are already being devoted to assisting clients with first-onset psychosis in the age group. These resources are then combined with the dedicated YEP service enhancement funding provided by the Department of Human Services to establish a comprehensive and integrated Youth Early Psychosis program as a specialist program within the adult mental health service. In order to assist services in that undertaking, a Census Kit has been developed. The kit enables services to compile a snapshot of their current early psychosis workload with the target group. The Mental Health Branch of the Department of Human Services generally expects new YEP resources to be matched by the auspice agency.

Standards and Guidelines

Regional Youth Early Psychosis services established in Victoria operate within a well-defined legal, regulatory and quality assurance context.

In addition to the legislative and policy context that Youth Early Psychosis services share with all other publicly funded specialist mental health services, two discreet sets of additional guidelines apply. These are:

1. *The Australian Clinical Guidelines for Early Psychosis*, EPPIC, s.d. [~2001]. These guidelines are currently out of print; a revised version is expected in 2007.
2. *Youth Early Psychosis Program Description*, Department of Human Services, revised version, September 2006.

Template

The Status Report project brief proposed a dual approach to data collection and consultation. As a first step, Youth Early Psychosis services were asked to complete a Status Report Template. This template invited services to comment upon their own achievement of key program parameters that were set out in the DHS *Youth Early Psychosis Program Description*. The templates were sent to Youth Early Psychosis services in June 2006.

Completed templates were received from the following Youth Early Psychosis services:

- Barwon Health
- Bendigo Health Care Group
- Eastern Health
- Goulburn Valley Area Mental Health Service
- Latrobe Regional Hospital
- ORYGEN Youth Health (covering EPPIC CCT)
- Peninsula Health
- Southern Health

In light of the fact that Eastern Health and Latrobe Regional Hospital were still establishing their Youth Early Psychosis service at the time the template was sent out, activity and performance data cited in this Status Report refer to the six other services established since 2003-04. As the focus of this report is upon program-wide learning to date, responses are not attributed to individual services.

Site Visits

By September 2006 all templates had been received and staff from the Mental Health Branch started arranging site visits. The purpose of these was to discuss the template responses with the service in order to gain a more in-depth understanding of each service and to clarify any issues arising from the template responses.

Nine site visits were made between September and November 2006. These covered all eight services that had completed the template as well as EPPIC Statewide, which was included because of the support it provides across early psychosis services.

The site visits were typically two hours in duration, and the Mental Health Branch had requested that the Area Mental Health Manager and YEP Manager would be in attendance for each visit, as well as any other staff at the discretion of the service. A list of persons who completed the template and/or participated in the site visits can be found in Appendix 6.

Other Data Sources

The Mental Health Branch also undertook an independent analysis of 2005-2006 RAPID data pertaining to YEP service activity, clients' clinical presentation and outcomes. The results of this analysis are discussed in the 'Themes and Findings' section of this report.

Themes and Findings

Establishing a YEP Service

Service Model

The Youth Early Psychosis program is described in detail in the DHS *Youth Early Psychosis Program Description* (see Appendix 1 for some selected excerpts) and some distinctive features relevant to the discussion below are:

- The YEP program is based on a diagnosis-specific approach;
- Its clientele (young persons aged 16 to 25) can receive services from either CAMHS (0-18) or Adult Mental Health Services (16-64);
- The program is a subspecialty within the Adult Mental Health Service but its approach is to become evident across all service elements; and
- The program uses existing triage mechanisms but effectively requires intake workers to lower their threshold when screening prospective YEP clients as the YEP service seeks to intervene earlier in the course of the illness.

This last point in particular is a reason why the YEP program was originally conceptualised and delivered as a discreet program type. Most staff agreed that without a separate program identity, YEP services could easily be subsumed into the adult mental health services stream. This could result in program drift to the 'harder' end and, in the longer term, the loss of early intervention capacity.

Two service types

However, other staff advocated for a 'function-based' service model (often referred to as an 'integrated model'). In this approach, YEP clinicians are inserted into existing adult teams, or existing clinicians screen off part of their workload for YEP work. Proponents of the function-based model acknowledge the risk that the YEP service can become diluted, but argue that measures can be taken to guard against this, such as monthly meetings of all clinicians with a YEP role. They believe that, while a function-based model may initially be more difficult to establish, it will make it easier in the long term to achieve a YEP focus across the continuum of services. They believe that a team-based YEP service risks creating additional boundaries and becoming a niche service.

There is one area of the State where a team-based and a function-based YEP service operate within the same regional area, each covering its respective catchment area.

The Mental Health Branch is of the view that the YEP services that have adopted a function-based service model provide a service response that is fully compatible with the spirit of the DHS *Youth Early Psychosis Program Description*. DHS will review the latter document, which currently prescribes a team-based model, with a view to providing more flexibility as to the service model. While there may be some flexibility as to the model of service, it is crucial that the model of care remains unchanged.

Recommendation:

That the Mental Health Branch of the Department of Human Services review and update the Youth Early Psychosis Program Description, particularly with respect to providing greater flexibility about the service model.

Change Management

Clinical leadership

“Cultural change precedes practice change”, commented one service. Another service indirectly substantiated this assertion by commenting it took clinicians who were used to working in adult mental health services six months to reorient themselves to a new model of care. Some YEP staff cited the lack of support from clinical leaders making implementation slower and more difficult. All services agreed that it is crucial to have a local clinical ‘champion’ who can act as an advocate for the YEP model and support its introduction in the organisation.

Staff also emphasised the need for psychiatrists, as medical leaders, and other senior staff to be engaged in service development from the outset, to promote ownership and to avoid resistance. The importance of engaging the authorised psychiatrist in particular was highlighted.

A generic project management approach unsupported by a service-based professional education component highlighting clinical benefits means that new programs risk not being well supported.

Critical mass

Several YEP services commented that achieving critical mass was important in ensuring program fidelity and expressed a preference for larger teams with strong organisational supports on site over small outposted teams in remote areas.

Guidance

One YEP service challenged the prescriptiveness of the *Youth Early Psychosis Program Description* developed by DHS. Other services, however, commented positively on the existence of clear program guidelines, adding they were a useful tool in the change management process.

Another useful resource is Jane Edwards & Patrick McGorry's *Implementing Early Intervention in Psychosis* (Martin Dunitz, 2002). It contains a practical chapter on ‘Developing an early psychosis service — nuts and bolts’.

Barriers to Implementation

Some YEP services experienced a significant lag time between funding being provided by the DHS and the commencement of clinical service provision.

The primary external constraints that have delayed service establishment include:

- Recruitment difficulties
- Accommodation problems
- Clarifying/resolving governance issues in a multi-provider service

Workforce

Recruitment and retention issues vary across geographical areas, professional categories and service types. It is not surprising that new service models are finding it difficult to recruit staff with the appropriate knowledge and skills in an overall environment of workforce shortage. These issues are discussed in more detail under the *Workforce* section later in this report.

Accommodation

Accommodation difficulties arise from the obvious need to find office accommodation on site for a new team. This generally involves office fitout, changes

to IT infrastructure and occasionally large-scale reconfiguration of the auspicing adult mental health service, or negotiating co-location arrangements with a third party. In rural areas, these issues are often replicated over a number of service delivery sites. Establishment costs have on occasions been met from the first year's operation budget, with approval from the DHS. Obtaining Council approval to operate a health service from the proposed site may be a further complicating factor.

Governance

Governance issues in a multi-provider service can be addressed through the development of a Memorandum of Understanding prior to service commencement and ongoing collaboration centred around regular meetings of a local steering committee. This requires considerable work and goodwill on the part of senior management and clinical staff.

In dealing with issues such as those identified above, it is proposed that health services adopt a formal project management approach to YEP service establishment, identifying key steps and timelines, undertaking a risk assessment analysis and developing fallback options to deal with constraints and setbacks (such as failing to obtain Council approval, or seeing a newly appointed coordinator 'shoot through'). Services should consider a staged approach to recruitment, whereby a YEP coordinator is recruited in the first instance. The coordinator then has the capacity to drive the establishment of the YEP service, addressing implementation issues as they arise, recruiting the broader team and developing a relationship with other stakeholders pending the commencement of clinical service delivery.

Recommendation:

That health services adopt a formal project management approach to YEP service establishment.

Operating a YEP Service

Target Population

The YEP Program Description developed by the Department of Human Services defines the target group for Youth Early Psychosis services as young people 16-25 years of age inclusive who are:

- displaying a vulnerable mental state and at risk of progressing to psychosis, including those with concomitant drug use and other risk factors;
- experiencing early psychosis, including those with concomitant drug use;
- at risk of, or having relapsed following, a first episode of early psychosis.

In their responses to the template, seven of the eight YEP services indicated that the program description accurately described the client population of their YEP service.

Clients in the Prodrome

How early is early? YEP services will generally accept a young person for assessment in the prodromal phase, which means that — in areas where a YEP service is in place — the adult triage worker will typically use a lower threshold in assessing referrals for the YEP age group. The task for the YEP service here is to intervene early, but within the remit of tertiary services. The intention is that, where appropriate, YEP assessments enable the team to support general practitioners managing and monitoring young people with an ‘at risk’ mental state.

Following triage, the YEP worker will engage the young persons and their families or carers, conducting a protracted assessment. If the worker is confident that the psychotic symptoms are indicative of early psychosis (rather than caused by, for example, depression, substance abuse or developmental factors) formal YEP intake follows. Non-accepted referrals will generally be referred on to another service provider; even in these cases the YEP assessment may have served to educate stakeholders about early psychosis.

YEP services emphasised the following points:

- The importance of effective joint work, in particular with Primary Mental Health and Early Intervention (PMHEI) teams, General Practitioners, Dual Diagnosis services and adult Triage.
- Resource limitations may constrain the capacity of the service to engage young people who are in the prodrome; and cause the service focus to shift towards clients with a more clearly established symptomatology.

Service Access

Local access

All YEP services comply with the requirement that the YEP service catchment is that of the combined catchment of the participating Adult AMHS. However, two YEP services signalled a temporary service gap resulting from an area not being covered due to problems in filling vacant positions.

With the exception of one YEP service that has the capacity to provide its own intake process, YEP intake typically occurs through the triage function of the adult mental health service. Potential YEP clients are identified at the point of intake, with the triage worker positively discriminating for early psychosis.

Operating hours

YEP operating hours are typically from 8:30am to 5:00pm. One service offers extended hours (until 10pm) and another is planning to do so one evening per fortnight. Several services provide after-hours group work or carer education sessions.

As the YEP program is integrated with other service elements, it utilises crisis response mechanisms of the broader service. The YEP after-hours response typically relies on the same arrangements as the local Community Care Team, with callers contacting either the daytime triage number or a dedicated 1300 or 1800 number, with clinical back-up and/or emergency response capacity provided by the CAT team, an on-call clinician or the local Emergency Department. One service commented that all its YEP clients have a crisis management plan that can inform a crisis response — and similar arrangements may also be in place in other services. The routine development of crisis management plans constitutes good practice as it facilitates continuity of care outside the normal operating hours of the service.

Service Duration and Discharge Practices

Service Duration

The DHS program description states that YEP services will work with and case manage the target population within the adult area mental health service for up to three years. YEP services were asked in the template to indicate to what extent their service met this parameter. The responses were:

Not in place	0
Partially in place	3
Fully in place	5

Six YEP services are providing a three-year service in line with the program description. One YEP provided an 18-month service, but is currently extending this to two years. One other YEP service provides a two-year service. The 'partially in place' response by a third service related to governance issues needing to be resolved, rather than service duration.

Services cited the following problems in adhering to the three-year timeframe:

- It can be difficult to keep the young person engaged beyond 12 to 18 months. The young person may become disengaged as a result of a number of factors— both internal (e.g. loss of motivation) and external (e.g. change of case manager).
- Demand pressures upon services tend to drive up caseloads and this in turn encourages early discharge where this is clinically feasible.

Discharge Practices

Upon YEP case closure, young people who need further services may be referred for ongoing support to a range of providers, including general practitioners, educational or vocational services or psycho-social rehabilitation programs. Young people who need ongoing specialist mental health services beyond three years are referred to Continuing Care Team of the local adult mental health service.

Some services commented that discharge trends are not yet clear, as only a few YEP services had been operating for two years or more at the time of the site visits. YEP clients should receive education about relapse management so they know where to go if their problems recur following discharge. The YEP service should have procedures in place to fast track former clients back into the service.

It is important to establish who has accountability for follow-up work post YEP intervention. A three-monthly follow-up phone call from the YEP worker was proposed as one way of monitoring post-discharge progress. If the level of intervention is reduced to this extent, it may be more appropriate for the GP to do the follow-up and the YEP service to consult with the GP to determine whether there is a need for any more intensive monitoring and support.

Effective discharge planning is an important component of providing quality care. YEP services need to ensure that concerns about the locus of clinical accountability in monitoring clients' progress following discharge do not compromise opportunities for the early identification of relapse. Clear guidelines that identify protocol and training issues need to be developed and shared with other providers, such as GPs.

Continued collaboration is required between the YEP service, the adult mental health service and other providers to improve transition arrangements and to ensure continuity of care for young people who need treatment and support beyond the YEP timeframe for service provision.

Recommendation:

That YEP services have in place arrangements for monitoring recently discharged clients and for re-engaging these young people promptly should they be at risk of, or experiencing, relapse.

Program Fidelity

As the YEP Status Report is not a service evaluation, it would not be appropriate to draw firm conclusions about program fidelity. It may however, be of interest to report how YEP services currently see their own performance in this regard. The services were asked, in the Status Report template, to indicate whether local YEP service provision, in their opinion, met the Key Service Criteria (KSC) set out in the DHS *Youth Early Psychosis Program Description*. An overview of service responses can be found at Appendix 4.

The following summary reflects the common view:

- YEP services 'deliver' on their primary role of providing intensive case management for young people between 16 and 25 years with early psychosis.
- The care being delivered is guideline-based, and supports phase-specific care. In some services, the guidelines can be embedded further.
- Intervention types vary according to the phase of the illness and include Cognitive Behaviour Therapy, psycho-education, medical pharmacotherapy, intensive family work, individual engagement and support; and relapse prevention work.
- A lower threshold for intake is in place and is supported by effective linkages with triage and CAT teams. However, some YEP services report that resource limitations restrict the extent of early intervention work.
- YEPs provide assessments, primary and secondary consultations to GPs and primary health care providers. Some YEP services are co-located with youth services and/or community health services. More community education can further strengthen these linkages.
- Crisis response arrangements are in place and supported by good linkages with triage and CAT teams. Clients have an individually tailored relapse prevention plan.
- Some YEP services report a strong focus on family work within their case management practice.

The self-ratings summarised in the table in Appendix 4 suggest that YEP services feel they have made significant headway in delivering the core dimensions of the program (see KSC 1, 2, 3, 4, 6 and 7) but have further to go in delivering on their early intervention mandate (KSC 12), in optimising continuity of care (KSC 13) and in developing effective linkages with stakeholders, including families (KSC 5) and primary care providers (KSC 10 and 11).

It is recommended that Area Mental Health Services review, at least every two years, the performance of the local YEP service against the national *Clinical Guidelines for Early Psychosis* and the DHS Program Description. Undertaking this local review could be a role of the Quality Manager.

Recommendation

That Area Mental Health Services review, at least every two years, the performance of the local YEP service against the national Clinical Guidelines for Early Psychosis, the DHS YEP Program Description and other relevant standards and guidelines.

Service Linkages

Internal linkages

The DHS program description states that the YEP service “will be dependent upon strong internal linkages within and across participating specialist Adult AMHS in order to operate effectively as a subspecialty incorporating all service elements including crisis, community, subacute and inpatient and rehabilitation services”.

In the Status Report template, YEP services were asked to indicate to what extent their YEP program has been able to establish a focus across the continuum of services. Five YEP services stated that this was “partially in place” and three that this was “fully in place”.

Examples of strong internal linkages cited were:

- Integration at management level.
- Joint work with adult services.
- Staff rotation with adult services.
- Referral frameworks are in place.
- Weekly meetings of senior YEP clinician with CAT team.
- Implementation of clinical pathways across the continuum of services.
- YEP coordinator conducts case reviews on-site with the adult team.
- Case management is integrated with the adult team.
- Adult CCT pick up YEP ‘overflow’.

The program description also recommends that a clearly identifiable YEP program be developed within existing inpatient resources as part of articulating the YEP response across the continuum of services. Only one YEP service stated that this was “fully in place”. Five other YEPs state that their relationship with the inpatient service is “partially in place”. In one YEP service this relationship is “not in place”.

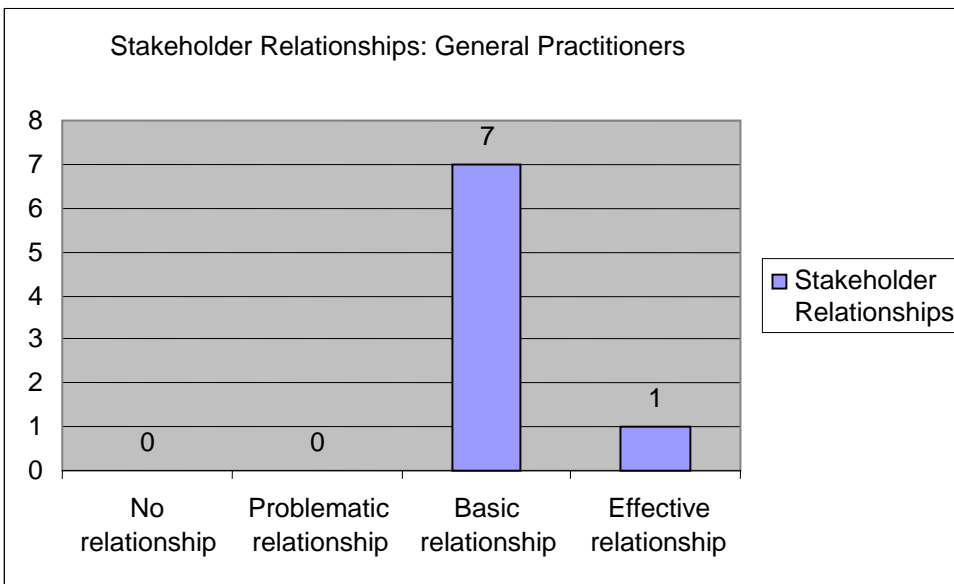
Examples of strong internal linkages with the inpatient unit included:

- Clinical guidelines for all phases of care to ensure consistent standards of treatment irrespective of service setting.
- YEP provides ongoing education regarding care and management of the target group.
- Implementation of clinical pathways across the continuum of services.
- Liaison with the Consultant Psychiatrist.
- Use of the PARC ‘step-down’ unit for supporting a recovery structure for young people with first-episode psychosis.
- Provision of training to inpatient unit staff by EPPIC Statewide.

External Linkages

In the Status Report Template YEP services were asked to ‘rate’ their linkages with other service providers. The options provided were “no relationship”, “problematic relationship”, “basic relationship” and “effective relationship”. These categories were not defined in the template.

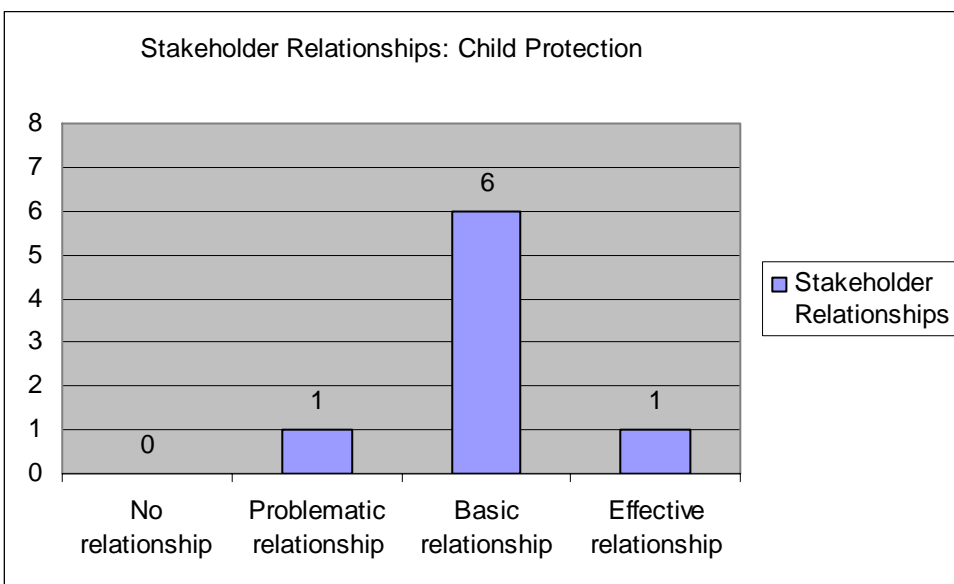
The graphs below show how YEP services rated their linkages with selected other providers. A full summary of responses can be found in Appendix 3.



Comment:

YEP staff cited the following examples of effective linkages with general practitioners that promote and strengthen shared care:

- Develop relationships with 'mental health-friendly' GP practices as the primary target group.
- Develop clear screening tools and discharge protocols with the local Division of GPs.
- Consult with GPs in relation to prodromal clients. Keep the GP informed, including in cases where the YEP retains primary management responsibility.
- One service 'rewards' mental health-friendly' GPs by fast-tracking their clients, guaranteeing a response by the consultant or registrar within 24 hours. Participating GPs in return see Clozapine clients.



Comment:

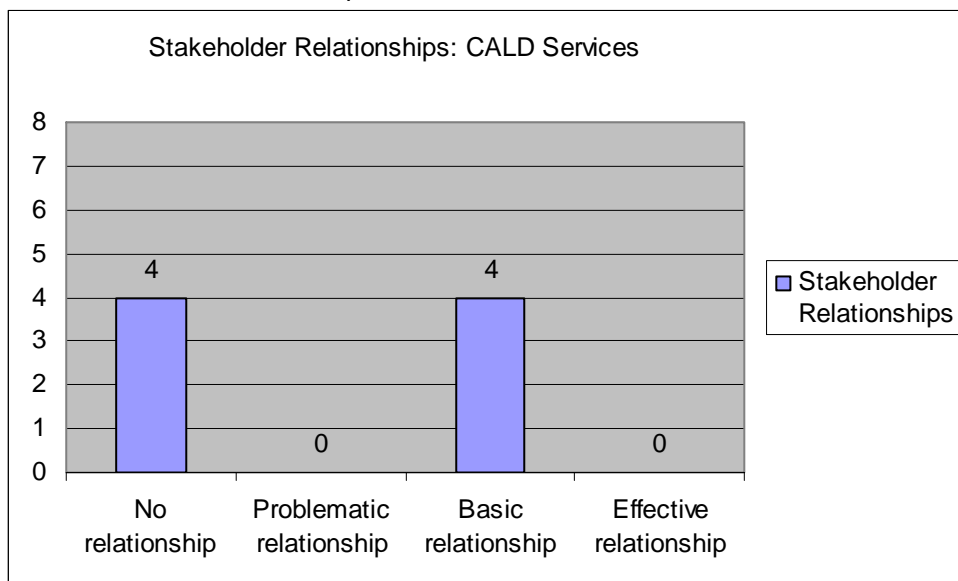
The service describing its relationship with child protection as 'effective' cites the following examples:

- Relationships are strong and protocols are in place.

- A Child Protection representative is on the local YEP advisory group.

The service describing its relationship with child protection as 'problematic' cites the following example:

- There are inconsistent practices and problem areas and the YEP service has identified the need to develop links with Child Protection.



Comment:

Four YEP services report they have no relationship with services for clients from culturally and linguistically diverse (CALD) backgrounds. Given the multicultural composition of our society, including in country areas, this gives cause for concern. Staff from one service rightly cautioned that an apparent lack of demand from CALD clients may mask underlying issues regarding service access and participation. Likewise, responses showed that there is scope for improving linkages with services for indigenous young people.

Strengthening Linkages

An effective way of periodically bringing together a range of diverse stakeholders is by convening a YEP Regional Reference Group.

Some of the larger reference groups include representation from consumers, carers, adult mental health services, CAMHS, PMH&EI teams, GPs, Child Protection, Juvenile Justice, Aboriginal Youth Services, youth workers, Drug & Alcohol services, the Department of Education, Employment and Training (DEET) and EPPIC Statewide.

It is advisable to have clear terms of reference which outline the purpose of the group, its objectives (for example, to develop referral pathways, or to strengthen networks), membership, frequency of meetings and the level of attendance required to constitute a quorum. The terms of reference should also reflect a focus on service coordination and collaboration to improve service access and continuity of care for consumers. YEP regional reference groups should also establish linkages with Primary Care Partnerships (PCPs) as the Victorian Government’s key platform for service coordination within primary care and between primary care and other service sectors in order to strengthen the link between service planning and delivery with population health needs.

Other strategies for strengthening linkages include:

- the development of a YEP service plan that clearly profiles the service within the local configuration of services and can be shared with other providers as a basis for dialogue;
- the development of screening tools, referral pathways and discharge protocols in collaboration with stakeholders;
- participation, as appropriate, in case reviews;
- community education sessions;
- staff rotation.

Recommendations

That YEP services establish better linkages with services for Culturally and Linguistically Diverse (CALD) clients and indigenous young people in their catchment.

That EPPIIC Statewide develop a strategy for assisting YEP services in establishing better linkages with services for Culturally and Linguistically Diverse (CALD) clients and indigenous young people.

Workforce Issues

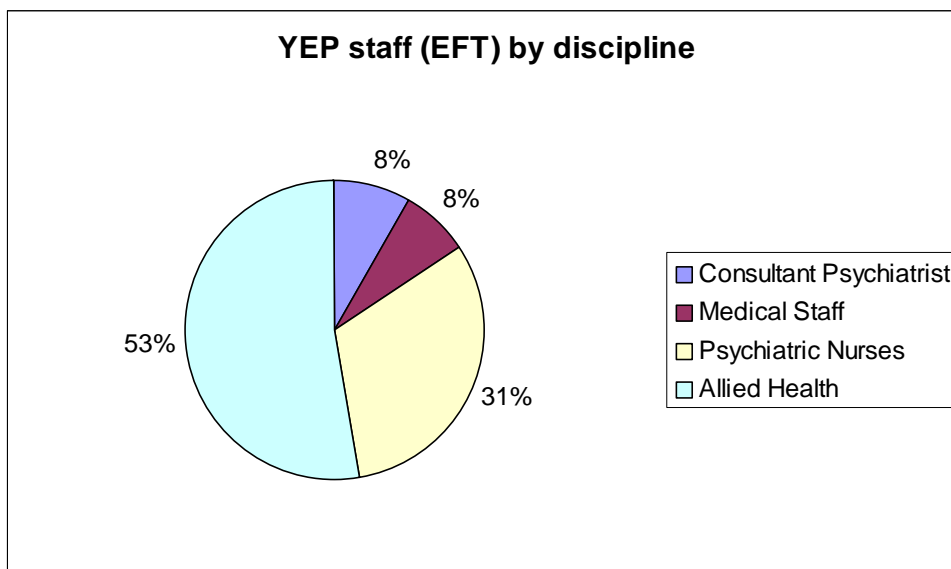
Team Composition

The effective size of the regional YEP teams covered in this report ranged from 2.3 EFT in a rural service with a number of vacancies at the time of reporting to 19 EFT in a large metropolitan service. Since the status report data were collected, this largest team has further expanded to 26.1 EFT.

DHS has provided dedicated YEP funding equivalent to 5 EFT to most health services auspicing a YEP in the expectation that services would match this level of resourcing, ideally on a one-for-one basis. This expectation has not yet been met by all services and this is an issue that the MHB will need to follow up. Some recruitment was still taking place, or planned, at the time of the site visits.

Some services observed that an EFT-based funding model with an established unit price does not adequately reflect the cost of senior medical input. The critical mass of larger services offers some economies of scale. This is not the case for small or rural services.

The chart below shows composition in the eight YEP services by discipline (n=59.5).



There is variety in how health services have configured their YEP team in order to be able to deliver on the key service criteria set out in the YEP Program Description.

Recruitment and Retention

Most YEP services have experienced severe difficulties in recruiting and retaining clinical staff. These were more pronounced, but by no means limited to, rural Victoria.

Examples cited included the following:

- One rural service recruited a team leader who departed before the service was fully established;
- One rural service is considering engaging professional ‘head hunters’ after persistent problems in trying to fill key positions on the YEP team;
- One metropolitan YEP service virtually “imploded” when, after a good start, a number of key staff left in a short period.

The consequences of these workforce problems include:

- The YEP service may need to be rebuilt from scratch: induction training needs to be repeated, as does networking with key stakeholders.
- A period of reduced staffing is likely to result in more restrictive clinical practice. The service becomes more inward-looking, focusing on the key priorities of providing safe care to clients and avoiding their relapse; but service development ceases until capacity is restored.
- The service’s capacity to meet its targets is severely compromised; young people’s needs cannot be met by the YEP service and demand upon other components of the service system increases.

Only one YEP service had a different experience and believed that the YEP service was easier to recruit to as its early intervention focus with young people made it more attractive to clinicians who wanted to be able to ‘make a difference’. On the other side of the spectrum, a clinician commented that the nature of YEP work is very challenging, requiring a new skill set that includes skills such as partnership development.

Workforce planning

The development of the new YEP model clearly provides an opportunity to build knowledge and skills in working with the young person and to further develop effective treatments for first-onset psychosis. Moreover, in the interest of ensuring that YEP service development is integrated with priorities for the sector, YEP services need to ensure that they are included in broader workforce planning activities. Some strategies to be considered include:

- Broadening the YEP skill base (for example, is there a role for a welfare officer or case management support worker to allow professional workers to focus on therapy)
- Providing student placements
- Rotational positions with other programs
- Entry level positions
- Shared positions with other teams
- Developing or strengthening a research focus (which could help to attract doctors)

Recommendation:

That YEP services pursue opportunities for contributing to broader workforce activities.

Clinical Leadership

Access to clinical expertise is a major issue for a number of YEP services. Every service needs a clinical leader who is acquainted with the latest early psychosis research, has enthusiasm and is supported by a psychiatrist.

When asked to comment, in the Status Report template, on the requirement of the program description that every YEP service have access to “leadership and management by a senior mental health clinician who has clinical, management, and community development and/or education and training experience”, one YEP service stated this was “not in place”, another that this was “partially in place” and six others that this was “fully in place”.

YEP access to a local consultant psychiatrist ranges from 0.1 to 2 EFT—the median is 0.5 EFT. Where clinical leadership is strong, the consultant psychiatrist may be assigned to the YEP

team and meet with the YEP managers and team on a regular basis. In other areas, access to clinical expertise may be compromised for lengthy periods as a result of staff turnover, or may need to be drawn from consultant psychiatrists based in the local Continuing Care Team.

Education and Training

Training provided to YEP services

EPPIC Statewide provides a number of training and education initiatives for regional YEP services. These include central activities for all YEP services, such as early psychosis training days held in Parkville, or a statewide forum to support discussion about early psychosis approaches.

EPPIC Statewide also offers a more tailored program that depends on the stage of development of the regional YEP service. In addition to generic support activities, such as tertiary consultation, training and resource provision, YEP services that are in the 'establishment phase' are offered early planning meetings and orientation days. Services that are in their 'workforce development phase' are offered access to secondary consultation, clinical mentoring and research and evaluation meetings. Established YEP services that are in their 'maintenance phase' can receive top-up training and orientation for new staff.

In the template responses, YEP services cited a range of EPPIC courses being provided, including:

- Why Early Psychosis.
- Workshop on assessment and intervention in the acute phase.
- Cognitive behavioural therapy in early psychosis.

In the course of the site visits, YEP service representatives without exception commented positively upon the support they had received from EPPIC Statewide. The only suggestion offered was to deliver training as much as possible on-site, particularly in rural areas, as this minimises travel time and backfill for YEP staff and maximises their opportunities to participate in training.

In addition to training programs offered by EPPIC Statewide, YEP staff also access courses related to early psychosis work that may be offered in-house or by other providers.

Training provided by YEP services

YEP teams also provide a range of education and training sessions. These include:

- 'General awareness' community education sessions — for example, education sessions for graduate nurses. One YEP service provides up to 50 of these sessions per year.
- Training sessions for primary care providers. One YEP service provides up to 30 of these sessions per year.
- Sessions for teachers, staff of community organisations, youth services, housing and refuge services. One YEP service provides up to 30 of these sessions per year.
- Sessions for families and carers who care for at risk youth. One YEP service provides up to 100 of these sessions per year.

While these education sessions for families and training initiatives across the program interface constitute an important strategy in educating the community and strengthening referral networks, we currently have no data to gauge the quality of the training that is provided.

Rural Issues

Respondents pointed out that the YEP program is more difficult and expensive to establish and operate in rural areas. Contributing factors include:

- Higher establishment costs. In one region, for example, four separate service delivery sites had to be established to cover the catchment area.
- Shortage of office space in some rural towns.
- The effect of the large distances is increase travel costs and to reduce the time available for clinical work.
- Recruitment difficulties are more acute. It is difficult to recruit staff, and they are easily lost to metropolitan services. Smaller teams and remote areas are most vulnerable.
- Access to clinical expertise may need to be 'subcontracted' from another service. In one region, the regional office of the DHS provides \$170,000 per annum to the YEP service in addition to the funding provided centrally in order to buy in clinical expertise.

On a positive note, one service commented that regional services network better—because they have to.

Preparing for YEP Service Evaluation

The MHB Evaluation Framework for YEP

The Youth Early Psychosis initiative offers a unique opportunity for service development in a promising area of practice to be undertaken strategically and in a consistent and evidence-based manner across the State. The Mental Health Branch of the Department of Human Services has therefore developed a framework to guide the development of Youth Early Psychosis evaluation activities and has to date also funded a number of evaluation activities.

The YEP evaluation framework comprises two stages. Stage One, which ran from 2003 to 2006, focused on developing practical tools, such as a census kit and a minimum data set (MDS), that would enable YEP services to collect baseline data in order to lay the foundation for future evaluation activities. The focus of Stage Two, which commenced in 2006-2007, is to support the ongoing development of youth early psychosis services in Victoria by encouraging and supporting local and statewide evaluation initiatives and by fostering practice-based research. Both stages are described in more detail below.

The evaluation framework reflects the fact that, for the time being, there is no prospect of an independent evaluation of the YEP program being funded or commissioned until YEP services have been established across the state and have all been operating for two or three years.

Stage One

In 2003-04 MHB allocated \$50,000 per annum recurrent out of the early psychosis service development funding for evaluation activities related to new YEP service developments.

At that stage, two regional Youth Early Psychosis services had been funded—one in the Southern Region and one in Barwon South West—in addition to the EPPIC service that was already established in the Western Region and auspiced by Orygen Youth Health.

In the first year, the dedicated YEP evaluation funding was allocated to Southern Health to establish some early data collection activity and to undertake a census of clinical activity related to early psychosis. It was envisaged that census data would provide baseline information to support local service planning and development and could be further developed to assist further service development and a broader evaluation process.

The MHB provided further funding in 2004-05 to the Southern Health Adult Psychiatry Research, Training and Evaluation Centre to further develop this early work with the aim of providing tools that will enable collection of a common early psychosis data set across all youth early psychosis service developments, and a census methodology and consultant support for activities to be undertaken by services. The centre has since been renamed Southern Synergy.

The Mental Health Branch also established an advisory group to assist with these developments and to advise on future evaluation activities and evaluation expenditure. The *Early Psychosis Evaluation Advisory Group* (EPEAG) met until August 2006, when its focus was broadened beyond evaluation. The revamped *Youth Early Psychosis Advisory Group* (YEPAG) will continue to support YEP services in relation to evaluation, as well as a range of implementation and quality assurance issues.

The work contracted to Southern Synergy in the period 2003-2006 effectively constitutes Stage One of Youth Early Psychosis evaluation. This stage can be summarised as follows:

Aims

To develop and refine evaluation tools and methodology that will support a strategic, statewide approach to youth early psychosis service development.

Objectives

- To develop a suggested early psychosis minimum data set for use by specialist clinical mental health services across Victoria.
- To review and revise that proposed data set in response to feedback received through an advisory group.
- To support the development of a common census methodology for all services undertaking youth early psychosis service developments.

Deliverables

- The development of a youth early psychosis minimum data set (MDS);
- The provision of a census tool kit for use by YEP services; and
- Analysis of YEP census data provided by participating services.

Stage Two

The Stage One deliverables will provide the growing network of Youth Early Psychosis services with a set of common tools: the census kit and a minimum data set. As services move beyond the implementation phase, it is important to develop a framework for the ongoing review and refinement of youth early psychosis services in partnership with stakeholders.

A set of possible aims, objectives and deliverables for this second phase is outlined below in order to provide a basis for discussion with the Youth Early Psychosis Advisory Group.

Aims

- To support the ongoing development of youth early psychosis services in Victoria by encouraging and supporting local and statewide evaluation initiatives and by fostering practice-based research.
- To refine, as required, the evaluation tools and methodology developed in Stage One.

Objectives

- To encourage use of a common data set.
- To support YEP services with local evaluation activities.
- To strengthen the evidence base for the continuing rollout of the YEP program.
- To identify opportunities for statewide evaluation activities.
- To foster service innovation and quality improvement.
- To identify implications for workforce and professional development.

Deliverables

- Status Report about implementation of regional YEP services (2006).
- Template for practice-based review of regional Youth Early Psychosis Services (2007).
- Other initiatives to be decided following consultation.

Current Evaluation Initiatives

Census Kit

The Census Kit (formally Meadows, Graham & Gray: *Innovation in Youth Early Psychosis Services. Mental Health Workload Census: Workbook and Method*) was finalised in November 2006. The kit enables health services to conduct a local workload census in order to determine the proportion of clinicians' time that is spent on service provision to clients with early psychosis. This provides clarity as to the level of resourcing that is required to establish a new YEP service. The census exercise is important as DHS YEP funding is 'service enhancement' funding, based upon the premise that services need to identify existing resources assisting young people with early psychosis within the adult program and combine these existing resources with the new dedicated YEP positions into an integrated YEP service across the continuum.

The census is designed to provide a snapshot of all clients seen on census day; and of all clients of the service with a diagnosis of early psychosis. Completing the census questionnaires takes between 30 and 40 minutes per clinician. Census data will inform the establishment of the YEP service and are also useful for profiling the service and client subgroups in other contexts.

The census kit provides a step-by-step description of how to plan for and undertake a local census. Areas covered range from seeking ethics committee approval to data entry. A CD-ROM included with the kit provides electronic resources, including sample letters and an Access database to support data entry.

YEP services that had undertaken the census commented positively and are currently preparing for a follow-up census.

Minimum Data Set

Southern Synergy is also developing a *Victorian Youth Early Psychosis Service Minimum Data Set* (MDS). This tool complements the census and has the potential to further support and strengthen the expansion and evaluation of YEP services across the state.

The proposed MDS aims to maximize utility for clinicians, managers and service planners while minimizing the data collection burden for clinicians. It therefore draws upon existing data collections, such as RAPID socio-demographic, activity and wellbeing data. The few new items are likely to be a number of fields required to capture Duration of Untreated Psychosis (DUP) and a list of intervention types (based on a checklist developed through the now completed Clinical Practice Improvement Network initiative, or C-PIN).

Capturing intervention types introduces a new strand of data which, in combination with outcome measurement data, holds great potential to inform reflective practice, professional development and organisational learning.

The MDS proposal is expected to be finalised early in 2007 for consideration by the Mental Health Branch of the Department of Human Services and for possible implementation across all Victorian YEP services.

Practice-Based Evaluation Project

The *Evaluation of the Early Intervention Program* currently being undertaken by Barwon Health seeks to canvass three major strands of the local YEP service, namely client outcomes, service implementation and change management issues; and consumer, staff and referrer attitudes. While local in scope, the project also aims to develop a matrix that can be used for practice-based service evaluation in other YEP services. The proposed methodology will incorporate questions from the YEP Status Report template developed by DHS as well as an audit of client files.

Other initiatives

Of the six YEP services that were operational at the time the Status Report data were collected, two had not engaged in any evaluation initiatives to date. The other four had, between them, engaged in a number of activities, including undertaking the YEP census or case file audits to establish a baseline in support of future evaluation activities, database development to support YEP clinical pathways, and a qualitative research project on service feedback involving consumers, carers and agencies. The Youth Early Psychosis Advisory Group convened by the Mental Health Branch provides a forum for sharing evaluation findings across YEP services.

Data Quality in YEP Services

While service evaluation was not a focus of this status report, it became clear to the MHB that, with some exceptions, YEP services are currently not in a good position to answer questions about service effectiveness. This is a strategic liability, as a new and growing service model needs to have a strong evidence base to reflect upon its effectiveness, to adjust aspects of its operation and to justify its ongoing expansion.

Most, but not all, YEP services have a separate RAPID subcentre, although there is no statewide consistency as to how these are named. Having a separate RAPID subcentre makes it easier to monitor service performance and to inform quality assurance and evaluation activities.

The responses to the Status Report templates show that only few YEP services were able to answer all data-related questions in the Status Report Template. This provides further argument to proceed with the development of an MDS for YEP services.

Recommendations:

That each Area Mental Health Service auspicing a Youth Early Psychosis service ensure that the service has a separate subcentre in RAPID in order to facilitate data retrieval and analysis.

That the Mental Health Branch of the Department of Human Services introduce a Minimum Data Set (MDS) for YEP services in order to strengthen the knowledge base about YEP services.

YEP Program Impact

Qualitative Feedback

There was, across all YEP services, a strong commitment to the early intervention model underpinning the YEP program and a belief that the YEP model really 'works'. Key factors contributing to the perceived service effectiveness were:

- Lower caseloads (the program description recommends 10-15).
- The capacity to engage the young person.
- Effective linkages with other service providers, especially CAMHS, Adult mental health services, GPs, PDRSS and PMHEI.

Examples of positive outcomes cited were:

- Improved, and more consistent, clinical care.
- Greater continuity of care.
- Reduced turnover of case managers.
- High level of consumer satisfaction.
- Positive feedback from families about psycho-education sessions.
- Consumer-assisted care is seen as a future direction.

Key Indicators

YEP services were asked, through the template, to gauge the impact of the program using the following indicators in the first instance:

- Reduced rates of unplanned and involuntary inpatient admissions.
- Reduced rates of inpatient admissions with police involvement.
- Reduced rates of seclusion during inpatient admission.
- Reduced rate of inpatient stay.
- Reduced readmission rates.

Two YEP services were not yet operational at the time the template was sent. Four others reported having either “no data” or were “unable to comment”. Two YEP services stated that the data were available within their organisation, but had not yet been compared in order to inform the analysis of trends. It is essential that systems are in place to support the routine monitoring of service trend and performance data.

One service commented that the level of police involvement during inpatient admissions was “significantly less” since the YEP service was established — but this assertion was not supported by data. Two services provided seclusion and readmission rates and details of length of stay in inpatient services but were not able to document the impact of the YEP program by comparing these against a benchmark.

The Mental Health Branch recognises that there is a tension between the inpatient-related indicators listed above and the needs of a community-based service with a strong early intervention ethos. More work may be required in developing more appropriate indicators for YEP services.

Service Activity Data

Clients

RAPID data show that the six operational YEP services saw a total of 1,229 unique clients in 2005-2006. One of these six services only became operational in the fourth quarter of that year and saw only 8 clients. The largest YEP service saw 587 clients, or 48% of the year’s total. Sixty per cent of the YEP clients (735) seen in 2005-2006 were male and 40% (494) female.

Contacts

RAPID data show that in 2005-2006 the six operational YEP services had a total of 38,086 client contacts. One of these six YEP services became operational in the fourth quarter of 2005-2006 and had only 41 contacts in that year. The largest YEP service had 16,857 contacts, or 44% of the total contacts for the year.

The total duration of contacts for registered YEP clients was 19,418 hours. Duration of the average contact for a registered YEP client varied across services (from 0.4 to 0.8 hours); the median duration was half an hour.

Throughput

Seven YEP services quantified the number of case managers currently available to the service in their template response. The range was from 2 to 12.6 case managers, with an average of 5 per service (median 4.2). Optimal casework capacity is higher for some services, but depends on a number of vacancies being filled. The YEP program is currently understaffed.

Actual casework capacity is further reduced by the fact that case managers devote a proportion of their time to delivering education and training activities to, for example, families or to primary sector health providers such as GPs. This component of service provision varies enormously across YEP services, from 2 hours per month per case manager in one service to 80 hours (30% of case manager time) in another. The median (n = 6) is 8 hours per month but the one outlier increases the average to 19 hours per month. One service uses a full-time Education and Promotion Coordinator whose time was not included in the above average as it is not a case manager position. The need to provide primary and secondary consultations is in addition to casework.

The average caseload again varies greatly across YEP services: from 7 cases per case manager to 30.2, making the median caseload 9.5 cases, and the average 15 cases (n = 6), on the upper end of the 10-15 cases recommended in the DHS program description.

The estimated number of contacts per case ranges from 11 to 156, with an average of 65 contacts (n = 4) per case. Case duration ranges from 16 to 78 weeks, with an average duration of 37 weeks (n = 4). Contact frequency therefore is 1.8 contacts per week.

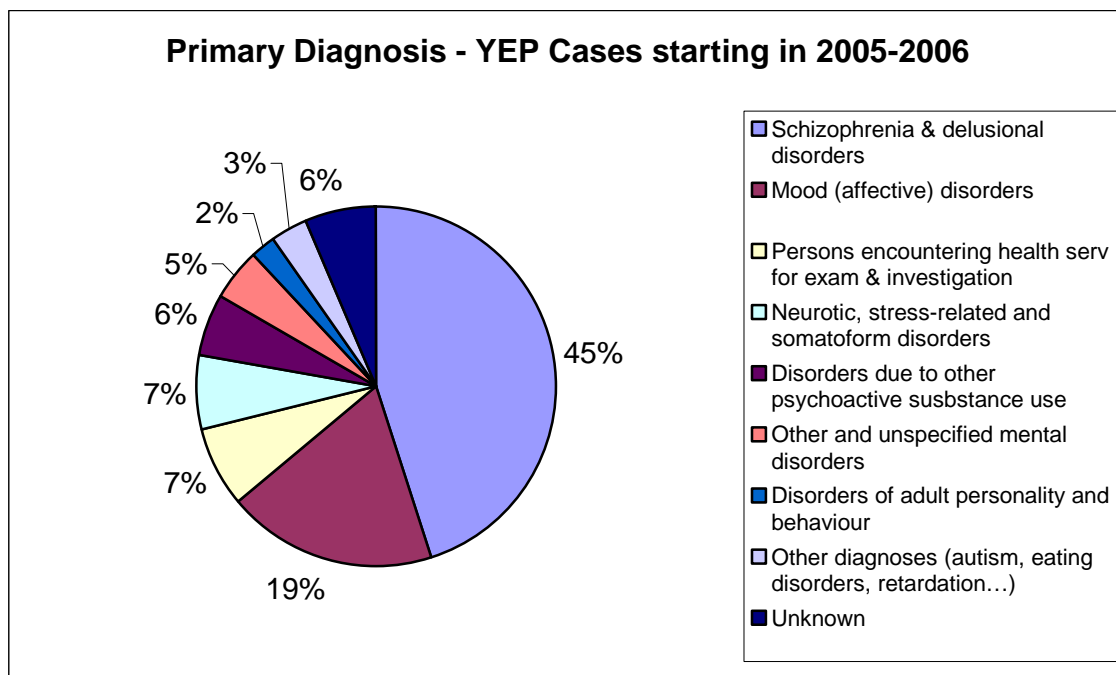
Annual throughput ranges from 62 to 234 cases, or an average of 103 cases per service (n = 4), though the data in this instance are positively skewed as they are drawn from well-functioning YEP services that have largely overcome their recruitment difficulties. Taking into account case duration data for each service, this amounts to an annual throughput per case manager of between 10 and 34 cases, with an average annual throughput of 19 cases (n = 4).

The four YEP teams providing data for this section typically receive a combined total of ~206 referrals per month. Of these, ~48 are accepted as new cases — an acceptance rate of 23%. The self-reported acceptance rate varies greatly across teams, from 100% for one service to 12% for the team with the tightest gatekeeping practice.

While 48 new cases are accepted across these four teams each month, only 27.7 cases are closed each month, leading to a build-up of roughly an extra 5 cases per month for each team, or a total of 60 cases per year should these demand pressures persist.

Clinical Presentation

RAPID data show the following diagnostic profile for new YEP cases that started in 2005-2006 (n = 552):



For the sake of clarity, a number of ICD-10 groups, which together make up 3% of YEP cases, have been combined under the “Other diagnoses (autism, eating disorders, retardation...)” category in the above chart. These diagnoses are “disorders due to use of alcohol” (0.72%), “mental retardation” (0.72%), “other organic mental disorders” (0.54%), disorders associated with puerperium (0.36%), eating disorders (0.18%) and autism (0.18%).

Of these clients, 19.6% had a drug or alcohol diagnosis. The proportion of dual diagnosis YEP clients in 2005-2006 ranged from 4.4% to 37.5% across the six YEP services covered by these data.

The average total HoNOS score at intake, which is a good indicator of overall severity, was 13 (n = 105) for YEP clients, compared to 10.9 (n = 36,187) for the best national population benchmarks currently available (AMHOCN *Adult NOCC Standard Reports*, March 2005).

Clinical Outcomes

Since 2003 clinical mental health services in Victoria have been participating in routine outcome measurement in accordance with the *National Outcomes and Casemix Collection (NOCC) Protocol*.

There are, however, a number of difficulties when drawing on outcome measurement data in order to review the clinical effectiveness of YEP services:

- Compliance levels (expressed as the number of eligible episodes for which a rating is completed) are slowly increasing from a low base.
- The NOCC Protocol prescribes specific 'suites' of measures for each of three age groups: children and adolescents, adults and older people. With its target population aged between 16 and 25, the YEP program straddles the first two of these OM suites. There is potential for YEP ratings to be scattered across different measures (e.g. HoNOSCA/HoNOS, or SDQ/BASIS-32) from both suites. Likewise, outcome measurement reporting is geared towards the age groupings developed by the NOCC Protocol, with youth-focused reports having to be developed on an ad-hoc basis.
- YEP services are resourced and configured differently in each area and therefore care should be taken in comparing outcomes across programs.

YEP services were asked, through the status report template, the following questions about outcome measurement:

What is the level of compliance in your YEP service?

- Two services were not yet fully established.
- Two services said it was too early to comment.
- One service said all clinical reviews consider outcomes.
- One service did not answer this question.
- One service estimated its level of compliance at 50% of eligible NOCC episodes. This service also stated it was unable to generate aggregate reports using the Wellbeing Reporting Tool developed by DHS and criticised the absence of a prompting system.
- One service reported "reasonable compliance", with both clinician and self-rated measures reported in clinical reviews and provided an ad-hoc report (n=94) showing the percentage of completed ratings increase from ~55% at first review to ~80% at second review and ~85% at third review.

What do the outcomes data show about the clinical effectiveness of the YEP service?

- Two services were not yet fully established.
- Three services said it was too early to comment.
- One service did not answer this question.
- One service pointed out the absence of a reporting capacity suited to the youth age range.
- One service had no access to standard OM reports yet, but an ad-hoc report (n=94) generated by the service showed a drop in average HoNOS score from ~13 at first review to ~7 at third review.
- An analysis of RAPID data undertaken by the MHB showed that the average total HoNOS score of YEP clients dropped from 13 at intake to 10 at case review (n = 848) and 8 at case closure (n = 126), compared to AMHOCN population benchmarks (see above) of 9.3 at review (n = 52,880) and 7.9 at closure (n = 16,980).

Have you compared outcomes data for your YEP with those of similar services?

- Two services were not yet fully established.
- One service said it was too early to comment.
- One service said YEP services in each area are configured to meet local needs.
- Two services said they need better data and/or appropriate standard reports first.
- Two services referred to participation in the C-PIN project.

What is the level of consumer/carer participation in self-rating (i.e. SDQ or BASIS-32)?

- Two services were not yet fully established.
- Two services said it was too early to comment.
- Two services did not answer this question.
- Two services estimated the consumer self-rating level at around 20%.

Mental Health Branch data show that YEP participation in outcome measurement is very uneven, with a total of 3,747 outcome measurement ratings (across all services, measures and data collection occasions) entered by YEP services to date. Of these, 3,010 (80%) were entered by just two YEP services. It should be understood that participation in routine outcome measurement is not an optional activity (with the exception of consumer self-rating, which is entirely voluntary) but a national requirement and an essential stepping-stone in understanding what constitutes clinical effectiveness.

The Branch acknowledges that perceived lack of utility can be a disincentive to compliance. It is therefore recommended that standard OM reports be developed that capture the youth age bracket. Simultaneously, YEP services should make a concerted effort to improve their OM compliance.

Recommendations

That the Mental Health Branch develop standard reports for the 'youth' age bracket (16-25), including OM reports.

That YEP managers identify strategies to improve local compliance with routine outcome measurement.

Conclusions

This Status Report has examined Youth Early Psychosis services from three perspectives: how they were implemented, how these relatively new services are currently operating, and how well they are currently positioned for a more comprehensive evaluation.

The first issue facing a local team planning a YEP implementation is to acknowledge that the DHS funding is not based on a 'greenfields' approach but is instead provided as service enhancement funding, premised on the fact all tertiary public mental health services have already been providing a level of service to the target population, albeit typically at a later stage of the illness. A key task is to identify the extent of resources being used to address early psychosis with young people aged between 16 and 25, to negotiate, within the organisation, the consolidation of these resources into a cohesive new YEP service.

The next key decision is to select an appropriate service model for the YEP service. The choice is essentially between a 'team-based' YEP service — a well-connected but clearly identifiable team within adult mental health services — and a 'function-based' model, where YEP clinicians are inserted into existing teams. Each approach carries some risk. Because of its clear focus, the team-based model may be easier to implement, but in the long-term the model may lead to the creation of a YEP niche and militate against the development of an early psychosis focus across the continuum of services. The function-based model may facilitate the development of precisely such a focus, provided the YEP effort does not become diluted and mainstreamed before the service gets to that point.

It is clear that implementing a YEP service requires more than adding just another component to the existing network of mental health services. As the YEP service is underpinned by an early intervention framework, clinicians are being asked to work in a different way: to intervene more proactively at an earlier point in the development of the illness, and to work longer and more intensively with a smaller group of clients. Implementing this extent of change to local service culture means that a coherent change management process needs to be developed. This process needs to engage, firstly, with clinical leaders in order to gain their support and their willingness to act as an advocate for the new service by providing direction, guidance and support.

Some YEP services experienced a significant lag time between funding being provided and the commencement of clinical service provision. The primary external constraints that have delayed service establishment include recruitment difficulties, problems in securing appropriate accommodation for the YEP team; and the need to clarify or resolve governance issues in a multi-provider service. YEP services also commented on the significant community development workload in the implementation phase, as effective linkages have to be established with a broad range of service providers.

In terms of operation, the picture that emerges from the template responses and the site visits is that the new YEP services generally 'deliver' on their primary role of providing intensive case management for young people aged 16 to 25 years with early psychosis. The care they deliver appears to be guideline-based and phase-specific. Intervention types vary according to the phase of the illness and include Cognitive Behaviour Therapy, psycho-education, medication, intensive family work and relapse prevention work. In keeping with the YEP service focus on early intervention, a lower threshold for intake is in place and is supported by effective linkages with triage and CAT teams.

YEPs provide assessments, primary and secondary consultations to GPs and primary health care providers. Some YEP services are co-located with youth services and/or community health services. Systematic and well-targeted community education can further strengthen these linkages.

Crisis response arrangements are in place and supported by good linkages with triage and CAT teams. Clients have an individually tailored relapse prevention plan and some YEP services report a strong focus on family work within their case management practice.

YEP service feedback indicates that, collectively, YEP services have made significant headway in delivering the core dimensions of the program but have further to go in fully implementing early intervention approaches, in optimising continuity of care and in further developing effective linkages with stakeholders, including families and primary care providers. More work is also required in developing linkages with services for young people and families from culturally and linguistically diverse (CALD) and indigenous communities.

Recruitment and retention cause a range of problems for most YEP services, but in particular for those in rural areas. Firstly, recruitment problems and staff turnover compromise a service's capacity to meet its targets. When young people's needs cannot be met by the YEP service, demand upon other components of the service system increases. A period of reduced staffing is likely to result in more restrictive clinical practice. The service becomes more inward-looking, focusing on the key priorities of providing safe care to clients and avoiding their relapse; but service innovation ceases until capacity is restored. Finally, the YEP service may need to be rebuilt from scratch: induction training needs to be repeated, as does networking with key stakeholders.

There was, across all YEP services, a strong commitment to the early intervention model underpinning the program, and a belief that the YEP model really 'works'. Key factors contributing to the perceived service effectiveness were the lower caseloads, the capacity to engage the young person, and the effective linkages with other service providers.

Examples of positive outcomes cited were:

- Improved, and more consistent, clinical care.
- Greater continuity of care.
- Reduced turnover of case managers.
- High level of consumer satisfaction.
- Positive feedback from families about psycho-education sessions.
- Consumer-assisted care is seen as a future direction.

While these comments are positive, most positive feedback about YEP services to date is based upon clinician or manager perception and is yet to be substantiated independently. In completing the template for this Status Report, YEP services were generally not able to access key data in order to critically reflect upon the effectiveness of their service and identify areas for improvement; and compliance with routine outcome measurement was patchy. The Mental Health Branch will work with YEP services to strengthen and unify data collection practices through the introduction of a shared Minimum Data Set in order to provide the program with a solid evidence base that can support and inform monitoring and quality assurance processes.

In the light of the findings of this report, it is recommended that the statewide rollout of the Youth Early Psychosis program be continued to extend service coverage across the State, subject to new funding becoming available. This is in keeping with the undertaking in *A Fairer Victoria. Progress and Next Steps* (June 2006) to "strengthen prevention and early intervention services".

Recommendation

That the statewide rollout of the Youth Early Psychosis program be continued to include the catchment areas covered by The Alfred, St. Vincent's Health, Austin Health and Northern AMHS, subject to new funding becoming available.

Recommendations

The recommendations below are based on consultation with the sector and the findings in this Status Report.

Recommendations for DHS

1. That the statewide rollout of the Youth Early Psychosis program be continued to include the catchment areas covered by The Alfred, St. Vincent's Health, Austin Health and Northern AMHS, subject to new funding becoming available.
2. That the Mental Health Branch of the Department of Human Services review and update the *Youth Early Psychosis Program Description*, particularly with respect to providing greater flexibility about the service model.
3. That MHB develop standard reports for the 'youth' age bracket (16-25), including OM reports.
4. That the Mental Health Branch of the Department of Human Services introduce a Minimum Data Set (MDS) for YEP services in order to strengthen the knowledge base about YEP services.

Recommendations for Health Services

5. That health services adopt a formal project management approach to YEP service establishment.
6. That each Area Mental Health Service auspicing a Youth Early Psychosis service ensure that the service has a separate subcentre in RAPID in order to facilitate data retrieval and analysis.
7. That YEP services have in place arrangements for monitoring recently discharged clients and for re-engaging these young people promptly should they be at risk of, or experiencing, relapse.
8. That YEP services pursue opportunities for contributing to broader workforce activities.
9. That Area Mental Health Services review, at least every two years, the performance of the local YEP service against the national *Clinical Guidelines for Early Psychosis*, the DHS *YEP Program Description* and other relevant standards and guidelines.
10. That YEP managers identify strategies to improve local compliance with routine outcome measurement.
11. That YEP services establish better linkages with services for Culturally and Linguistically Diverse (CALD) clients and indigenous young people in their catchment.

Recommendations for EPPIC Statewide

12. That EPPIC Statewide convene an annual Youth Early Psychosis Forum to present the latest research findings to the sector and to foster an exchange of ideas across services.
13. That EPPIC Statewide develop a strategy for assisting YEP services in establishing better linkages with services for Culturally and Linguistically Diverse (CALD) clients and indigenous young people.

Appendices

1 Extracts from the YEP Program Description

Aims

The aim of this initiative is to establish regional Youth Early Psychosis (YEP) services across Victoria and thereby reduce the prevalence and impact of first onset psychosis on young people and their families within the designated service catchments.

As a subspecialty within the Adult Area Mental Health Service, the YEP service will:

- assist primary care services and other specialist services such as drug and alcohol services in the early identification of young people displaying vulnerable mental states and provide appropriate responses and timely referral for those in need of specialist care;
- increase the capacity of specialist mental health services to provide evidence-based phase-specific treatment and support to young people as early as possible in the course of illness and across the period known to be associated with the greatest risk of relapse;
- achieve measurable improvements in consumer outcomes and service and practice quality for this cohort and their families;
- in partnership with Orygen Youth Health and EPPIC Statewide, lead best practice service development for this client group and their families and actively contribute to the ongoing development of knowledge regarding service models and practice.

Target Population

The target population for the initiative is young people 16-25 years of age inclusive who are:

- displaying a vulnerable mental state and at risk of progressing to psychosis, including those with concomitant drug use and other risk factors;
- experiencing early psychosis, including those with concomitant drug use;
- at risk of, or having relapsed following, a first episode of early psychosis.

Expected Outcomes

The aims of this initiative will be achieved by the provision of additional community resources to assist specialist adult mental health services to engage in service development enabling:

1. the signs and symptoms of first onset psychosis to be identified as early as possible;
2. the delay between the emergence of first-onset psychosis and the delivery of appropriate treatment to be significantly reduced;
3. treatment consistent with the evidence-base and clinical guidelines;
4. disability resulting from the disorder to be prevented or minimised; and
5. service planning and delivery to be informed by young people and their families.

Key Service Features

Within the Adult AMHS, the YEP service will operate as a subspecialty program within the Continuing Care Team operationally integrated with other Adult AMHS service components and with strong linkages to CAMHS, PDRSS and primary care services.

The YEP service will:

- Develop as a subspecialty program involving all relevant community and inpatient components of specialist adult mental health services and develop effective operational linkages with Child and Adolescent Mental Health Service;
- Provide age-appropriate and phase-specific interventions consistent with the Australian Clinical Guidelines for Early Psychosis and other reputable clinical guidelines, service and practice standards;
- Provide expert assessments for young people with vulnerable mental states referred by primary care providers based on high levels of suspicion rather than a certainty of psychosis, and ensure a low threshold for reassessment;
- Provide intensive case management for young people 16–25 years with early psychosis in the care of the participating Adult AMHS for up to three years;
- Actively involve young people and their families/carers in their own treatment and work towards maintaining their engagement with other natural supports (such as family, or peer groups) and their participation in community life (such as education or work);
- Provide more timely responses to those within this group who are experiencing, or at risk of experiencing, crisis as a result of psychosis;
- Integrate with the AMHS triage and intake as the common point of entry to the service to ensure timely and ready access to consultation and assessment;
- Support and enhance the early intervention work undertaken with primary care providers by the Primary Mental Health and Early Intervention (PMHEI) Team, including education and training activities and consultation services to GPs and other primary care workers and other specialist services including drug and alcohol services;
- Deliver services in ways and locations across the community that result in better engagement and retention of young people and result in minimal disruption to their lives;
- Provide support and monitoring for young people with an 'at risk' mental state or showing prodromal features — either directly or through support for their primary care provider, including shared care arrangements with GPs;
- Increase shared-care arrangements between primary care providers and specialist mental health services for this cohort;
- Identify and implement care pathways for this population delivered through an integrated early intervention network of health, education and community support providers across the catchment;
- Develop comprehensive handover arrangements to ensure continuity of care for young people who require ongoing care and treatment beyond three years.

Funding

The Department of Human Services typically provides additional funding to assist Adult AMHS engaged in Youth Early Psychosis service developments.

The YEP funding model requires services to identify the extent of existing resources already being targeted to assisting clients with first-onset psychosis in the 16-25 age group. These resources are to be combined with the dedicated YEP growth funding to establish a comprehensive and integrated Youth Early Psychosis program as a specialist program within the adult mental health service and in keeping with the requirements of these guidelines.

Services are therefore expected to identify existing resources and activities as part of early service planning. A Census Kit that enables services to compile a snapshot of their current early psychosis workload with the target group is currently being finalised and will soon be available to assist mental health services in that undertaking.

2 Overview of YEP Services

Sector	Region	Lead Agency	Partner Agencies	Service Delivery Sites	Status	YEP EFT funded through DHS service enhancements
Statewide		EPPIC Statewide (Melbourne Health)		Parkville and on site	Established in 1992	5.1
Rural	Barwon South West	Barwon Health	Northeast Health Wangaratta, Wodonga Regional Health Service Mildura Base Hospital	Geelong, Corio, Bellarine, Colac, Surfcoast	Funded since 2003-2004	5
	Gippsland	South West Health Care Latrobe Valley Hospital		Warrnambool	Established in December 2006 Funded since 2005-2006	2.5 5
	Grampians	Ballarat Health Services		Ballarat	Expected to be operational by 31 March 2007	5
	Hume	Goulburn Valley Health		Seymour, Shepparton, Wangaratta, Wodonga	Funded since 2004-2005	6
	Loddon Mallee	Bendigo Healthcare		Bendigo, Mildura	Funded since 2004-2005	5
Metro	Eastern Metro	Eastern Health		Box Hill, Ringwood	Funded since 2005-2006 for Outer East and Central East since 2006-07	11
	North West Metro	St. Vincent's Health EPPIC Continuing Care Team (Melbourne Health)		Hawthorn Parkville, Footscray, Wyndham	Commenced in October 2006	0 26.1
	Southern Metro	Southern Health		Dandenong	Funded since 2003-2004	11.5
		Peninsula Health		Frankston	Funded since 2003-2004	5
Total EFT:						87.2

Note: The last column shows staff numbers recruited through dedicated service enhancement funding only; the actual size of the YEP team is larger in most cases.

3 Stakeholder Relationships

The table below summarizes how YEP services rated their linkages with other service providers. Some of these ratings are discussed in the body of the report.

<i>Stakeholder</i>	<i>No Relationship</i>	<i>Problematic Relationship</i>	<i>Basic Relationship</i>	<i>Effective Relationship</i>
Adult mental health services			4	4
CAMHS			4	4
PMH&EI Teams	1		2	5
General Practitioners			7	1
Community Health Services	1		5	2
Youth Services			4	4
Drug & Alcohol Services			4	4
Police	1		5	2
Juvenile Justice	2		4	2
Child Protection		1	6	1
Take Two	2		6	
Koori Services	2		5	1
CALD Services	4		4	
PDRSS			4	4
Education	2		3	3
Housing services			5	3
Vocational services			6	2

4 Service self-rating against the YEP KSC

Key Service Criteria	KSC not met	KSC partially met	KSC fully met	Comments
1. A subspecialty program involving all relevant community and inpatient components of specialist adult mental health services and with effective operational linkages with CAMHS.		4	4	Some gaps re prodrome services.
2. Provide age-appropriate and phase specific interventions consistent with the Australian Clinical Guidelines for Early Psychosis and other reputable clinical guidelines, service and practice standards.		3	5	Guideline-based care is delivered supporting phase-specific care. To be further embedded in some services.
3. Provide expert assessments for young people with vulnerable mental states referred by primary care providers based on high levels of suspicion rather than a certainty of psychosis and ensure a low threshold for reassessment.		4	4	Low threshold in place. YEPs provide assessments, primary and secondary consultations to GPs and primary health care providers. Resource limitations restrict early intervention. More community education required. Access to clinical expertise an issue for some rural services.
4. Provide intensive case management for young people 16–25 years with early psychosis in the care of the participating Adult AMHS for up to 3 years.		4	4	Primary focus of the YEP service. Not all YEP services offer a full 3-year service.
5. Actively involve young people and their families or carers in their own treatment and work towards maintaining their engagement with other natural supports (for example family, peer groups) and their participation in community life (eg: education/work).		5	3	KSC should be reflected in program guidelines, clinical pathways and professional development initiatives. Some services refer all families to an after-hours psycho-education and support program.
6. Provide more timely responses to those within this group who are experiencing, or at risk of experiencing, crisis as a result of psychosis.		4	4	Crisis response arrangements are in place and supported by good linkages with triage and CAT teams. Clients have an individually tailored relapse prevention plan.
7. Integrate with the AMHS triage and intake as the common point of entry to the service to ensure timely and ready access to consultation and assessment.		2	6	YEP service access is through adult triage.
8. Support and enhance the early intervention work undertaken with primary care providers by the Primary Mental Health and Early Intervention Team including education and training activities and consultation services to GPs and other primary care workers and other specialist services including drug and alcohol services.	1	6	1	Extra resources and further education of Tier 1 providers would strengthen work in this area. Some YEP services co-located with youth services and/or community health services.
9. Deliver services in ways and locations across the community that result in better engagement and retention of young people and result in minimal disruption to their lives.		7	1	Individualised care planning allows for active and assertive engagement of young clients. Consumers reportedly value the continuity of relationships.

Key Service Criteria	KSC not met	KSC partially met	KSC fully met	Comments
10. Provide support and monitoring for those young people with an at risk mental state or showing prodromal features either directly or through support for their primary care provider including shared care arrangements with GPs.		5	3	One service has developed a referral pathway for Ultra High Risk clients. In other YEP services, monitoring occurs in collaboration with PMH&EI teams and primary health sector. Resource limitations limit a more active approach.
11. Increase shared-care arrangements between primary care providers and specialist mental health services for this cohort.		7	1	Not all clients do have a GP. In some areas GPs take no new clients. Not all GPs are prepared to work intensively with young people and/or mental health issues.
12. Identify and implement care pathways for this population delivered through an integrated early intervention network of health, education and community support providers across the catchment.		7	1	
13. Develop comprehensive handover arrangements to ensure continuity of care for those young people requiring ongoing care and treatment beyond three years.		8		Facilitated by YEP location in adult mental health services. Some services use staff rotation as a professional education tool. Less of an issue for YEP services using an integrated model. Reasonable discharge processes exist but could be improved by earlier discharge planning and longer handover periods. Transition from CAMHS to Adult an issue for some services.

5 Resources for YEP Coordinators

Guidelines

The Australian Clinical Guidelines for Early Psychosis, EPPIC, s.d. [~2001]. These guidelines are currently out of print; a revised version is expected in 2007.

Youth Early Psychosis Program Description, Department of Human Services, revised version, September 2006.

Implementation Resources

Jane Edwards & Patrick McGorry: *Implementing Early Intervention in Psychosis* (Martin Dunitz, 2002).

Meadows, Graham & Gray: *Innovation in Youth Early Psychosis Services. Mental Health Workload Census: Workbook and Method* (2006).

Research

Monthly Research Update

Contact Anne Troy, Coordinator of the National Early Psychosis Resource Centre by emailing altroy@unimelb.edu.au to subscribe to the research newsletter email list. You will receive a free monthly newsletter of journal abstracts about early psychosis.

Mental Health Library

http://www.mh.org.au/Royal_Melbourne_Hospital/LIBRARY/City_Campus/

Training

EPPIC Statewide Services provides education, consultation, and development support to early psychosis services in Victoria and around Australia.

EPPIC Statewide is funded by the Mental Health Branch of the Department of Human Services to assist Victorian public mental health services to optimise their response to young people with emerging psychotic disorders.

EPPIC Statewide:

- provides tertiary consultation to public mental health clinicians working with people affected by early psychosis;
- provides support and guidance to Primary Mental Health Team and Early Intervention Workers through the Early Intervention Initiative; and
- has developed a range of multimedia resources.

Victorian public mental health services may access EPPIC Statewide Services for tertiary consultation to assist with a range of local initiatives aimed at optimising service response to young people with early psychosis including:

- consultation to clinical groups
- development of local clinical guidelines
- psycho-educational group programs for young people and their carers
- identification of training needs
- locally targeted training
- development of strategies designed to evaluate early psychosis initiatives

For more information about tailored training contact training@orygen.org.au

Websites about Early Psychosis

Early Psychosis Australia:

<http://www.earlypsychosis.org/>

Early Psychosis Prevention and Intervention Centre (EPPIC)

<http://www.eppic.org.au/>

International Early Psychosis Association

<http://www.iepa.org.au/>

Information for Consumers, Carers and Families

A number of fact sheets about early psychosis in English and a range of community languages can be downloaded from the website of ORYGEN Youth Health at

<http://www.eppic.org.au/contentPage.asp?pageCode=PSYCHOSIS>

Peer Support

Talk to other YEP coordinators about their experience and attend meetings of the Youth Early Psychosis Advisory Committee convened by the MHB.

Mental Health Branch

Information for families and carers:

<http://www.health.vic.gov.au/mentalhealth/carers.htm>

Online directory of public mental health services in Victoria:

<http://www.health.vic.gov.au/mentalhealth/services/index.htm>

Chief Psychiatrist's Guidelines:

<http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>

Program Management Circulars:


<http://www.health.vic.gov.au/mentalhealth/pmc/index.htm>


Order MHB publications:

<http://www.health.vic.gov.au/mentalhealth/publications/index.htm>

YEP contact in the CAMHS and Youth Team:

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Mental Health Branch

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 <http://www.health.vic.gov.au/mentalhealth/>

6 Consultation

We would like to thank the following people, who took part in the YEP Status Report site visits or contributed to this report in other ways:

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7 Glossary

AMHS	Area mental health services
CAMHS	Child and Adolescent Mental Health Services
CCT	Continuing Care Team
C-PIN	Clinical Practice Improvement Network
DEET	Department of Education, Employment and Training
DHS	The Victorian Department of Human Services
DUP	Duration of Untreated Psychosis
EFT	Equivalent Full-Time (positions)
GP	General Practitioner
KSC	Key Selection Criteria
MDS	Minimum Data Set
MHB	The Mental Health Branch of the Department of Human Services
NOCC	The National Outcomes and Casemix Collection protocol
ODS	Operational Data Store—a component of the RAPID database
PARC	Prevention and Recovery Care
PCPs	Primary Care Partnerships
PDRSS	Psychiatric Disability Rehabilitation and Support Services
PMHEI	Primary Mental Health and Early Intervention
Prodrome	In <i>Implementing Early Intervention in Psychosis</i> (2002), Edwards & McGorry define the 'prodrome' as: "A period of behavioural or functional change prior to the onset of obvious psychotic symptoms is referred to as the prepsychotic Prodrome. In most cases, the Prodrome is defined retrospectively once a diagnosis of psychotic disorder has been made" (p. 25)
RAPID	The statewide database that stores all client service-level information collected by public clinical mental health services in Victoria. The acronym stands for the <i>Redevelopment of Acute & Psychiatric Information Directions</i> .
YEP	Youth Early Psychosis
Youth	'Youth' in this document refers to young people aged between 16 and 25 (inclusive)