GOOD IDEAS FROM “DOWN UNDER”
- IMPROVING HEALTHCARE FOR SCOTLAND’S YOUTH

VISIT TO ORYGEN YOUTH HEALTH, MELBOURNE

7 March – 13 May 2011

Dr Robert McCabe
Churchill Fellow of 2011
1 **ORYGEN – the beginning....**

A considerable time back, in August 2009 I sent an e-mail to Professor Patrick McGorry, Executive Director at Orygen Youth Health (located in Parkville, Melbourne, Australia) outlining my interest in applying for a period of 3 months Sabbatical leave from my NHS post to undertake a visit to Orygen Youth Health, and ……

“ the rest, as they say, is history....”

1.1 **MY BACKGROUND**

I work as a Consultant Child & Adolescent Psychiatrist in two specialist mental health teams in Edinburgh, Scotland. One of these teams is the EPSS – Early onset Psychosis Support Service, a CAMHS-based (Child & Adolescent Mental Health) Early Intervention in Psychosis (or First Episode Psychosis) team. We have the unique distinction of being the only such specialist CAMHS-based team in Scotland.

Unlike the NHS in England and Wales there has not been the widespread development in Scotland of regional Early Intervention (in Psychosis) teams. Across NHS Lothian the EPSS team within which I work does not have an adult counterpart – the local NHS managers have been proposing the possibility of the EPSS team (that currently works with young people up to their 22nd birthday) extending the age range we provide for, up to the 25th birthday.

1.2 **PAT McGORRY, EPPIC & EARLY INTERVENTION**

For approximately two decades now there has been growing evidence of the merit of providing intensive therapeutic input to individuals who develop their first episode of psychosis. Such input can lead to improved outcomes and much of the evidence of such endeavours has come from the pioneering work of McGorry *et al*, at the EPPIC service in Melbourne, Australia.

More recently Alison Yung and Patrick McGorry (both Professors) through the research from the PACE clinic, have produced evidence of the capacity to not only identify individuals “at risk” of developing a first episode of psychosis, but to provide therapeutic input that can postpone the onset of the anticipated illness episode. I also knew that their clinical services under the umbrella organisation Orygen Youth Health worked with “youth” aged between 15 - 24 years, an age range not catered for by services in the UK within the NHS.

My awareness through reading their research publications and chapters in books of this ground-breaking activity in First Episode Psychosis filled me with enthusiasm to learn more ideally at first hand about their activities.

1.3 **MY WCMT APPLICATION**

During 2009 I learned that my former NHS Colleague, Dr Graham Bryce, like me also a Consultant Child & Adolescent Psychiatrist was about to travel to North America as a Churchill Fellow. I had rather wrongly assumed that the WCMT might not make awards to senior doctors in the UK. On learning of Graham’s Fellowship in 2009, I began to plan for a visit to Orygen Youth Health, with the prospect of securing a Churchill Fellowship in my own right.

1.4 **AIMS OF MY VISIT**

My aims in visiting Orygen Youth Health were threefold:-

- To be attached to the Inpatient Unit and observe and learn about the service delivery in a Unit that caters for young people under the age of 18 and young adults.
aged 18 years and over. No similar model exists of this nature within the UK NHS provision

- To witness service delivery from the **PACE team** – this team works with young people identified as being at “high-risk” of developing a First Episode of Psychosis with the treatment provided aiming to delay or even prevent such an outcome
- Thirdly, to be attached to the **Early-onset Bipolar Disorder** team and learn about that approach

I identified these aims in my application for the Honorary Clinical Observer placement at OYH, and understood I would learn more about the planning and time-tabling for my visit on my arrival.

### 1.5 BRIEF INTRODUCTION TO ORYGEN YOUTH HEALTH

Orygen Youth Health (OYH) is a collective term that describes a range of specialist mental health services available to “youth” in the North Western Health catchment area of Melbourne and its outskirts. (see map below and at Appendix 1)

The age range for the young people considered “youth” in this context is 15 – 24 years inclusive. Initially the forerunner of these various services was the EPPIC service (Early Psychosis Prevention and Intervention Clinic) catering for young people suffering from a First Episode of Psychosis (FEP) and in the last two decades addition teams have developed ie PACE, YAT etc

### 1.6 MEETING SIMON DODD

On my first morning on Monday 7 March I was warmly welcomed by Simon Dodd, Senior Nurse Coordinator in the Training & Communications arm within OYH, who provided me with an overview of the opportunities available to me during my placement. Simon gave me a brief historical account of the growth of OYH from EPPIC from the early 1990s onwards. He informed me of the current workforce within OYH totalling over 300 staff spread across the 3 arms of OYH, namely Orygen Clinical services (150+ people), Orygen Research Centre (approx 130 staff) and the Training & Communications arm. This impressive total attests to the success of the OYH venture and the significant commitment in funding from the Colonial Fund in Australia to enable this.

Simon then told me he was a keen Liverpool FC supporter, and was on a “high” as Liverpool had only the evening before beaten Man United, the English Premiership League leaders.

Simon gave me a timetable (table below) for my 10 weeks’ placement, rotating me through 5 of the 6 specialist teams at OYH. For the first 4 weeks I would be located at the Western Hospital, in Footscray, while for the last 6 weeks I would work at the Parkville campus.
1.7 FIRST MEETING WITH DR MACMILLAN

Later that same afternoon I met up with Dr Iain Macmillan, Medical Director of OYH and a UK-trained Psychiatrist. He has been working in OYH for over a year, previously having worked in an Early Intervention (in Psychosis) team in Norwich, England.

Dr Macmillan told me he’d been a psychiatric trainee in the Newcastle Psychiatric training scheme in the UK. (I recognised the names of some of his past contemporaries, Nicol Ferrier, Allan Scott, and Jan Scott; all leading academic Psychiatrists in the UK). Some years back he’d worked as a Psychiatrist in Perth, WA before later moving to work at the Black Dog Institute in Sydney. He’d gone there through his particular interest in the treatment of Bipolar Disorder.

From that post Dr Macmillan moved to take up his current post as Medical Director at OYH. He is responsible for providing senior medical leadership to the senior Psychiatrists across OYH. His clinical responsibilities are to Inpatient care at Orygen’s Inpatient Unit located at the Western Hospital at Footscray.

2 THE INPATIENT UNIT at FOOTSCRAY (Mon 7 - Fri 18 March)

2.1 This Inpatient Unit caters for an age range that highlights the central tenet of OYH’s approach, given that it treats young people aged 15 through 24 inclusive. Such provision to inpatient care with this mix of adolescents aged under 18 and young adults aged 18 and over does not occur in this way within UK mental health services – young people under 18 are generally catered for in Adolescent IP (Inpatient) units, while Adult mental health Acute Admission wards would admit adults aged 18 and over.

For the first two weeks of my 10 week placement at OYH, I was based within the IPU (Inpatient Unit) and had an unobstructed opportunity to observe staff at work caring for this group of young people with high levels of symptomatic difficulties and presenting high levels of risk either self-directed eg through self-harm or suicidal behaviours or towards others.

2.2 FIRST OBSERVATIONS AT THE IPU

2.2.1 On arriving in the Ward duty room I noted the wall-mounted white board was crammed full of data relating to each inpatient and his /her care. This was a matrix with 16 room numbers (interestingly omitting “13” and in sequence running through ….12, 12A, 14, 15 etc ….) in the first column with the first names of the young person in column 2 and then 15 other columns with headings such as MHA State (Mental Health Act ie whether a voluntary
2.2.2 The ward environment was decorated in bright colours and there was an open-plan living environment just adjacent to the nurse observation area that looked out in two directions, firstly through glazing onto the main communal area for the clients, and also onto the “High Dependency Unit”, a one bedroom environment that also contains two seclusion rooms. Such seclusion rooms that offer the nurses the capacity to isolate a patient placing himself / herself / others at extreme risk (of suicidal actions or aggressive threat) are not routinely found in acute admission mental health wards in the UK.

2.3 AGE-RANGE WITHIN ORYGEN IPU

Orygen Youth Health pioneered in the 1990s through their EPPIC program, services directed at “youth” with mental health care for young people aged 15 through 24 years. I was particularly interested to observe how care to this group of adolescents and young adults, would be provided “on the ground”, particularly as the needs of 15 and 16 year olds can be very dissimilar to those of young adults aged 23 or 24 years.

2.3.1 Both Dr Iain Macmillan, Psychiatrist and Carolyn Lavery, Clinical Nurse Educator provided a similar account of how this occurs in practice. The developmental functioning and needs of the 15 and 16 year olds, particularly so if still in school or still living at home with parents. If it is considered that the 15 year old young person with a First Episode Psychosis, can have his needs best met “next door” – the Banksia Adolescent Unit run by the Children’s Mental Health services affiliated to the Royal Melbourne Children’s Hospital is immediately physically adjacent on the same site at Footscray – then that adolescent would be admitted to the “Children’s Unit”. Contrastingly if the 16 year old has left home, is adult statured and presenting in an aggressive or threatening manner it would be more likely he/she would be admitted into the Orygen IPU.

2.3.2 I looked at the ages of all the residents on two consecutive Tuesdays, 8 & 15 March and found that the ages ranged between 16 and 24 years on the first Tuesday with a mean age of 19.6 years, while the range on Tuesday 15th was 17 to 24 with a higher mean of 21.9 years.

2.4 DETENTION UNDER THE MENTAL HEALTH ACT 1986

There is within Victorian State law the means (Mental Health Act 1986) to detain and treat individuals suffering from mental health disorders against their will. On Tuesday 15th there were 7 clients held in hospital under the Act. At the time of this “snapshot” there were 15 inpatients, giving a 47% detention rate. Earlier that morning I had spoken with Carolyn Lavery and she reckoned that the detention rate ranged between 40 – 50% at any time.
2.5 CONVERSATIONS WITH IPU SENIOR STAFF

2.5.1 DR IAIN MACMILLAN

Dr Iain Macmillan is a UK-trained Psychiatrist (trained in Adult Mental Health) who has accrued considerable experience in the assessment, diagnosis and treatment of Psychotic disorders in the UK. He took up his current post within OYH after a gap following the departure of his predecessor Dr Rick Fraser, former Medical Director who also worked at the IPU. Iain recalled the difficulties for the IPU team immediately prior to his arrival as there was no permanent senior Psychiatrist presence on the ground.

Iain has considerable regard for the skills held by many staff within the IPU workforce – he is however concerned that there is a rapid throughput of more junior nursing staff. I noted the lack of a Clinical Psychologist presence in the IPU team. While it is standard back in the UK in NHS Adolescent IP Units to have a Consultant Clinical Psychologist within the team, Iain considers there would be relatively little for them to do in an acute admissions unit with a fast throughput and short LoS (length of stay) intervals.

It had become clear to me that I had had the erroneous understanding that the Orygen IPU would routinely admit those 15, 16 and 17 year olds requiring admission. Younger adolescents, those still living at home and “developmentally immature” young people aged 15 through 17 would be much more likely to be admitted into the Banksia Unit. From speaking with him, I gained the impression Iain felt the “grey area” overlap with admissions at the lower age range with the Banksia Unit to be a workable solution, with the young person being admitted into the service most likely to work best for him/her.

2.5.2 CAROLYN LAVERY

Carolyn Lavery is the Clinical Nurse Educator within the IPU. She has been working within the EPPIC services since March 1997. Carolyn Lavery previously worked as a clinical nurse in the “old” EPPIC IPU before the new Footscray located Unit was opened in 2003. Her key role within the service relates to facilitating the continuing professional development of both nurse undergraduates and postgraduates in the Unit. She is directly involved in clinical supervision of graduate Nurses and Postgraduate Nurses.

She leads a once weekly Staff Support Group for these Nurses that utilises different formats – a reflective practice approach, an “action-learning” opportunity and lastly a meditation-based group format. She is in no doubt there is a high level of “passion” and commitment evident across the Nursing workforce. She considers too the working relationships with medical staff are good with bilateral respect for each others’ opinions being evident.

Carolyn informed me there is an ongoing focus upon the use and practice of Seclusion within the IPU. There is a “Seclusion Minimisation Project” up and running and clearly the focus is upon attempting to contain agitated patients avoiding excluding them if at all possible.

2.5.3 CATHIE MacLENNAN

Within minutes of my introduction to Cathie, I realised that we had, in fact, both worked as part of the mental health services organised out of the same psychiatric hospital, Leverndale Hospital in Crockston, Glasgow, during the late 1980s. Cathie told me she has been working within OYH since 1989, mostly as a Nursing Shift Leader in the IPU firstly on the Parkville site, and later at Footscray following the move in 2003. She has been the Nurse Unit Manager for the past 18 months.
A particular challenge for Cathie and other senior Nursing staff relates to the Seclusion activity level within the IPU. She considers there is an continuing need to promote the skills base enabling Nurses to manage increasingly challenging behaviours without recourse to a “Grey Code” call with the involvement of Hospital Security staff and the inevitable seclusion that results. She also identified another problem the Unit encounters - the fairly rapid throughput of junior level trained Nurses who move away from the IPU after relatively short periods of tenure. This is a matter that will require ongoing management by both Cathie and Carolyn.

3. OBSERVATIONS REGARDING THE ORYGEN IPU

3.1 ITS UNIQUENESS

The first and most evident observation, as I had anticipated, is that this is very different from IP care available routinely in the UK, in two specific areas
- A unique age range of 15 – 24 years, and
- A service dedicated principally to youth suffering from psychosis

However these are not hard and fast specifiers of the IP care delivery – many young people aged 15 -17 inclusive who could be admitted to the OYH IP Unit are preferentially admitted “next door” to the Banksia Children’s Unit. In addition while the “Psychosis” target group describes the original EPPIC team’s focus, not every young person admitted into the IPU, suffers from a psychotic disorder. Put another way young people / young adults are admitted with a range of mental health problems where in common their level of risk mandates hospital admission.

3.2. ITS MODE OF SERVICE DELIVERY

The Unit caters for 16 unwell young people whose levels of “risk” obviates against continuing care in the community. And yet, there is a rapid throughput of care delivery with young people remaining an IP for a mean of 10 days only – a remarkably short LoS (length of stay) cf to UK Adolescent Units. The opportunity to discharge youth into the YAT team where a high level of intensive contact would occur after discharge, facilitates such rapid throughput.

Furthermore it struck me that the IPU had negotiated very appropriately with its neighbour, the Children’s IP Unit, an agreement that young people at the lower age range would be admitted to the unit that offered “the best fit” between clinical need and service available.

3.3 THE HIGH DEPENDENCY AREA AND THE SECLUSION ROOMS

Finding a High Dependency Area created within an “acute ward” environment is something very unfamiliar to a UK Psychiatrist. The general policy within NHS mental health care is to have a totally separate Intensive Psychiatric Care Unit that is physically removed from the acute ward. I was rather taken aback by the spartan nature of the Seclusion rooms and was disconcerted by what appeared to me to be a bare and restrictive environment to care for an acutely unwell client.

Having individuals “stuck” in seclusion was a major concern to the IPU senior staff. I was pleased to find the senior staff were concerned about an unacceptably high level of seclusion. Under Carolyn Lavery’s leadership the “Seclusion Minimisation Project” is attempting to educate nursing staff to avoid the use of Seclusion where possible and to return a client once secluded back to the Low Dependency area as soon as possible.

3.4 THE APPARENT SYNERGY BETWEEN THE IPU AND THE SPECIALIST OYH COMMUNITY TEAMS

The IPU can only operate in the manner it does, and as such deliver a quality of service that meets the needs of its key stakeholders its clients, referrers and colleague Orygen OP teams, by virtue of the well established and resourced specialist community teams. There is clearly a
highly valuable inter-dependency of the IPU Unit on the OYH specialist OP teams and vice-versa.

4 THE YAT (YOUTH ACCESS TEAM) SERVICE (Mon 21 March - Fri 1 April)

The YAT service is a specialist youth mental health team within the network of interconnected Orygen Youth Health teams. The team is situated in modern purpose built accommodation in the Rushforth Annexe at 35 Mavis Road, Footscray on the Western Hospital site. The YAT team moved to this location in 2006, having previously been on the Parkville site.

The Rushforth Annexe (home of YAT) - named after a former Nurse, Mick Rushforth who worked in the service

4.1 REMIT OF YAT SERVICE

The YAT team functions as the “intake” into Orygen Youth Health services unless the young person has been admitted directly from an Emergency Department (as in a hospital A & E Dept. in the UK) into the Inpatient Unit. Initially a referred youth is assessed within YAT Triage to determine whether the individual's needs carry such a high level of risk that they merit entry into “YAT Acute” ie if considered ‘urgent” – if that level of support is triggered then that young person will receive a package of care that combines “face to face” interviews with telephone call reviews. If not meriting pick-up by YAT Acute, then a youth enters the slower response stream (by virtue of a lower level of clinical need) within YAT Entry, although this would ordinarily entail the client being seen within 2 weeks. This speed of response for a “non-urgent” referral would be considered fairly quick compared to UK services.

4.2 REFERRAL ON FROM YAT

Subsequent to this the comprehensive evaluation within the YAT team helps identify which of the specific OYH teams the youth should then be referred into – ie one of EPPIC, PACE, HYPE and Mood & Anxiety Clinic. As the major thrust of service delivery here is to support

<table>
<thead>
<tr>
<th>REFERRAL PATHWAYS out of YAT into SPECIALIST TEAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are there psychotic symptoms present?</strong></td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td><strong>EPPIC teams</strong></td>
</tr>
<tr>
<td><strong>Are there pre-psychotic symptoms?</strong></td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td><strong>Refer into PACE</strong></td>
</tr>
<tr>
<td><strong>Are there borderline personality features</strong></td>
</tr>
<tr>
<td>present?</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td><strong>Refer to HYPE team</strong></td>
</tr>
</tbody>
</table>
Are there Mood / Anxiety symptoms present? | Yes | Refer to MOOD & ANXIETY Team

young people at risk of developing psychosis, or already experiencing psychotic symptoms with associated compromised functioning, the finding on assessment of the presence of psychotic symptoms will inevitably lead to referral on into the EPPIC team. This referral pathway process operates as shown above, implemented from the top down.

4.3 STAFFING WITHIN THE YAT TEAM

As is the case within Community Mental Health teams in the UK, the staff within YAT come from a number of professional backgrounds – mental health nursing, psychiatrists (the 2 Consultant Psychiatrists being Linda Kader & Carolyn Marks), social workers and occupational therapists. The head count of colleagues in the team is 21.5 EFT (Effective Whole Time = WTE in the UK) with more nurses than any other discipline. There are 37 staff in the clinical team with roughly a 2:1 part-time to whole-time staff ratio. There are also 1.4EFT Admin posts and 1.8EFT Managers (Rob Oldani and Simon Blaikie).

YAT team staff (some of ….)

Left to Right

Javier, Maria, Kath, Serena. Melissa, Denise, Myself, Suzie, Laura and Nigel

………IT WAS A GOOD JOKE!

Staff work two shifts during the day - an early shift from 08:30 until 17:00 and a late shift from 13:30 till 22:00 hours. Generally speaking there are 3 staff on the early YAT shift and 4 on the late, with other staff rostered separately each shift for YAT Triage activity.

4.4 A TYPICAL DAY – two examples

Any clinical team would tell an interested observer there is no such thing as a typical day. On Thursday 23 March the Whiteboard in the YAT office contained an outline of the day’s tasks & business. In brief, there were a number of face to face assessments being conducted on-site, some undertaken by YAT non-medical staff, several Medical reviews booked in, a Social work meeting scheduled for 1pm, a Professional Development activity at 1.30pm, Telephone calls such as the “Bed Conference calls” and 15 booked calls to clients for telephone review (one of which was that day requiring a Cantonese speaking interpreter)

On Wednesday 30th March, the running order was:-

09:00 Bed Update & ward Round
09:30 Home Visit to client AB – Medical Review
09:30 Client CD - Entry Assessment
10:00 Assessment of client EF on Banksia (Children’s IP Unit) (being rescheduled)
11:00 Client GH - Medical Review
11:00 Bed Update and Conference Call
11:30 Assessment – client IJ
Visit to Orygen Youth Health (OYH)

13:30 Handover
15:00 Client KL - Assessment
15:00 Client MN - Medical Review
16:00 Bed Update and Conference Call
16:00 Client OP - Y/R (ie YAT Review)
17:30 Client QR - Assessment

In addition, there were 23 booked telephone calls to be made during office hours – alongside the client’s name there might be a specific issue to address / perform; for the most part these calls are Telephone Reviews to ascertain how a young person is managing in terms of their mental health. Additional issues to be addressed by phone calls that day included: text reminders of next Assessment appointment; notifying of Referral elsewhere; phoning the GP and providing an update; rescheduling a YAT Assessment.

4.5 VISIT TO THE HEADSPACE PREMISES, SUNSHINE - Thursday 23 March

This activity was planned as a staff “Professional Development” event. Headspace is an organisation that “provides mental and health wellbeing support, information & services to young people and their families across Australia” (taken from web site) and likewise…

headspace National Youth Mental Health Foundation Ltd is funded by the Australian Government Department of Health and Ageing under the Youth Mental Health Initiative Program

Immediately below is wording from this Webpage

Welcome to headspace western Melbourne (hWM)

hWM is a health service for all young people in the Maribyrnong, Hobsons Bay, Wyndham and Brimbank areas.

You might come to headspace if:

- You are aged between 12-25
- You need some help with your health
- You are having difficulty with something in your life
- You are worried about your mental health or feeling depressed or anxious
- You are worried about your drug and/or alcohol use
- You are worried about a friend or a family member.

hWM also has an Access Team that is available to meet with and talk to young people. They can spend time talking about how things are going and link you into other services you may need. Please feel free to call our reception and ask for the access team on 9091 8222.

hWM is located in the Visy Cares Hub Building - a big red brick heritage building. The easiest way to find us is to find the Sunshine library in Hampshire Rd then go around the back of it. We are in the carpark. For those who know the Sunshine Marketplace, we are behind the Village Cinemas and only a short walk from the Sunshine Train Station.
Visit to Orygen Youth Health (OYH)

The YAT team staff had the opportunity to discuss with Headspace colleagues the interface between the two services. We met up with Nick Prendergast (Executive Officer), Alison McRoberts (Clinical Services Manager) and other Headspace staff. I witnessed a friendly exchange between these two partner services with Headspace able to offer support to young people with less severe or established mental health problems, with input from psychologists, counsellors and youth workers. Headspace refer young people who need the more specialist input from OYH into the YAT team as required.

4.6 CASELOAD MANAGEMENT IN YAT

At 13.30 each day in the YAT Team’s timetable there is a Clinical Review / Handover event where all staff are expected to contribute to an update of the active caseload. The senior team members present ensure the team works through the open YAT caseload, viewing this detailed Excel Spreadsheet projected onto an office wall. One team member proficient as an Excel user updates specific “cells” in the Spreadsheet with the most recent data.

For example, when an “Assessment Pending” case is considered through the Assessment having been completed the day or so before, the ensuing discussion of the Assessment enables a more detailed entry to be typed into the last column – the Action column – and that case entry can then be appropriately moved out of the “new Assessment Pending” Excel Page onto a more appropriate Page such as a Team A or Team B page. This action is moving the entry for that case “Shane Jones” into the Team A page denotes that the YAT team worker is “holding” that Team A case prior to the case being picked up by an OCM – an Outpatient Case Manager within one of the specific Team A specialist teams such as PACE or EPPIC.

4.7 CASE APPORTIONMENT AS OF THE CASE REVIEW OF MON 28 MARCH

By the end of the Case Review held on Monday 28 March at the start of my second (and final) week placed in the YAT team, the distribution of the Active caseload was as shown below in Table 1. In total the team on that day was dealing with 72 “active” or “open” cases or clients, the majority of whom (64%) were male. Twenty of these 72 clients (28%) were engaged in the Triage & New Assessments stage within YAT – this describes the group of clients who are in the early stages of having their needs assessed. The terminology “New Assessments Not Presented” describes a client who has been assessed but where the findings have not yet been discussed at the daily “Clinic Review” activity at 13:30 hours each day.

Once “presented” the staff group identify which specialist team would best meet the client’s needs and one “provider” team eg EPPIC or HYPE would be identified. The client’s listing then on the Spreadsheet is by Region x Provider team such as Team A & Accepted by HYPE. On Monday 28 March there were 15 such cases within Team A’s region who had been allocated to a provider team and were awaiting an Outpatient appointment time from their OP Case Manager – similarly there were 7 such Team B’s region cases allocated. A further 4 cases had been allocated to HYPE (Helping Young People Early) and one client to the IMYOS (Intensive Mobile Youth Outreach Service).

Table 1 on next page.....
### TABLE 1  DISTRIBUTION OF CLIENTS IN YAT  ( at 28 MARCH 2011 )

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>N Total Cases</th>
<th>N of FEMALES &amp; (Age or Age Range)</th>
<th>N of MALES &amp; (Age or Age Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRIAGE &amp; NEW ASSESSMENTS</td>
<td>20</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Entry Clients</td>
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<td>1 (18)</td>
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<tr>
<td>New Assessments Pending / “Not Presented”</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Region (Team) A</td>
<td>12</td>
<td>3 (18 – 24)</td>
<td>9 (15 – 24)</td>
</tr>
<tr>
<td>Region (Team) B</td>
<td>3</td>
<td>2 (15 &amp; 22)</td>
<td>1 (17)</td>
</tr>
<tr>
<td>Awaiting Admission to IPU</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>BANKSIA IPU</td>
<td>2</td>
<td>1 (16)</td>
<td>1 (15)</td>
</tr>
<tr>
<td>TEAM A</td>
<td></td>
<td></td>
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<tr>
<td>ASSESSMENTS IN PROGRESS</td>
<td>11</td>
<td>3 (19 – 21)</td>
<td>8 (18 – 24)</td>
</tr>
<tr>
<td>Accepted YMC</td>
<td>3</td>
<td>1 (16)</td>
<td>2 (20 &amp; 21)</td>
</tr>
<tr>
<td>Accepted EPPIC</td>
<td>5</td>
<td></td>
<td>5 (18 – 24)</td>
</tr>
<tr>
<td>Accepted PACE</td>
<td>6</td>
<td>3 (16 – 21)</td>
<td>3 (16 – 23)</td>
</tr>
<tr>
<td>Accepted nm HEADSPACE</td>
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<td></td>
<td>1 (15)</td>
</tr>
<tr>
<td>Not Accepted – Refer Out</td>
<td>1</td>
<td></td>
<td>1 (19) to Private Psychologist</td>
</tr>
<tr>
<td>TEAM B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASSESSMENTS IN PROGRESS</td>
<td>11</td>
<td>5 (15 – 20)</td>
<td>6 (16 – 24)</td>
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<tr>
<td>Accepted YMC</td>
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<td>2 (18 &amp; 20)</td>
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<tr>
<td>Accepted EPPIC</td>
<td>1</td>
<td>1 (17)</td>
<td></td>
</tr>
<tr>
<td>Accepted PACE</td>
<td>2</td>
<td>2 (15 &amp; 25)</td>
<td></td>
</tr>
<tr>
<td>Accepted nm HEADSPACE</td>
<td>2</td>
<td></td>
<td>2 (15 &amp; 23)</td>
</tr>
<tr>
<td>Not Accepted – Refer Out</td>
<td>2</td>
<td>1 (20) Plan to archive</td>
<td>1 (24) to Private Psychologist</td>
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<td>HYPE</td>
<td>4</td>
<td>2 (16 &amp; 21)</td>
<td>2 (22 &amp;23)</td>
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<tr>
<td>IMYOS</td>
<td>1</td>
<td>1 (17)</td>
<td></td>
</tr>
<tr>
<td>TOTAL CLIENTS</td>
<td>72</td>
<td>26</td>
<td>46</td>
</tr>
</tbody>
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#### 4.8  MEETING WITH SIMON BLAIKIE AND ROB OLDANI

Rob Oldani is the YAT Manager while Simon Blaikie is the YAT Depute Coordinator. Talking to them together reveals their commitment and passion for the work with young people with psychosis and the YAT team in particular. I spoke with them on the afternoon on Friday 1 April, my last day in YAT.

They told me about a major pressure upon the team through an ongoing shortfall of staff – a 19% vacancy in clinical staff – while there has been an increasing need to keep pace of an increasing demand upon the service. There has been a 31% increase in the volume of YAT contacts between two consecutive 12 month intervals, March 09 - Feb10 and March 2010 - Feb 2011.

They spoke too of their shared concern that the shift in direction of focus in OYH away from an exclusive First Episode Psychosis (FEP) service onto high prevalence disorders across
Visit to Orygen Youth Health (OYH)

the age range 15 - 24 years inclusive, has led in their opinion to a dilution of the quality of services tailored to youth with evolving psychosis.

4.9 MY CLINICAL EXPERIENCES IN YAT

I was able to sit in with a number of YAT team members and observe them “at work” in clinical interviews – in addition for the majority of time I was an active observer, a “fly on the wall” watching various team members conducting their business.

I sat in mostly with Dr Yang Yun a senior psychiatric trainee attached to the team. Each day there were usually 2 – 3 “Medical reviews” booked in for the service. On other occasions I sat in with non-medical team members, with Nigel Hine (a psychiatric nurse, who formerly worked in an EI (Early Intervention) team in England) on an Assessment interview, with Suzie Hancox assessing a 15 year old depressed young man in the Banksia Adolescent Unit, and on a YAT review contact through a home visit with Maria Stevens (a Social Worker). I observed experienced clinicians confident in their practise and not perturbed by the older onlooking Scottish psychiatrist!

5 OBSERVATIONS OF THE YAT SERVICE

5.1 THE “SHARP END” OF THE SERVICE

The YAT team offers the first OYH contact with all clients excepting those admitted urgently into IP care. As such, its workers specifically within YAT Triage have to undertake important assessments of youth with considerable mental health problems, often presenting (or being presented by parents, friends, significant others) in crisis, when the engagement task is thus made all the more challenging. It is testimony to the considerable skill and competence of the YAT team that very few cases fail to progress through from YAT Triage into YAT Acute and then on in due course to one of OYH’s specialist teams.

5.2 THE CAPACITY TO THROUGHPUT MANY CLIENTS

I became very aware, very quickly of the rapid pace of service delivery within the YAT team. Yet this challenging task was accommodated with little fuss through a strong team culture, a shared commitment to the model, effective within-team leadership from more senior colleagues and the healthy use of humour and at times, song!

5.3 UTILISING IT INFRASTRUCTURE TO ASSIST

The YAT team is the first specialist mental health team I have witnessed incorporating an electronically recorded patient management system so centrally in their daily activity. At 13.30 every day Mon – Fri (a time chosen during the overlap of the “early” and “late” shifts to ensure maximum attendance) each available team member participates in the Clinical Review process. The obvious merit of this electronic mass client record is that it allows staff coming back on shift to quickly review any specific client’s care at that time by opening this record on a computer terminal.

5.4 HIGH-QUALITY ASSESSMENTS & RECORD KEEPING

Being very familiar with record keeping, and having in the past needed to examine clinical records following a formal complaint of health care, it was highly satisfying to witness a team committed to maintaining clinical records in a highly structured format, with a set range of agreed assessments being undertaken. Not only did this yield benefit for the ongoing work within YAT, but it provided an excellent record that would support the task of engaging with a new client when the youth was referred on.
5.5 THE IDIOSYNCRATIC ROLE OF THE CONSULTANT PSYCHIATRISTS WITHIN YAT

In Scotland Consultant Child & Adolescent Psychiatrists undertake a role that entails they hold a central and senior role within CAMHS teams, with other colleagues often seeking out advice on issues relating to patient risk. In addition they carry a significant client caseload usually involving chronic or complex cases.

I did not see much evidence of either of these aspects in my placement in YAT. As far as the risk management task is concerned I gained the impression the non-medical team members deal with this competently and confidently and would only pull in Drs Kader or Marks if there were major concerns. As for the separate issue of centrality in the team and holding a significant caseload, the rapid throughput in YAT works against this “British” style of working – clearly the YAT task is transformational. Ie the input is an unknown, un-assessed youth with major mental health problems, with a process of engagement and assessment (the transformation) ensuing leading to the output of an identified mental health need being directed appropriately into the next specialist team. I am aware this type of role would not appeal to a high proportion of my CAMHS Consultant Psychiatrist colleagues back in Edinburgh.

6 THE PACE TEAM (Mon 4 - Fri 15 April)

6.1 MEETINGS WITH DR ANDY THOMPSON, CONSULTANT PSYCHIATRIST

Dr Andy Thompson and I arranged to meet up late on in the morning of Mon 4 April at the start of my two week placement in the PACE team. He informed me he is one of two Consultant Psychiatrists working in PACE, with 0.5EFT while Dr Corinne Haber, his Consultant colleague provides 0.2EFT. Dr Thompson is also an Honorary Senior Research Fellow at the University of Melbourne. There are two other trainee Psychiatrists working in the team, Andeas Polari (from Switzerland) and Miriam Shafer (from Austria) and their additional sessions contribute to a total presence of 1.2 EFT Psychiatrists.

The PACE team helps young people who have been identified as being “at high risk” of developing a psychotic episode by the “sub-threshold” presence of some symptoms, by offering psychological therapy intervention and possibly, too, low-dose antipsychotic medication to reduce the likelihood of any further untoward decline in mental health. As well as the psychiatrists in the team there are also “Case Managers” and upon allocation each young person is linked up with two professionals ie 1 psychiatrist and 1 case manager. PACE is expected to work with a client for only 6 months, the expectation being that the young person will become more psychologically robust and able then to discontinue attendance.

Within the staff group in PACE there are a number of Case Managers (OCM = Outpatient Case Manager) from different clinical disciplines, being Clinical Psychologists, Social Workers, Occupational Therapists and Nurses, whose full-time and part-time posts amount to approximately 3.5 – 4EFT clinicians. There are currently between 100 and 110 active PACE cases.

On the morning of Tuesday 5 April I sat in on a couple of Outpatient Reviews of PACE clients. One of these clients is identified within PACE as an “EPPIC C case” While the
PACE team operates as a single unit, cases are identified as “PACE A” and “PACE B” cases - in line with the geographical split operated by the Inpatient Unit at Footscray with the two IP teams A and B catering for 2 separate geographical catchment zones.

The terminology “EPPIC C” relates to a PACE client who during his/her treatment episode at PACE develops a full-blown Psychotic episode. While such a case identified earlier within YAT would then be passed over to the EPPIC team, to maintain continuity of treatment it has been accepted across OYH that such cases will continue to receive EPPIC treatment from their existing Psychiatrist and OCM within the PACE team, although being identified from then on as an “EPPIC C” case.

The second contact that afternoon entailed a follow up contact with a young man participating in a current clinical Research trial – the Neuropro E Trial. There has for some time within the mental health research field been interest in the possible value in the use of highly unsaturated Omega 3 fatty acids in the treatment of individuals with specific mental health disorders, such as psychoses.

Limited evidence suggests that long-chain n-3 fatty acids delay or prevent the progression of certain psychotic disorders in high-risk children and adolescents. The individuals diagnosed with schizophrenia exhibited reduced levels of both n-6 and n-3 polyunsaturated fatty acids, and the results of a study in which the treatment of high-risk children with a dietary supplement containing both eicosapentaenoate and docosahexaenoate produced a statistically significant (95% confidence, but not 97.5% confidence) decrease in progression to schizophrenia. From Wikipedia article http://en.wikipedia.org/wiki/Omega-3_fatty_acid

Dr Paul Amminger, the senior researcher in this work is an Austrian psychiatrist, attached to ORY-Research Centre in Melbourne. He is continuing with this line of research exploring the neuroprotective potential of Omega-3 fatty acids.

6.2 OBSERVING THE PACE TEAM MEETING

This team meets once weekly at 9am on Wednesday mornings. In addition to Andy and Andrea and Miriam (psychiatrists) mentioned above, also present were Steve (Team Manager), Helen, Annalise, Jon, Kristan, and Lori. Dr Corinne Haber is unable to attend the Wednesday meeting as she doesn’t work that day at Orygen. There was also a student Clinical Psychologist on placement and two female visitors (that team meeting only).

Like the approach at YAT, the PACE team members utilise a digital projector to display a word-processed case record review that is then shared orally with the team. Case Managers are required to produce detailed Case Management Reviews at specific intervals in a PACE client’s care viz. at 1 month; at 3 months; at 6 months; at 12 months; and at discharge. This gives the team the opportunity to comment on aspects of that individual client’s case management. For each of the Reviews, content relating to the clinical management can be altered “live” with the updated revised record then “saved”.

There were 4 mandatory Reviews that morning, of which I will summarise 2 cases :-

#1 Female: 14 months into treatment in PACE....a difficult client to work with, unwilling to engage in therapy and repeatedly verbally abusive and threatening to her male therapist. It became evident such behaviours over a number of sessions were not unusual....the team supported the male therapist's proposal that she be discharged rom PACE with her care being handed on to the GP.
#2 Male: 16 years old, depressed with PTSD (Post-Traumatic Stress Disorder) features. After 6 months of treatment within PACE, he is symptomatically recovered. He wants to close treatment. Case manager endorses this. PACE team happy with proposal.

Then Steve informed team colleagues there were 4 new cases awaiting allocation to Case Managers – unfortunately there were no offers forthcoming to take a case, as all case managers reported working at full capacity.

### 6.3 MY MEETING WITH STEVE LEICESTER (TEAM MANAGER, PACE)

Steve told me he had been with OYH for over 12 years. While he entered mental health services after training as a Clinical Psychologist, he had previously been a teacher, and had also worked in a community mental health setting. He has been the PACE Team Manager for just under 3 years.

Steve gave me a “potted history” of the PACE team. Prior to 2006, the PACE service existed exclusively as a research team, based in the Highpoint Shopping Centre in Sunshine. Then during 2006 guaranteed recurrent funding was secured and the clinical PACE team was established. The team should only hold a client for a full 6 months – if that client develops a full-blown psychotic episode then as an EPPIC C case, PACE can then continue to work with that client for up to a total of 18 months.

With only about 5 EFT Case Managers, and a current caseload of over 100 cases (of whom about 30 are “EPPIC C”) each case manager is holding a caseload of between 20 – 25 clients. Steve recognises that the team is constantly under pressure to accept more and more referrals. The catchment areas covered include “to the North” and “to the West”, a couple of major “growth corridors” for Greater Melbourne with expanding populations in these suburbs. These population zones have tended to include areas eg in Footscray and Sunshine of markedly diverse ethnic groups with considerable socio-economic disadvantage. In addition Steve mentioned the availability of having provided an easy contact “0800” telephone number had led to more and more referrals in through YAT. Orygen had been “caught up by its own success”, he implied.

When asked by me to consider the major challenges facing PACE, Steve mentioned the “silo-ing being a major problem” and of “the need to create fluidity between the silos” Coping with ever increasing referrals, providing a service where the population is hours distant by public transport, and maintaining a clear focus upon the positive symptoms were also reported by him as ongoing challenges. While evidently concerned about these issues Steve sounded activated by the challenge and up for it, there being little pessimism in his attitude.

### 7 OBSERVATIONS ABOUT THE PACE TEAM

#### 7.1 CLEAR CORE IDENTITY

I was impressed by the evident sense of clarity of purpose in the PACE team. Up until several years ago this team was wholly comprised of research workers who were undertaking ground-breaking research under Alison Yung and colleagues, before the clinical service was established. This is now a team integrated within OYH-Clinical with Consultant Psychiatrist leadership coming from Drs Andy Thomson and Corinne Haber.

The team is clear and unambiguous about its remit and purpose. It exists to work with young people identified as being “at high risk” (of developing psychosis) and the input is sharply focussed by the limit of only a 6 month treatment opportunity.

#### 7.2 TENSION AT INTERFACE WITH EPPIC TEAMS

Through comments made by several members of the team, the presence and incorporation of clients identified as “EPPIC C cases” within the PACE team’s workload is an ongoing source
of mild frustration, tolerated more readily by some team members than others. While Steve, the Team Manager appears more relaxed about such EP PIC C clients, other team members feel burdened by this additional caseload, without any additional staff resource to offset the demand.

7.3 THE “SILO” EFFECT

While not exclusively a PACE problem, it did seem to me that the workload pressures have influenced the tendency for a small team like PACE, to reduce its overall vision inwardly upon itself and be less aware of and sensitive to larger organisational issues. This was clearly cited by Steve, the Team Manager who commented upon “the silo-ing being a major problem”. This would have the potential of isolating a specialist team like PACE. Thankfully various team members attend meetings in other settings and groupings across OYH and that offsets this tendency for the team to isolate itself, ie Andy Thomson attending the weekly Doctors” meetings; Steve Leicester joining other middle management meetings.

7.4 ENGAGEMENT WITH THE RESEARCH AGENDA

Although a busy clinical service, I noted there is support across the team to engage in and support ongoing clinical research – ie PACE are recruiting young people into the Neuropro E trial. It was evident Dr Thomson is committing considerable energy to maintain this.

8 ATTACHMENT TO EPPIC (Mon 18 April – Mon 2 May)

8.1 MEETING WITH RICHARD BELL, TEAM COORDINATOR – EPPIC B

I met up with Richard in the afternoon of Fri 15 April. Richard, a Clinical Psychologist told me he has worked in EPPIC (“old service”) for approx 15 years, long before the commitment to expand from solely a “Psychosis service” to a “Youth Mental Health” service. More recently he has been the Project Manager working on the Implementation of Initial Stages of Melbourne Health Youth Mental Health Service Plan – He provided me with a copy of this Project paper v.10

He spoke about two major challenges to the service - 1. there are significant “growth corridors” in areas of North, West and South-West Melbourne leading to the pressure of increasing referrals and 2. attempts to ensure Acute ( ie YAT) retains focus on Acute work only. A major future development would entail OYH working with clients within the age range of 15 – 24 years inclusive, not only for 24 months but throughout the age range up to becoming 25 ie potentially for much longer than the current maximum of two years.

Linked to this Richard is proposing there could be the development of a “sub-acute” residential care model & facilities appropriate to youth eg a Prevention & Recovery Care Unit (PARC). He clarified for me the thinking behind Stage 3 of the Plan. This entails “relocation of clinical teams to Youth Hubs and co-location with headspace” The first such move would entail EPPIC B + Mood & Anxiety B teams moving out to new premises in Sunshine ( out into West Melbourne)

It was clear to me Richard feels very strongly about the merits of Orygen’s philosophy and is keenly aware of the challenges upon the committed Orygen staff to maintain a high quality of service in the current climate of increasing referral numbers. He has worked out, what seems to me to be a well-considered Implementation Plan and he hopes his proposals are supported.

8.2 JOINING THE EPPIC A TEAM MEETING

My attendance at my first EPPIC A team meeting coincided with the return of Craig McNeil, an experienced Clinical Psychologist, who had just returned to work following a period of 3 months Long Service Leave during which he had returned to Scotland. I obviously knew in
advance of arriving in Melbourne that I would be meeting up with Craig again. Craig was the Clinical Psychologist in the team I helped establish a long time back in the mid 90’s when I was the Clinical Director for the Adolescent Mental Health services in Greater Glasgow.

The team meeting involved approximately 10 staff, the majority female, although there were 4 male colleagues present, Gideon Dubow, Consultant Psychiatrist, whose time is split between the IP Unit and EPPIC A and 3 male OCMs, one of whom is Craig. Dr Linda Kader, also a Consultant Psychiatrist was present too, this team having part-time sessional input from two senior Psychiatrists, herself and Gideon.

As the meeting progressed it became clear to me the first group of clients being discussed were being considered for closure or discharge; later there was discussion about relatively new cases, being presented for their First EPPIC Review. There were 6 cases in the former category, and I am providing here succinct data relating to two clients:-

- A 19 year old male, first presentation with a manic episode needing IP care. Was in hospital for 1 month. He discontinued his medication after 6 months but has remained in contact with his OCM and he has remained well. The OCM proposed he be discharged and the team concurred.

- A 22 year old male with a background of significant substance misuse and paranoid delusions. Previous consumption of large amounts of “ice” (methamphetamine) He required a period of IP care when acutely unwell with psychotic features. He had responded well to Quetiapine (an anti-psychotic drug) medication. Is working (as a labourer) with his Father. The team felt a further face to face review was needed before planning his discharge.

Then a number of “initial” Review cases were discussed with the OCM leading the presentation and the psychiatrist involved adding information where appropriate. Here is one such case

- A 22 year old woman, whose early contact with mental health services was secondary to a combination of eating difficulties and mood problems. She then suffered a manic episode in Dec 2010. While ill she thought she had the power to treat her mother’s Bipolar illness; in addition she believed she could see demons in other people’s eyes. At recent follow-up it was evident she was hypomanic in mood, probably related to having discontinued taking her medication – had been prescribed Lithium (a Mood Stabiliser) and Quetiapine – after discussion with the OCM, she agreed to resume Quetiapine (150mg dose) only.

After the discussions of these clients there was some discussion of the activity of the Working Group involved in the Revision of the Entry & Discharge Guidelines for EPPIC Clients.

8.3 CONVERSATION WITH DR LINDA KADER (EPPIC A)

A Bangla Deshi by birth, she had moved to Australia following her medical training in India. She completed a training post in EPPIC as a Psychiatric Registrar and enjoyed it a lot.

Linda works full-time – 0.5 EFT in YAT, and 0.5 in EPPIC – She also does 1 session / week in private practice. Her EPPIC caseload is excessive at 60 cases – according to her job responsibilities she should hold a total caseload of 35 (calculated as 5 sessions worked x 7 cases/session = 35 expected caseload). In addition to her direct clinical care duties, she is
responsible for supervising the Registrar. Across the two teams in which she works, she supervises 2 psychiatric trainees at present.

She feels the caseloads held currently by EPPIC workers are far too large ~ 30 -35 cases. She is in no doubt this has ked to major staff “burnout”, with dissatisfaction with the job & a large exodus of colleagues several years back. Through the demands upon the EPPIC A Team, the weekly team meeting increased in duration approx 1 year back to 2hrs (from 1 hour). She told me that the EPPIC B team is anticipating moving out to the “Sunshine hub” in the future. There is no date yet for this move.

8.4 CONVERSING WITH HANNAH BLOOM (EPPIC A team member)

I had hoped to sit in on a client contact with Hannah, an experienced clinician in Early Psychosis work. The non-arrival of the young adult male gave me an immediate opportunity to speak with Hannah about her work in EPPIC A. She told me she had worked years before setting up a First Episode Psychosis service in Outer Eastern Melbourne. More recently before joining OYH, she had worked within St Vincent’s Hospital, Melbourne, training staff to acquire skills enabling them the capability to work with clients with First Episode Psychosis. While Hannah had enjoyed that training experience she became aware she was missing the direct clinical contacts she enjoyed so much and she applied for a post within EPPIC at OYH.

Hannah who told me she was a Social Worker by background, is currently holding the role of the EPPIC A Team Coordinator and she is busy in a small working group revising the Entry & Discharge Criteria for EPPIC teams – unlike PACE, Mood & Anxiety and the HYPE team where case loads are “capped” there is no such ceiling on caseloads within the two EPPIC teams. She echoes concerns I had heard voiced by other EPPIC team members as to the difficulty working with excessively large case loads when there continues to be a never-ending referral load into the team. While the document has still to be finalised Hannah is hopeful that solutions will not only be identified but implemented.

8.5 ATTENDING THE EPPIC B TEAM MEETING

I attended the EPPIC B team meeting where the permanent Consultant Psychiatrist was still off on maternity leave. Prof. Pat McGorry, (Executive Director of OYH) himself a Psychiatrist had started to help out in her absence by attending the team meetings. There were 9 team members present, 7 OCMs and 2 Registrars (junior Psychiatrists).

I saw the team functioning well with cases being presented by OCMs and discussed fully. While Prof Pat McGorry is an extremely senior individual in the OYH organisation, there was no sense whatsoever of the team being anxious or uncomfortable in his presence – in turn, I found Prof. McGorry’s contributions “light-handed”, very positive and complimenting the good work undertaken by the OCMs and the two Registrars.

8.6 REUNION WITH CRAIG MACNEIL

Craig MacNeil is a Senior Clinical Psychologist who previously worked in EPPIC B prior to a period of Long Service leave in late 2010/early 2011 (during which time he returned to Scotland). On his return to work he has moved into the EPPIC A team. Years ago in the 1990s Craig worked alongside myself in the Gorbals in Glasgow as the newly formed team he worked in was temporarily “homeless” and he and his East Glasgow Adolescent Mental Health team were sharing the South Glasgow team’s premises, where I worked. On Friday 29 April in the afternoon we spent time together and I learned of Craig’s perspective on Orygen Youth Health.

Craig recalled he’d come to Australia planning initially to stay only for 1 year. He’d worked in the Student Mental Health service in Sydney and was about to return home when, “on spec”, he phonned up EPPIC here in Melbourne to ask if they had any suitable jobs. Within the following week, Craig had applied to a post that had almost “closed”, was called for interview, and was appointed to post! He is now considered an “old hand” within EPPIC (not exactly what he said but the same adjective was used in his two word epithet), having been with the
organisation over 10 years. He has gained considerable experience as a Case Manager in EPPIC, but he has also through a keen wish to develop services and be involved in research, become a leading agent in service delivery to young people with mania, a form of Bipolar Disorder. I had been aware he was the first author of a textbook entitled “Bipolar Disorder in Young People” (Cambridge University Press 2009) which he confided had been a long protracted challenge over 5 years. As a Senior Psychologist within Orygen Youth Health some of Craig’s time is taken up in supervision of more junior colleagues, alongside his clinical caseload and his research activity.

He is a passionate EPPIC worker, strongly committed to maintaining the core strengths of the approach. He spoke of the considerable challenges facing the team. Like others before him, he also mentioned the caseload sizes being excessive and a regular burden. He is very aware more junior staff often feel they are just “keeping their heads above water” (my description). Working flat out can become overwhelming and Craig is aware there has in recent years been a worrying loss of relatively junior staff secondary to the heavy workload. At the same time Craig recognises there is such a “buzz” around for staff working here within Orygen, and a strong drive to want to remain working here within an enthusiastic, dynamic team at the “cutting edge” of service delivery. Orygen staff are very aware of the service regularly attracting international visitors like myself who want to capture some of the Orygen “magic”. Craig did tell me he felt the organisation lost out when Prof Pat McGorry the charismatic “father figure” was off the scene much of last year, when he was Australian of the Year (2010) – at the same time staff knew that Prof McGorry was capitalising on this media attention to argue for more much needed funding for youth mental services, not just for OYH but nationwide.

On the third last Friday of my time attached to OYH Craig took me along to the Mania research group weekly meeting – Craig has a strong research interest into First Episode Bipolar Disorder and its treatment. Professor Michael Berk, the senior Academic leading the study described its aims – a Neuroprotective study looking at a head to head comparison of two drugs – Lithium and Seroquel – in the treatment of Mania. Michael and his research colleagues are very excited with their study – “the world’s first First Episode of Mania Neuroprotection Study” as Michael described. In addition to a thorough clinical evaluation at specified times in the prospective 1 year long treatment study, the study subjects will have neuropsychological assessments and also MRI brain scans. During the meeting Andreas Bechdorf, a German researcher and academic came in to join the group - by chance I learned fortuitously of original research he and his academic team in Cologne, Germany were conducting – I was pleased to learn of this as I knew it would be of interest to colleagues back home within the EPSS service in Edinburgh.

It was so gratifying to be able to meet up with Craig again after a long gap in contact. Getting Craig’s particular perspective on the Orygen services was especially valuable.

9 REFLECTIONS ABOUT THE EPPIC TEAMS

9.1 A STRONG TEAM IDENTITY

I was very impressed by the strong team identity that exists across both EPPIC teams. The staff are very committed to the task of caring for youth with first episode psychosis, and using the therapeutic skills and approaches available to achieve as the OYH logo reads “opening minds to a brighter future”. Several people across OYH had told me of a mass “exodus” from the EPPIC teams several years ago – there was little evidence that there has been any lasting damage to the integrity and functioning of the current EPPIC teams.
9.2 HIGH QUALITY SERVICE DELIVERY

I was able to witness first-hand some clinical contacts across both EPPIC teams with this experience complemented by discussions with a number of staff. Combining that with my presence at a number of team meetings left me in no doubt as to the high calibre of the work of the clinical staff. They displayed considerable skill in their therapeutic contacts and a passionate commitment to their work. Having said this, while the means of delivering it is different I felt my colleagues back home in our EPSS team are delivering a similar quality of care.

9.3 A TEAM UNDER PRESSURE

At the same time I noted the comments being made about the onerous and burdensome caseloads. Holding an “active” caseload of 35 clients does seem a problematic challenge to me – while our approach in the EPSS team in Edinburgh is not directly comparable, and the prevalence of psychosis increases through late adolescence into the twenties, my colleague Key Worker nurses have caseloads of 10-12 each. There is clearly considerable hope invested in the work Hannah Bloom, Shona Francey and others are undertaking with the rewrite of the Entry & Discharge Criteria for EPPIC teams.

9.4 CONCERNS ABOUT THE MOVE TO A “HUB & SPOKE MODEL”

There is the expectation to suit the growing referral rates from the two population “growth corridors”, one in Western Melbourne and one in Northern Melbourne that the specialist teams will be relocated off the Parkville site. The Mood and Anxiety team, previously one unit, split just over a month ago into Mood & Anxiety A and Mood & Anxiety B in advance of the anticipated relocation. The first expected move involves staff in three teams – PACE B + EPPIC B + Mood & Anxiety B – all moving out to a new location in Sunshine.

10 MEETINGS WITH KEY ORYGEN ACADEMICS & OTHER STAFF

10.1 PROFESSOR PAT McGORRY AO

I met up with Prof. Patrick McGorry (locally colleagues address him simply as “Pat”) in his office in Building B on the Orygen campus. Last year Prof. Pat McGorry was awarded the highest accolade in Australia for public services, the award of Australian of the year. He was a welcoming, engaging host and I gained from our interview a heightened understanding of his commitment and passion for the establishment of “youth-friendly” services.

I asked Pat first about what had drawn him into the field of First Episode Psychosis. He had mentioned to me in passing that he had come to Australia in 1968 when aged 15 (I then realised we might both share the same year of birth, 1953) having left South Wales in the UK. I learned later from hearing him at a public lecture that his father had been a TB Physician. He had been inspired he’d told me by the work of the late Prof David Maddison, Psychiatrist and Dean of the Medical School at University of Newcastle, NSW, although he added, his first experiences of inpatient mental health care were disconcerting given the “asylum” style treatment he witnessed then. Before coming into psychiatry he told me he’d worked in diabetic medicine and had been treating newly diagnosed diabetic patients with considerable focus being education about the illness and of living with diabetes. He himself made the link between the early stage of the patient’s
life with diabetes and of his later use of the concept of “clinical staging” in mental health disorders.

Through his early career experiences in Psychiatry, Pat told me he became more and more interested in therapeutic inputs that would help the patient cope better with the diagnosed illness. He was given the responsibility in Melbourne of establishing a Research Unit and later he headed up the establishment of an early detection (of mental illness) team. He was involved in developing “psychosocial programmes” to help effect the patient’s social rehabilitation. Over time this concern focused upon helping the client cope better with the onset of psychotic disorder, the field of mental health now described as First Episode Psychosis. By the late 1980s/early 1990s Pat’s clinical interest had well and truly settled upon the age range of older adolescents & young adults.

In 1991 he was successful in gaining a large research grant which allowed the study of the prodrome (the period of time prior to the onset of the psychotic episode). When the former Adolescent Unit closed down in, Pat and colleagues in the EPPIC service moved onto the former Royal Park Hospital campus at Parkville. His academic colleague at OYH Professor Alison Yung was recruited into the EPPIC service with a key interest in making sense of the individual’s decline into ill-health during the pre-psychotic stage or “prodrome”. A couple of years later in 1994 the Inpatient Unit relocated onto the Parkville site alongside the EPPIC (Early Psychosis Prevention & Intervention Centre). In 1996 I learned that EPPIC was re-badged as one component within a developing “Youth Mental Health” service.

Pat told me of the massive injection though funding from a leading pharmaceutical company that enabled a particularly significant PACE (Personal Assessment and Crisis Evaluation) research study to be undertaken — that study looked at the effects of utilising CBT (Cognitive Behavioural Therapy) and / or antipsychotic medication to treat “at high risk” individuals to prevent the onset of a full episode of psychosis. While PACE had survived on Research grant money for some considerable time, it was a relief when permanent State funding was committed.

Prof McGorry spoke earnestly about his ongoing commitment to broaden the services available to youth – he has been central in the drive to establish the Headspace provision across Australia and complementing this Orygen Youth Health has expanded both its age range (formerly 18 – 24) to cover youth aged 15 to 24 inclusive and its reach to include mental health problems and disorders other than “psychosis” with the establishment of the HYPE team (for emergent Borderline Personality Disorder) and the Mood and Anxiety team. While Pat McGorry is very pleased about this expansion of service delivery under the Orygen “umbrella” he recognises gaps remain in the service delivery ie no dedicated service within OYH for Drug and Alcohol misuse, nor any specialist service for young people with Eating disorders. I asked whether he had any concern that this expansion might dilute the service delivery within EPPIC, ie services to young people with psychosis, the “brand name” by which OYH services are known world-wide. He acknowledged he was aware that the two EPPIC teams are under great pressure with case managers holding caseloads that are unacceptably large – there is a plan to relieve this.

When I enquired which key research areas he’d most like to see addressed soon by OYH – Research he quickly threw out a list, almost not pausing for breath, of 5 key themes, listed here......

- Using the “staging” approach to develop more “targetted” interventions linked to the stage of the psychotic disorder
- Developing a method for identifying those youth “at risk” of developing a Bipolar Disorder
- Enabling further expansion of the “youth-friendly” services available across OYH by filling in the “gaps”, and ascertaining how services deliver more effective care
- Finding evidence for “Neuroprotective” agents in the management of Psychotic Disorders.
- Effecting the earlier identification of clients likely to be “Incomplete Recovery” cases and testing out earlier use of Clozapine medication.
The speed by which Pat provided these key ideas reveals self-evidently how thoroughly immersed and expertly so, he is with the research agenda and the big clinical questions that still require answered. Following my request, he was more than happy to ask his secretary to come in and photograph us together.

10.2 PROF ALISON YUNG

I met with Prof Alison Young on Wed 4 May. Alison Yung is a Consultant Psychiatrist who is an internationally recognised expert in the field of psychosis and particularly, of people at risk of psychosis and of then developing the illness through “transition” ie from being “At Risk” (of Psychosis) to actually developing a Psychosis Episode. I learned from our time together that she has two sons aged 11 and 12. She is also known for having developed an assessment tool called the CAARMS (Comprehensive Assessment of At-Risk Mental States) that the EPSS team in Edinburgh use routinely.

On request, Alison told me what brought her into the Mental Health field as a young doctor. She recalls and described vividly the impact upon her of assessing a woman with major mental health problems who had set fire to herself, by setting alight oil she had poured over herself. Through the serious burns inflicted that woman required the amputation of an arm. Alison found herself attracted to learn more about how a person’s life could be ravaged by mental illness. Early on in her psychiatry training she recalls sounding rather dissimilar when in a group of young psychiatric trainees describing their future career ambitions she confidently (and uniquely) indicated she “wanted to do schizophrenia research”.

She remembered too being very interested in reading some of (then) Dr Pat McGorry’s early published articles as his developing academic interests paralleled hers. Soon thereafter as a young psychiatrist she undertook research for her Masters degree, collecting qualitative data from 21 patients who had experienced their first episode of psychosis. She than worked in 2 Melbourne Inpatient Units named after world-famous Australian Psychiatrists – the Aubrey Lewis Unit and the John Cade Unit.

Prof Alison Yung, me and the Poster

It was in the Aubrey Lewis Unit that Alison had the very positive and rewarding experience of working with Dr Pat McGorry, inspiring her to join him later in the field of Early Psychosis. She worked then with Pat on the Early Psychosis Assessment Team. Soon thereafter she told me she moved to the Centre for Adolescent Health located in the Royal Melbourne Children’s Hospital. While there she began researching the High Risk groups in Early Psychosis and in due course developed the first draft version of the CAARMS tool.

She and her PACE research team produced impressive research on the back of establishing a highly innovative “drop-in” centre in the shopping mall in a Melbourne suburb. She was the driving force in two major RCTs (Randomised Clinical Trials) in Early Psychosis and it was on the basis of her research teams well-received service delivery in the community and the high quality research publications, that Pat McGorry was able to convince the Victoria State Health managers to commit permanent funding into PACE to enable it to become one of the various specialist mental health service streams within OYH.

Through this permanent funding the PACE service returned to the Parkville campus to be alongside the other clinical specialist teams and 25m only away from the large OYH – Research facility. Alison’s current post is located within OYH Research although she has one clinical session a week attached to the PACE team. She was quite taken by my bringing to her attention that she and her publications were cited more than any
other researcher in the reference list of a major overview paper written by New York based academics in Barbara Cornblatt’s (Professor of Psychiatry at Albert Einstein School of Medicine) team – it seems Alison is not very familiar with the journal that paper was in (Journal of Child Psychology & Psychiatry) and asked to have a photocopy of it.

In the week we met for this interview she was very aware and concerned about a possible funding crisis for medical research in Australia. As the photo shows she wanted the poster to be readily displayed, an indication of her strength of feeling about this issue! I had some years before seen Alison present a paper with OYH colleagues at an International Early Psychosis Association Conference in Birmingham, UK – this opportunity to meet her in person confirmed only too readily that she is a world leading and most personable leader in the Early Psychosis field.

10.3 MEETING WITH RAY ANASTASI

Ray Anastasi is one of two Family Peer Support Workers, the other being Sue Rinaldi. As the OYH “Information & support for families” flyer reads

“Family Peer Support Workers are a trained part of the OYH team supporting families and friends.” It also notes “Our Family Peer Support Workers have a family member with mental health issues. They understand how stressful it can be for families”

Ray (a former Accountant) was free when I knocked on his door (morning of Tuesday 19 April) and I spent the next hour being thoroughly impressed by the passion and commitment he brings to his work as he told me of the support he and Sue provide to families in need.

Ray’s son graduated with an Honours Engineering degree and landed an excellent position soon thereafter. Within a year he had become unwell with a psychotic disorder and Ray and his wife, Luisa, began their difficult journey as parents and carers of a son with what in due course was identified as Schizophrenia. Ray’s experience as a lost and confused parent, unable to simply “fix it” for his son has over the past decade been transformed into one half of the Family Peer Support Workers team.

Having been through the torment other parents face has enabled Ray with his abundant concern and empathy to support parents when they most need that. After a new client has been registered within the EPPIC service, Ray and Sue receive notification from the EPPIC Case Manager of the client’s name and the contact telephone number of the main carer. Most of the time, Ray noted, it is a mother who receives Ray’s “cold call” – having previously often having had to seek help from emergency medical services amidst a crisis, Ray or Sue’s phone call is experienced as a welcome opportunity to talk with an understanding other parent (and both Ray and Sue have undergone training from experienced OYH staff to skill them up for their current roles). Ray informed me his chief task is to get the parent on the phone to talk not about their son or daughter but about how they, as the parent, are coping.

Following that first telephone contact, different parents respond in different ways – for some that first valuable contact appears to have helped considerably, with the parent often being supported by Ray or Sue’s feedback to ensure they pass on their account at outpatient reviews as to their son or daughter’s functioning in detail and to raise whatever concerns they might have. They might then hardly need to phone Ray or Sue again. Other parents follow up that phone conversation with dropping in to Parkville and having face to face contact with Ray and Sue. Others benefit from continuing telephone contacts over time.

So, in summary, as Ray indicated their role is to provide specialist family peer support to both parents and friends. In addition to their work, on two occasions each year over 3 consecutive
Tuesday evenings (next scheduled round due to occur on 3, 10 and 17 May) there are Psycho-education “Information Sessions” that occur from 6pm onwards for 1½ hours. These sessions are facilitated by two EPPIC staff and either Sue or Ray is involved in Session 3, as listed here…..

Session 1: What is Psychosis?
Session 2: Medication and other treatments (facilitated by a Doctor)
Session 3: Recovery (facilitated by Family Peer Support worker)

### 10.4 MEETING GINA CHINNERY & KELLY ALLOTT

My former work colleague Craig Macneil, Clinical Psychologist strongly recommended that I meet up with Gina. That was such valuable advice. Gina Chinnery is a Youth Employment Consultant, employed by OYH and she has been in her current post for 5 years now. She invited along Kelly Allott to join our meeting as they are both involved in the Psychosocial Recovery research program in OYH.

Gina worked in the public sector and had particular experience in advising disabled clients (mostly with physical health disability) on employment opportunities. Here within OYH Gina can be called upon to assist clients to prepare for future work…from vocational/career discussions through preparing résumés (CVs) to developing interview skills. She can also support clients going to look at prospective employment. Her input doesn’t stop there – if needed she can act as a “Job Coach” in effect liaising with the new employers to help anticipate and resolve small problems as they arise, increasing the prospect of success in the employment.

The Psychosocial Recovery research group have published their research findings (Killackey, Jackson et al., 2008) and they now plan to pursue the promising findings from that study with a more elaborate study with a longer follow-up period.

### 10.5 CONTACT WITH GINA WOODHEAD

Ray Anastasi recommended that I meet up with Gina. Gina is the Coordinator of the Orygen Group Program. Bursting over with evident commitment and enthusiasm for group work with young people she told me “How can you not have a Group program? The OCMs do great work with a cognitive approach that influences thoughts and mood, but the Group Program is necessary to translate that into action, to build confidence in everyday living” So obvious, when framed like that.

Gina outlined the Orygen Group Program for me. She pointed out that it works closely with the Travancore School unit adjacent (in the next door villa) that offers secondary education to Orygen clients on 4 days a week, Monday, Tuesday, Thursday and Friday, a 2½ hour slot each time. There are 6.8 EFT staff in the OYH Group Program, one person being the Admin support. Gina also manages the 2 OT staff in the Inpatient ward at Footscray. Including these 4 Educational sessions, the Group Program offers a total of 14 separate activities Monday through Friday - examples of these are the Horticulture Group 1.00 – 3.00pm on Thursdays, and the Music Jam event on a Tuesday from 10.30 till 12.30.

Gina described a specific activity that she feels especially pleased with – the Catering event that occurs every Wednesday from 9.30 onwards. This involves the Program’s staff involving a selected group of clients in running the Orygen Café from 9.30am onwards and as such in the preparation of mid-morning coffees and drinks, and the lunches for staff and dispensing the food and drinks over the counter at lunch time. This activity is undertaken in conjunction with external training staff who are able to offer the clients educational input in Food-handling and preparation, leading to an approved State-recognised qualification.

Gina also stated that the staff are mindful of the difficulties that can sometimes arise with too large a spread of ages of clients within 1 group. Given this, the Club 21 group is exclusively for clients aged 18 and over. I felt Gina was justifiably pleased with the comprehensive spread of groups on offer. She and colleague staff have over the past 6 years or so built up a
list of 30 or so specific groups that can be run, all developed in modular form with specific outcomes expected for the participants. Their Group Program seemed to me strongly embedded now within the OYH organisation.

11 MOOD & ANXIETY TEAMS (Tues 3 May – Fri 13 May)

11.1 MOOD & ANXIETY TEAM B MEETING

I joined Dr Chris Davey, Consultant Psychiatrist, Adam, the trainee psychiatrist and 5 OCMs at this meeting. It quickly became evident to me that the structure and process of the meeting was broadly similar to the other specialist teams’ once a week Team Meetings I had previously attended. There were 5 Reviews to be completed and then there was discussion of a planned Discharge.

The first Review presented was of a 17 year old female, first referred into Mood & Anxiety in early October last year. In Year 12 (last year) at school – Initially considered to be suffering from a Major Depressive Episode, now re-formulated as having Borderline Personality disorder. Recently had an IP stay in the Banksia IP Unit. Is being seen once weekly by the OCM. Is being treated with Duloxetine (an SSRI antidepressant)

There were 4 other Reviews, before the discussion of a planned Discharge. The Discharge case was of a 22 year old graduate, with a “draughting degree” who took up said employment (?) as a draughtsperson”) Found she didn’t settle in employment, and subsequently became depressed. She deteriorated in health and needed to be hospitalised. Then was diagnosed as suffering from Bipolar disorder and was treated with Lamotrigine and Quetiapine. Did well with CAT (Cognitive Analytical Psychotherapy) therapy and regained a wish to return to employment, but not in “draughting”. Has remained well in recent months and is now ready for discharge. This plan was agreed by the team.

11.2 MOOD & ANXIETY TEAM A MEETING

There were 5 team members present, Dr John Koutsogiannis, Consultant Psychiatrist and 4 OCMs, all female. The team activity was structured similarly to that of Team B earlier that day – working through set “groups” of clients ie First Reviews, later Reviews, Discharges, “Difficult” cases. Although there were a number of Reviews coming up the deadline for these were more than a week away and it was agreed to delay these Reviews by 1 week.

Wooden sculpture in grounds

The needs and treatment of an 18 year old female client were considered. She lives in difficult circumstances in an unsettled family. She misuses cannabis – this occurs within a home where her Mother also uses cannabis. She continues to be depressed but has been unable to engage in the psychological therapy on offer, through the effects of her heavy cannabis intake. The therapist has used Motivational therapy to attempt to influence the young woman’s reliance on cannabis, but the young woman presented as being “pre-contemplative” (ie not yet prepared to see her cannabis use as a problem and displaying no motivation to change whatsoever). The team supported the Case Manager’s thinking that an elective admission to hospital with the client’s agreement might be the best means of enabling her to challenge the cannabis use.
11.3 **MEETINGS WITH THE MOOD & ANXIETY TEAM CONSULTANTS**

I was able to have individual meetings with Drs John Koutsogiannis, Christopher Davey and Mark Phelan about their roles and responsibilities. In sharp contrast to the UK where male Consultant Psychiatrists mostly hold full-time posts, all three of these individuals hold part-time positions within OYH. John has 5 clinical sessions (1 session = ½ day) with OYH, and 3 sessions are in private practice. Chris holds a University of Melbourne Academic post with 3 clinical sessions. Differently again Mark has 3 sessions in Mood & Anxiety, 2 sessions at the West Melbourne Headspace and the remaining sessions are committed to his MD research. John is the most senior of the three having been a Consultant Psychiatrist since 2002, while both Chris and Mark were appointed to their senior posts in 2008.

John has been in his senior post for approximately 9 years. He served as the sole Consultant in the initial, sole Mood & Anxiety team, the team only recently splitting into two separate teams, Team A and Team B in advance of the planned relocation of the Orygen “B” teams into the suburb of Sunshine. While clearly very committed to the clinical service delivery he expressed some concerns about the shortfall of clinical staff to service demands across several clinical teams.

11.4 **SITTING IN ON CLINICAL CONTACTS**

I had a number of opportunities to sit in on clinical contacts with various members of the Mood & Anxiety teams. The approach taken by the OCMs was in line with my expectations. Using a CBT approach the therapist would firstly review how the young person/young adult had been keeping since the last contact, before resuming the CBT treatment plan that would have been developed in collaboration with the client some sessions back. It was gratifying for me to see that the style and content of therapy delivered was very similar to that provided in my local CAMHS service back home in Edinburgh.

11.5 **MEETING WITH MELISSA THURLAY**

A number of OYH staff had recommended I should meet up with Melissa, who prefers to be known at OYH as Mel. Mel Thurley is the Youth Participation Coordinator who heads up the **Platform** team & the **Peer Support** programme at OYH. The Platform team open to all past and current OYH clients aims by constructive feedback to improves services at OYH. The Peer Support Workers (PSWs) are available to support clients who are in contact with OYH clinical teams. Mel told me of the training program whereby recruited PSWs are inducted into their roles. Experienced PSWs help deliver the training. These PSWs are all individuals who themselves have experienced significant mental health problems in their past. The PSWs are supported by protocols that guide their work – for example they are expected to desist in talking with clients about the clients substance misuse. They are also told to ensure they look after their own mental health first and foremost and not to attempt to help clients if not well themselves.

The PSWs work 2 hour stints and are employed on a sessional basis being paid an hourly rate. There are 3 nominated Senior clinicians across OYH who are available to provide supervision support to each Peer Support Worker. The **Drop-In meeting** event occurs twice each week at Parkville and a number of PSWs are always available to offer company, chat and time “to chill” to OYH clients. In addition to those contacts the Peer Support Workers visit the InPatient Unit at the Western Hospital to offer support to youth being treated as inpatients.

Mel Thurley came into this post from a diverse background with worked experience in Juvenile Justice, in Youth Work, Youth Mental Illness services and Community Development. She clearly displayed enthusiasm for the Youth Participation Programmes and spoke with considerable personal satisfaction about the clients within the Platform group assisting Prof Pat McGorry on several occasions during the previous year, in 2010 when he was Australian of the Year, at events to publicise the need and benefits of Youth Mental Health provision. She also told me about Platform seeding the development of the **Speak Out** group that enables clients anonymously to make complaints, comments and suggestions about any aspect of the OYH experience.
12 REFLECTIONS ON THE MOOD & ANXIETY TEAMS

12.1 KEEN & COMMITTED PROFESSIONALS

I was impressed by the clear enthusiasm and commitment shown by these workers within the Mood & Anxiety teams. There can always be a tendency where a clinician is working with broadly the same clinical problems day in day out, to become tired, and staid in one’s practice. There was no evidence whatsoever of this.

12.2 A ROBUST CLINICAL PRODUCT

Youth with mood and anxiety problems may well be experiencing the beginnings of what could well be recurrent life-long mental health disorders. The work that is undertaken with young people in the Mood & Anxiety teams does not only address the current symptomatic difficulties but includes cognitive & behavioural strategies to mitigate against the impact of future relapses.

12.3 A VISION FOR THE FUTURE

The two Mood & Anxiety teams are both anticipating a move off the Parkville campus to suburbs of Greater Melbourne to be relocated on a campus shared with the local Headspace provision. The move of Mood & Anxiety team B to Sunshine, and adjacent to the nwM Headspace facility will be both good for young people in need but also to improve the working relationship between Orygen Youth Health and Headspace.

13 CONCLUDING THOUGHTS

13.1 BRIEF SUMMARY OVERVIEW

Orygen Youth Health is a pioneering youth mental health service that is leading a highly specialised mental health provision to young Australians with significant mental health problems. While principally the brainchild of Patrick McGorry, his enthusiasm for improving the lot of young Australians affected by mental health problems, and his tireless energy to achieve solutions often in highly creative ways, has led to a considerable number of like-minded individuals to join him initially with the EPPIC developments, the early vanguard of the more extensive, later developed OYH empire. Orygen Youth Health has so vastly expanded its research arm, OYH-Research, that it is now the largest youth mental health research campus in Australia.

From its early days with the development of the EPPIC service – Early Psychosis Prevention and Intervention Centre, its evident success in delivering a flexible “youth-friendly” service to youth aged 15 through until 24 years old, has led to the sponsorship of firstly the PACE clinic (Personal Assessment and Comprehensive Evaluation) that began as a wholly research-funded venture, and over time to the PACE team becoming an established element in OYH-Clinical Program, and to the establishment of additional component clinical teams, namely the OYH Inpatient Unit, the YAT (Youth Access Team) team, the HYPE team and the Mood and Anxiety teams.

Orygen Youth Health has grown from strength to strength and its pioneering approach to delivering high-quality “cutting-edge” care has not only led to world-wide recognition but has attracted leading academics and researchers to join its research arm - OYH-Research – and these researchers working in tandem with their clinical colleagues are producing some of the best new research papers in the field of Early Psychosis in youth. Orygen Youth Health utilises the phrase “opening minds to a brighter future” in its literature about its services.
13.2 UNEXPECTEDLY QUICK LEARNING POINTS

I believed I knew a lot about EPPIC and the Melbourne services from my reading over the last decade or so. I had also had the opportunity of hearing Patrick McGorry present aspects of his work at a Day Conference in Glasgow in the late 1990s and in 2006 I heard him and Alison Yung when they both presented papers at the 5th IEPA (International Early Psychosis Association) conference held in Birmingham, UK that year.

Of course, as an experienced clinician, having visited many services around the UK I was only too well aware that what one gains from reading about a service can be very different from what one can observe if actually there. And so it was for me at OYH.

Two early examples spring to mind – “early” as both these misunderstandings on my part became abundantly clear within my first day at OYH – Firstly, I had somehow formed the impression, partly related to knowledge of Craig Macneil’s recent book, *Bipolar Disorder in Young People* (Cambridge University Press, 2009) that there was an Early-onset Bipolar Disorder team at OYH. There is no such specific service so the 3rd aim of my visit, namely

- Thirdly, to be attached to the Early-onset Bipolar Disorder team and learn about that approach became meaningless. Simon Dodd and Iain Macmillan compiled a broad-based placement timetable for me that provided me many excellent opportunities to learn about 5 specialist teams

Secondly I had been very intrigued by knowing that the OYH Inpatient Unit catered for young people aged 15 through till 24 years old. Through working in Edinburgh in an Adolescent Unit catering for 12-17 year olds inclusive, I was impressed with the idea that the OYH IPU could find a way of working with a range of ages that entailed developmentally very different young people comparing a 15 year old school pupil with say, a drug using, offending 23 year old with psychosis. I didn’t even have to speak to anyone to gain clarity about that issue – while waiting in the reception area in Building B at Parkville the perspex Information boards revealed that younger Orygen clients requiring admission might be preferentially admitted to the Banksia Adolescent Unit that is “next door” to the Orygen IPU!

So, two significant learning points “ticked off” within the first day of my placement.

13.3 MORE SPECIFIC GAINS & BENEFITS FROM MY PLACEMENT

13.31 EPSS DOES THIS JUST AS WELL! – THE WORK OF EPPIC

The team I work in back home provides a service to young people who have already developed the features of an Early Psychosis. Our service delivery most closely corresponds to what the two EPPIC teams do in Melbourne. It was very gratifying for me to note that the actual care provided in Melbourne was little different than what my team colleagues provide in our service in Edinburgh. I knew that my colleagues back home would be delighted to learn this. In addition we also offer a small volume of work with “At High Risk” adolescents, utilising an assessment and therapy approach that closely matches what is available in the PACE teams at OYH.

13.32 THE EXTREMELY PRODUCTIVE INPATIENT UNIT

From taking up my Consultant post I have worked on three separate occasions with responsibilities for IP (inpatient) care. At no time have I worked in a Unit with such a rapid turnover and short length of stays as the Orygen IPU. With 16 beds, and an occupancy rate running between 95% and 100% full, it was turning over more than 400 admissions per annum. Within acute mental health care rapid IP throughput could lead to clinical errors, mismanagement, insufficient treatment and premature discharge. Using my considerable experience as a Consultant Psychiatrist in the NHS (over 25 years Consultant experience) I could detect no evidence of poor care, rather of a clear focus on symptom reduction, mental health stabilisation, reduction of suicide risk and then discharge to intensive follow up care.
Visit to Orygen Youth Health (OYH)

The only issue that disconcerted me related to the use of seclusion of patients into the Intensive High Dependency Unit – this was a concern that was already being addressed by the senior clinical staff, with the development of a Minimal Seclusion Policy that was being implemented after I left. I obviously could track “on the ground” what did happen to younger adolescents who needed admission to IP care while I was within the Orygen unit for 2 weeks. There were several such young people admitted to the Banksia Unit, whilst the youngest individual in the Orygen IPU on Tues 8 March was a 16 year old, while one week later on 15 March the youngest was aged 17 (the mean age for the 16 inpatients that day was 21.9 years)

Having the opportunity to witness how such a ward could operate was an important learning opportunity for me, enabling me to contribute to future discussions within NHS Lothian as it considers how to develop an Early Intervention in Psychosis service that builds on the EPSS team already in operation.

13.33 YAT – ENSURING SAFE INTENSIVE DELIVERY TO THE SPECIALIST TEAMS

I was very impressed by the YAT team. It works at the sharp end of service delivery with new cases or cases just discharged from IP care and has the task of supporting the young person/young adult in the community, while assessing which of 4 specialist teams – PACE, EPPIC, HYPE or Mood & Anxiety the client should be matched up to for their continuing care. I had never seen a team utilise an active EXCEL web page containing summarised client data by projecting it onto an office wall, as the means of offering a daily review. This ensured no important clinical management data was “lost” and enabled staff coming on shift that day to view that day’s case review at the daily 1.30pm meeting. The team seemed a cohesive closely working group that provided abundant support to high risk clients. They also utilise well a broad range of screening mental health tools to assess comprehensively for a range of disorders. While hard working this team enjoyed their humour and while workmanlike their communal office nevertheless seemed a fun place to work.

YAT personnel very effectively identify which team to hand the client onto – from my perspective, thinking of “the patient’s journey” and influential perspective for health care evaluation in the NHS, I was left a little concerned that the client could well have encountered 3-5 or so YAT team members before being introduce to the pair of specialist team workers, the Psychiatrist and the OCM (Outpatient Case Manager). Our team in Edinburgh would identify the 2 or 3 team members to become involved at the outset of the EPSS journey with those 2 or 3 staff remaining involved from beginning to end of treatment contact. In comparison it did seem our EPSS team provides fewer workers for the client to engage with.

13.34 PACE – EXCELLENT INPUT TO “AT HIGH RISK” CLIENTS

This team provides input to youth considered “at high risk” ie likely to develop an episode of “full blown” psychosis within the next couple of years. Two workers, one a psychiatrist and the other, a case manager utilise a therapy approach to help the young person gain an insight into the meaning of their intermittent psychotic symptoms and more importantly develop their own means of problem-solving emotional disturbance and postpone or possibly even prevent that anticipated first episode ever in fact happening.

It is clear within PACE through ongoing research findings that the “transition rate” into psychosis has in fact been falling, through these treatment inputs – as yet it is not clear what is differentiating exactly why the approach works for some but not others, but ongoing research is addressing this question. Witnessing this work in Melbourne has convinced me of its merits and strengthened my enthusiasm in maintaining this service within our EPSS provision back in Edinburgh.

13.35 FAMILY PEER SUPPORT

Meeting Ray Anastasi, Family Peer Support Worker confirmed for me a lesson I’d learned many years ago – of the merits in supporting the family members where a son or daughter suffers from psychosis. The Family Peer Support activity at Orygen is a real gem – two
parents with their own past “lived experience” offer in a relative unobtrusive manner support initially by phone to parents struggling to come to terms with the psychotic episode. I would strongly advocate any EI (Early Intervention) service to consider developing Family Peer Support if they are not already actively supporting families.

In fact in Edinburgh we decided several years ago that we would routinely offer BFT (Behavioural Family Therapy) to all families engaged with our service and this enables the parents an opportunity to share their upset relating to the impact of the psychosis on themselves and the family, and more importantly to attempt to develop as a family through BFT better family-based problem-solving strategies. Were we not to have that already available I would be advocating to local colleagues the merits of establishing Family Peer Support.

13.36 THE ALL-ENCOMPASSING ORYGEN GROUP PROGRAM

I would challenge anyone to attempt to spend 45 minutes in Gina Woodhead’s company and come away unconvinced about the merits of Group Therapies for youth. Being convinced of the benefits of such approaches and working in a service in EPSS with a small but permanent group activity program, I found myself enthused further by Gina’s infectious energy. At OYH they have the most extensive Group Therapy program I have ever encountered and each element (one group activity) within their broadly based program that runs morning and afternoon 5 days a week, has been improved over time and reproduced in “modular” form so that each one individual group can be “taken down off the shelf” and used to suit a group of youth likely to benefit from that specific group module.

13.37 A YOUTH EMPLOYMENT CONSULTANT IN THE TEAM

Finding Gina Chinnery, in her specific role as a core team member of OYH –Clinical staff was quite an unexpected surprise. Her influence upon the continuing recovery of young people with psychosis can be life-transforming. After significant illness be it physical or mental-health related, it can be extremely difficult to return to former employment – getting into employment for the first time can be close to impossible. Gina’s past experience has enabled her to join OYH and offer clients the best prospect of matching their potential with employment opportunities and even better remaining actively involved to support the new worker and the new employers of that one individual.

Within our own service in Edinburgh, our experienced Senior Occupational Therapist attempted to undertake this work and achieved considerable results, but was aware of her own limited knowledge of resources available to support the disabled get back into employment or enter work for the first time. Someone like Gina who comes from a background in public sector employment advice (such as the UK “Job Centres”) is ideally suited to bring such skills into the mental health sector. Were our service within Edinburgh to expand as anticipated to serve the 15 –24 years old then there would in my view be scope to explore he merits of developing such a post within the expanded service.

13.38 THE PLATFORM TEAM

Peer Support Workers are a relatively new development in mental health services in the UK. Orygen Youth Health have developed an impressive Peer Support Worker presence, managed by Mel Thurley. Speaking to Mel left me in no doubt as to the benefits of such a provision. In feasibility terms I was left feeling our service within EPSS at present is too small to sustain such a specialist provision. Were our provision to be expanded, we would do well to review the merits of having a Peer Support Worker presence.

13.4 OYH-RESEARCH CENTRE

The facts speak for themselves. Taken from the OYH Website..........
**Visit to Orygen Youth Health (OYH)**

**OYH-RC is now regarded as Australia’s largest youth mental health research institute and it has 130 Academic staff, including 6 full Professors and 5 Associate Professors**

Actually those figures above may be a little outdated – Simon Dodd told me (in early March 2011) there were 157 research staff working at Orygen Youth Health – Research Centre. It has mushroomed through its own success and now attracts staff from all over the world with a research activity base that goes beyond First Episode Psychosis – for example, Professor Tony Jorm has been very active in developing awareness and approaches in the area of Mental Health First Aid; Professor Nick Allen has been researching adolescent-onset depression and linking it up with studies of brain changes following illness-onset.

Over the years the clinicians and researchers at OYH have collaborated in creating an ongoing research database that now contains the world’s largest single site cohort of First Episode Psychosis. This is a rich, ever enlarging research database that offers limitless opportunities to research staff to explore a number of important questions regarding First Episode Psychosis. Across OYH-Clinical Program there is a widespread commitment to supporting the research colleagues in their work. Aware of the large number of scientific publications that come out of OYH, I know that there is often a large number of authors cited on each paper, usually a mix of academics and clinical staff. Receiving credit in this way is an important and influential incentive to clinical staff to feel invested in the OYH research activity.

Orygen Youth Health and leaders in the Early Onset Psychosis research there, principally Patrick McGorry and Alison Yung are now recognised as being world leading researchers in this field. Indeed in Spring 2010, at the Early Psychosis 7th International Conference on Early Psychosis, Alison Yung was awarded the prestigious Richard J Wyatt award “in recognition of her contribution to Early Psychosis” Orygen Youth Health – Research Centre is likely to continue to be in the forefront of Early Psychosis research for many years to come.

**14 ACTIONS SINCE RETURN**

- **Creating a short press release for WCMT**
  With helpful input from Sue Matthews, Press Officer at WCMT, I produced a short summary about my placement in Melbourne for publication in the press.

- **Circulating the press release to specific Scottish papers**
  Disappointingly, to date, no regional Scottish daily has picked up on my story.

- **Contacting the local NHS Lothian staff paper to run my story**
  I have been in communication with the Editorial team of Connections, the staff paper for all NHS Lothian Healthcare staff, that is published every two months. I have just had confirmation (Sat 13 August) that my story will make the next edition.

- **Gave a lunchtime talk to EPSS colleagues**
  I have spoken about my placement at OYH to my team colleagues in EPSS. They were very pleased to learn of my impression that the care we provide compares very favourably with EPPIC at OYH.

- **Meeting with Mr Tim Montgomery COO of REAS to share my findings and discuss possible future development of a Lothian EI team**
  Mr Tim Montgomery is the Chief Operating Officer at REAS (Royal Edinburgh Hospital & Associated Services), the mental health management unit within NHS Lothian. We spoke about my visit, the key findings and my hopes that REAS will in the fullness of time commit to the development of an Early Intervention (for First Episode Psychosis) Team.
15 FUTURE PLANS

- Continuing commitment to the future development of a Lothian Early Intervention team.
  I remain strongly committed to this and consider alongside my own experience within EPSS over 8 years, that I will be able to profitably draw upon my first-hand observations of services within OYH, to influence the development of an Lothian Early Intervention team.

- My intention to speak about my visit to the Scottish Faculty of Child & Adolescent Psychiatrists at their Academic Annual Meeting in November 2011.
  I intend to speak at this event that generally attracts about 50 attendees and share my observations and thoughts about the OYH services.

- Producing a short article about OYH in Melbourne.
  I plan to prepare such an article by summarising my visit for the journal The Psychiatrist, an official publication of the Royal College of Psychiatrists. I think many psychiatrists in the UK would be interested to learn more about these youth-friendly services. To ensure accuracy I plan to ask Patrick McGorry to scan the draft before submission.

16 ADDITIONAL READING

- www.oyh.org.au the web site for Orygen Youth Health is an obvious place to start to obtain more information about the Orygen provision.

- To learn more about the Headspace organisation that Patrick McGorry helped establish, you could start with the Western Melbourne Headspace web site. http://www.headspace.org.au/headspace-centres/headspace-western-melbourne

- http://en.wikipedia.org/wiki/Omega-3_fatty_acid this is the Wikipedia link for an article relating to the neuroprotective effect of these fatty acids

For very interested readers I am including three scientific publications - the first a Commentary by Patrick McGorry and others that clearly describes the research focus at OYH, and two papers relating to aspects of that research activity.


POSTSCRIPT

I was able to go to Orygen Youth Health through my employers in NHS granting me a Sabbatical Leave period. The support from the Winston Churchill Memorial Trust greatly facilitated my placement. Without this opportunity to get to Melbourne I would never have had any of the following wonderful / inspiring / moving moments (and many others that don't get a mention here………….)
Visit to Orygen Youth Health (OYH)

- The opportunity to reside in Academic Fellows accommodation in University College, Melbourne and more importantly the chance to experience Univ of Melbourne College campus life, in all its facets – including the opportunity to present one evening a “Fireside Chat” to postgraduate tutors and undergraduates.

- Speaking at the Hopper’s Crossing Rotary Club (invitation courtesy of my brother-in-law) I spoke about mental health and young people but incorporated an acknowledgement of support to WCMT and some commentary about Winston Churchill’s amazing life.

- Taking part in a Dawn Memorial Service on Anzac Day in the small town of Stawall in the Grampians region of Victoria state. This was a very moving event, the memory of which will abide with me for a very long time.

- Riding on Melbourne’s extensive tram network (mostly the no 19) Such fun getting here and there on trams of varying ages – of course this struck a discordant note for me….as a citizen and taxpayer of Edinburgh our proposed tram network still only comprises one 11 mile stretch of tramlines, and nothing else !!

- Staying in the Seppelt Winery Lodge at Seppelt Winery, Great Western Staying in this rented accommodation over the Easter weekend 2011 provided so many lovely memories, one being watching the many large cockatoos roosting in the front garden trees ; and another – hearing of the,apparently true, account of Dame Nellie Melba having a bath in Seppelt champagne!

- Witnessing the star studded Southern Sky Words cannot do justice to the spectacle of looking upwards from upstate Victoria onto a sky with no illuminated light from street lighting whatsoever and gazing upon a Milky Way - It was awesome and I was dumbstruck, unable to describe how stunning a display it was……

ACKNOWLEDGEMENTS

There are a number of individuals I need to thank for their support before and during my Winston Churchill Fellowship :-

Dr Duncan Manders and Dr Matthias Schwannaueur for their references in support of my application to the WCMT.

Tim Montgomery and Dr Peter leFevre for permitting me a period of Sabbatical Leave from my NHS post.

To Simon Dodd, Leonie Slavin and Dr Iain Macmillan who all supported me during my placement at OYH resolving various problems and offering helpful support all the while.

To all the staff at Orygen Youth Health who gave of their time and allowed me to sit in as unobtrusively as I could to get the feel of their service delivery.

To Dr Jennifer McDonald, George-Ann Sullivan, Marie McKee and Lisa Margerison for their kind hospitality during our stay at University College, Melbourne.

…..and most importantly, my wife Sheila whose presence in Melbourne during my placement turned a wonderful opportunity into such a memorable, never-to-be-forgotten, joint experience
• **ORYGEN Youth Health** covers the Inner West, Mid West, North West and South West areas.

• The **Adult Area Mental Health Services** (AMHS) of NWMH are Inner West, Mid West, North West and Northern.

• **Aged Persons’ Mental Health Program** covers all five areas of the map (only parts of South West).

**PS**  *I am interested in any comments readers might wish to e-mail to me. My e-mail address is robertmccabe@talktalk.net*