Mental Health’s
‘Stitch in Time’

My Visit to Orygen Youth Health
World Leaders in Early Intervention in Psychosis

Melbourne Australia

October – November 2012

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Churchill Fellow 2012
We are the Pilgrims, Master;

We shall go
always a little further:

It may be
beyond the last blue mountain barred with snow,
across that angry or that glimmering sea.

*The Golden Road to Samarkand*

*James Elroy Flecker*
Acknowledgements

I would like to thank The Winston Churchill Memorial Trust for giving me this fantastic opportunity to pursue something close to my heart.

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To Gina and Simon and everyone at OYH who made my 6 weeks very special, thank you.

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I would also like to thank my ex colleague Amy Evans for her support.

None of this of course would have been possible had it not been for those who went before and made the ultimate sacrifice to ensure that the likes of I could live my dreams in freedom.

Apologies

Although striving to be as accurate as possible in my report on my Fellowship with OYH, I appreciate that I might have some things wrong. In the event of this being the case, I would like to offer my apologies to any one at OYH who I might have inadvertently misquoted, or conveyed information about OYH which might be inaccurate.
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Introduction

My Background

For the past 18 years I have worked as an Occupational Therapist (OT) in Mental Health, in many different clinical settings, with the past 14 being in Inverness. For the last 4 years I have also worked as a Cognitive Behavioural Therapist (CBT). Although my main remit is to provide an Occupational Therapy Service to people with Mental Health Rehabilitation needs, I also have a small CBT case load and a small Military Veteran case load. More recently, I have also widened my remit to screening the acute wards for young people who might be experiencing their First Episode of Psychosis.

Background to Application to WCMT

In the main, my work over the past 14 years in the Highlands has been with young people, mainly young men under the age of 30 with a diagnosis of Schizophrenia. Over the past 8 years, through my own professional development reading, I first became aware of the benefits of Early Intervention in Psychosis. The champions of this concept are Orygen Youth Health (OYH) in Melbourne, Australia, of which the Early Psychosis Prevention and Intervention Centre (EPPIC) are an integral component.

For the past 2 years I have been screening the acute wards at New Craig's Hospital for any young person who might be experiencing their First Episode of Psychosis (FEP) and those who might still be within that window of opportunity to intervene optimally. The effective intervention period is up to 2 years from the onset of the first psychotic symptoms but can also be effective up to 5 years after onset of symptoms (Lloyd et al 2000; Birchwood et al 1998). A wealth of evidence suggests that if biological and psychological and social interventions, commonly known as biopsychosocial interventions, are co-ordinated and applied in a focussed and timely manner, then the outcomes or prognosis for that young person is greatly enhanced than if it were Treatment As Usual (TAU). However, not only are there benefits for the young person, but also their family. In addition to these benefits, there are others. For example, Schizophrenia is recognised as one of the main costs to a mental health system in bed usage (Simpson 2011) and society as a whole from indirect costs through benefits paid and lost productivity (The Institute of Scotland 2012; Killackey 2008). Timely interventions can also dramatically reduce these costs making it a viable and feasible concept to adopt by Mental Health Services (Killackey 2010).

My main focus of intervention for young people in their FEP is on psychosocial interventions. However, due to my other remit responsibilities this means that I can only work with a very small case load. The result of this is that there might be a considerable amount of young people who are not receiving focussed and sustained psychosocial interventions specifically for FEP and those who are within the window for effective interventions.
With this in mind I have attempted to raise awareness of the importance of early intervention in psychosis with my colleagues in the hope that they may help identify those in FEP and perhaps also become interested in providing FEP interventions. I have also discussed this concept with the Highland User Group (HUG) to increase their knowledge of best practice in Early Intervention in Psychosis (EIP). HUG is a very proactive Mental Health User Group who could help highlight the need for EIP. I have also taken my message to Development Groups within NHS Highland in the hope that an Early Intervention Strategy (EIS) or Policy could be ratified and incorporated into our services. To date this has not happened despite recommendations from the Scottish Government that we should have Early Intervention in Psychosis teams.

It was against this back ground that I decided to not only enhance my own skills and knowledge in the field of EIP, but also to raise awareness further to a wider audience of the importance of EIP.

**WCMT Application**

I initially heard of the Winston Churchill Memorial Trust many years ago from an OT colleague. However, it was another OT, who upon hearing about my special interest in EIP, suggested that I might want to consider applying for a Churchill Fellowship, and that is exactly what I did. I applied to spend 6 weeks with Orygen Youth Health, the world leaders in early intervention in psychosis.

**EPPIC and Orygen Youth Health (OYH)**

The Early Intervention in Psychosis Prevention and Intervention Centre (EPPIC), the forerunner to OYH, was initially the brainchild of Professor Patrick McGorry, who over the past 20 years has postulated that early intervention in Psychosis could (similarly to early intervention in other illnesses) prevent the illness progress. EPPIC has been the template for Early Intervention in Psychosis services throughout the world and is seen as a centre of excellence in the field of psychosis. EPPIC is now an integral component of Orygen Youth Health which is the name for the overall youth service.

**My Aims**

- To obtain first-hand experience of the benefits of an EIP team through experiential learning as opposed to theoretical evidence, which can be obtained from literature.

- To spend time with as many Therapists in various clinical settings and teams as possible as an observer, with a view to how I can optimise my own interventions on my return to Scotland.

- To share my findings with colleagues, students, service users and the general public.
• To use the skills and knowledge acquired by visiting OYH to promote greater overall awareness of the need for Early Intervention in Psychosis (EIP) in the Highlands.

• To help make a difference to young people and their families in the Highlands by working towards providing a service for young people in their First Episode of Psychosis (FEP).
My Fellowship Begins

A meeting with Simon Dodd and an Introduction to Orygen Youth Health

On my first morning I met with Simon Dodd who had just arrived back from an International Psychosis Conference in San Francisco. Simon, a nurse by profession, now manages the training and communication section of OYH. Simon informed me that Gina Woodhead, who manages the Psychosocial Group Program and is a very experienced OT, would be my mentor for the duration of my stay with OYH. First of all, Simon gave me an overview of OYH. I was immediately struck by Simon's extensive knowledge and passion about OYH in general, but also his current role. Simon informed me of the different funding bodies in Australia, the Federal Government and the State Government. The funding for OYH came from State Funding he told me. This, I understood, was ring-fenced money or money that was guaranteed. However, this was dependent upon OYH maintaining its clinical and research work. OYH is the only one of its kind in Australia, which surprised me, given its success and worldwide acclaim. As such, it is Australia’s largest Youth focussed Mental Health system. I do believe, however, that similar type models might be rolled out nationwide in the future. Simon explained to me that OYH have 332 staff, 157 belong to the research component of OYH and 175 are clinicians.

OYH specialises in providing tailored made programs for young people between the ages of 15 and 24 with mental health issues, but can continue beyond the age of 24 if they come to the service aged 24. The population of the catchment area is 900,000, of which 160,000 people fall within the age range covered by OYH. Annually, OYH receives 2000 referrals for screening and assessment and then goes on to provide a service to 750-800 of these young people. OYH provide services to a young person for 18 months but can extend this to 2 years if required. Anyone requiring on going services after their 24th birthday would be referred to Adult Services.

Main entrance at OYH’s Parkville Campus
As my main interests lay with the clinical program it is this that I will now go on and explain more in depth.

**OYH Clinical Program**
Simon furnished me with my timetable. All of the visits would be at OYH’s Parkville Campus, with the exception of the Inpatient Unit and the Youth Access Team (YAT) at Fotscray.

To help the reader better understand the structure and various clinics and care pathways within OYH, I will discuss my findings in an order that I believe reflects this, which is not necessarily in chronological order of where and with whom I spent time.

**Acute Services**

**Youth Access Team (YAT)**

I spent a pleasant but busy afternoon with YAT who are based next door to The Western Hospital in Melbourne’s Fotscray suburb. Lachlan, an OT in their team, who although very busy, went out of his way to give me a flavour of what YAT was about.

YAT is a multidisciplinary mental health team who act as gate keepers or triage to OYH and offer a 24 hour, seven day a week service. Their main remit is three fold, triage, assessment and acute care. Lachlan explained that referrals can come from any source including parents, teachers or indeed the young person themselves. Triage entails a member of the YAT discussing the referral with the referrer to assess issues such as risk, urgency of the situation and whether the young person requires a more in depth mental health assessment. Lachlan also explained that due to Melbourne having a
culturally diverse population, an interpreter might be required to assist with the process.

If a young person’s situation is deemed to be urgent, then they will receive a face to face interview and in depth assessment in order to make a clear diagnosis and treatment plan. My understanding is that if YAT determine that a young person would benefit from urgent and immediate interventions, they will work with that young person until an Outpatient Case Manager (OCM) is allocated from one of the Continuing Care Teams which the young person has been referred on too.

The referral route to the Continuing Care Teams is;

1: Young person presenting with psychotic symptoms  ➔ EPPIC
2: Young person presenting with pre-psychotic symptoms  ➔ PACE
3: Young person presenting with borderline personality disorder ➔ HYPE
4: Young person presenting with mood or anxiety symptoms ➔ Mood & Anxiety

My observations of YAT from the afternoon I spent with them were of how busy they were. They reminded me of a busy A&E department but for mental health issues. Telephones were constantly ringing and there was much coming and goings of the staff. Staff however appeared to be ‘up for’ this frenetic pace. It made me think that one would benefit from having a certain personality to work with YAT, perhaps one where a clinician was good at multitasking, had high energy levels and was able to cope with, what looked to me, quite stressful situations. I observed that the majority of the staff appeared quite young. However, Lachlan informed me that usually there was a greater age range.

I was also impressed by the handover which was achieved very professionally by projecting details of clients onto a large white smart board. In my opinion it enhanced communication as it helped to maintain a focus by utilising both visual and auditory modalities.

It comprised of the following:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Surname</th>
<th>Age</th>
<th>Referral Source</th>
<th>Reason for Referral</th>
<th>Suburb</th>
<th>Plan</th>
<th>History</th>
</tr>
</thead>
</table>

12
tommy.mcleod@nhs.net
**Inpatient Unit (IPU)**

During the second half of my day at Fotscray, I spent time in the IPU. The IPU is a 19 bedded unit, 2 of which can be used for Intensive Psychiatric Care, but currently operates with a maximum of 16 beds at any one time. The day I visited, 13 beds were in use, with 7 clients being on a Community Treatment Order (CTO) and 6 being informal. The IPU is responsible for taking referrals for young people 15-24 of age who require hospital admission to ensure their safety (10 – 13% of people with schizophrenia and 15% with Bipolar Illness complete suicide) or in very rare occasions other peoples safety. The IPU also treats young people to reduce high levels of psychological distress which otherwise cannot be managed safely in the community.

It was emphasised to me that there was great importance placed upon, what for many young people, is their first contact with OYH and mental health services. As one clinician highlighted to me, 'It is imperative to get this right, if we do get it right, then we can hope to engage the young person optimally which everyone knows is paramount when aiming for a salubrious outcome’. Considering that 65% of young people with FEP who are referred on to outpatients and continuing care teams come through the IPU, one might begin to appreciate the importance of this. The importance of this first contact with services is so important that it is embodied in the Australian Clinical Guidelines for Early Psychosis 2010 and OYH's The Acute Phase of Early Psychosis 2004. Going by the comments I heard later from young people themselves, who came through the IPU to the OYH outpatient program, it was definitely not just ‘lip service’, for without exception, the young people I spoke too believed that OYH, in the main, had achieved this.

My own impressions were, that not only was that first impression important for building a therapeutic relationship with the young person, but it was equally important for minimising further trauma which can occur after hospitalisation (Gwen et al 2010).

As has already been highlighted previously, the IPU has the capacity to offer Intensive Psychiatric Care to 2 clients at any one time using their seclusion rooms. This differs somewhat from the NHS in the UK, whereby an Intensive Psychiatric Care Unit or IPCU is separate from the main acute psychiatric wards. Some of the UK trained nurses whom I spoke to on this practice informed me that seclusion was probably the most difficult concept for them to 'get their heads around', with several of them wondering if it in fact created more trauma for the individual. Everyone I spoke to at the IPU however informed me that it was the policy to try and minimise the use of seclusion and only use it as a last resort. Other British trained nurses that I spoke to on this matter, who did not work at OYH commented that they believed UK trained nurses were often looked upon by their Australian colleagues as being better equipped at dealing with high levels of violence and aggression and wondered if this reflected an aspect of training which required to be addressed by the Australian Nursing Profession. Some Australian nurses however highlighted to me that in the UK, Acuphase medication was...
more regularly used than in Australia to subdue acutely distressed psychiatric clients, which could, they hypothesised, be even more stressful to the client than seclusion.

OYH’s evolution from purely working with young people who are psychotic, to encompassing a variety of other psychiatric conditions is clearly demonstrated in the IPU where not every young client has a diagnosis of psychosis. A young person’s average length of stay in the IPU is around 9 days, which I believe reflects the excellent on going care pathways available to them to help them meet their needs in the community.

On the question of staffing, I was informed that there were 5 nursing staff members on duty morning and mid shift, with 3 on night shift. The morning and mid shifts were augmented by on call Psychiatrists and a Group Therapy Team. The Group Therapy Program, which was quite similar to the group activities I was familiar with in NHS Highlands, was facilitated by a 1.0 whole time equivalent (wte) OT and Social Worker, and 0.4 wte Music Therapist. An Activity Nurse augmented this program further.

**Continuing Care Teams (CCT)**

After assessment by The Acute Services to identify what Continuing Care Team (CCT) would be best placed to meet the young person’s overall needs, they would be referred on to that CCT (see above, referral to CCT). The CCT’s are staffed by Outpatient Case Managers (OCM’s) from a variety of different Mental Health Professions, such as, Psychologists, Psychiatrists, OT’s, Nurses or Social Workers. A young person accepted by the CCT’s can expect to receive clinical care for up to 2 years.

All CCT’s are suffixed by A or B denoting which geographical area they cover.

**EPPIC**

As highlighted previously, any young person referred to the EPPIC CCT would have been assessed to have a psychotic illness.

By the time a young person is considered for referral to an EPPIC Team they are usually in, what is referred to as, the early recovery phase. In this phase, psychotic symptoms might still be present, but risk and distress have been reduced enough so that the young person can be managed in the least restrictive environment, which is in keeping with the *Australian Clinical Guidelines on Early Intervention in Psychosis 2010*. This phase of intervention can be characterised by the young person attempting to understand or integrate their psychotic experience. This can be facilitated by a clinician using psycho-education for psychosis and includes family work. A re-establishment of roles and routines is also central to the recovery phase, as is work on the young
person’s self-efficacy, which invariably has been damaged by the psychotic experience (Lloyd et al 2000). As recovery is a very personal journey, no two recovery stories are the same. Therefore, to make this concept work optimally, client centred care must be exactly that and have the young person truly at the centre of ‘their care’. If this is achieved, it further makes manifest 3 important universal principles of recovery;

1: The installation of hope for the future.

2: Choice.

3: Empowerment.

**EPPIC A - Clinical Review Meeting**

This meeting was scheduled for 2 hours and was attended by the 10 multidisciplinary Outpatient Case Managers (OCM’s) who discussed referrals, reviews and discharges to and from EPPIC A.

The following is a synopsis of a referral for a young man who was deemed to be a ‘high risk’ case. A 20+ year old homeless male on a Compulsory Treatment Order with a forensic history, who also had a physical illness due to using a Class A drug, was referred by the Mood and Anxiety Team, who he had not engaged with, to EPPIC. It transpired during discussions that he was not intending to engage with EPPIC either. The team planned to initially engage him with an assertive outreach approach and then attempt to find someone he trusted to give him a lift to OYH, which would reduce his social isolation as well as encourage him to engage with the EPPIC CCT at Parkville Campus. A staff member also agreed to discuss a referral to ‘Flagstaff’, a housing organisation, with him.

The next case synopsis was a 3 monthly clinical review for a young person still at school, who was initially referred to OYH mood clinic for suicidal ideation and depression. This young person also presented with low mood, heard voices (auditory hallucinations) and experienced insomnia. The staff believed that he was developing psychosis as the young person was experiencing an increase in hearing derogatory command voices, which affected his cognition and increased the risk of harm to him. As a result of this they were referred to EPPIC. This referral was made all the more urgent as there was a family history of completed suicide. Various current stressors were highlighted, these consisted of the family of the young person being high achievers and the young persons need to strive for perfectionism, frequent school changes and recent emigration.

The young person was currently engaged with the psychosocial group program pursuing a particular interest. As they were already engaged in the group program it was suggested, that to increase social interaction with their peers, an activity which presented the opportunity to develop social networks should also be offered to the
young person. It was also suggested that Cognitive Behavioural Therapy (CBT) be continued, to address the young person’s distorted thinking that they needed to be ‘perfect’. Further, it appeared that as the family were struggling to understand the nature of psychosis (in part due to their cultural beliefs) it was felt they might benefit from being offered support, which could involve psycho-education about psychosis.

EPPIC A - Clinical Session

One of my aims was to be able to sit in on as many clinical sessions as possible. Of course I knew the difficulties of this given that many young people might find it difficult enough engaging with a clinician and speaking about issues they might far less someone who they didn’t know. One young man, whom I got to know, informed his OCM that he was prepared to let me sit in on one of their sessions.

I went into the session not really knowing what to expect between the OCM and the young man, other than that the OCM was going to raise the issue of discharge from OYH with him again. The young man knew that he had been with OYH for 18 months and that his time with it was coming to an end. After pleasantries were exchanged, the issue of discharge was raised and I was struck how tactful and sincere or congruent the OCM was. The OCM listened to the young man’s concerns about leaving OYH without minimising any of these. The young man suggested that he would like to stay on at OYH by joining ‘Partnership or Peer support’ where young people who have used the service assist in the development of OYH as well as offering Peer Support to other young people new to OYH. The OCM thanked him for volunteering and informed him that this would be considered by the rest of the team.

On conclusion of the hour long session, my impression was that there was no secret ‘magical ingredient’ about the session. I suggested this to the OCM who totally agreed with me. This observation that there was no ‘magic’ formula or mystical techniques used by OYH staff was something that I observed over and over again, with clinicians giving me the same response as this OCM. If anything, what made this and other clinical session I ‘sat in on’ work, was the clinicians having excellent basic generic mental health skills, such as warmth, empathy, communication skills and being congruent. If there was any magic it was in the passion they had for working with the client group they worked with.
Prolonged Recovery and Treatment Resistant Early Assessment Team (TREAT)

Complimenting EPPIC’s Continuing Care Team (CCT) is TREAT. If any young person has been on an EPPIC OCM’s case load for longer than 3 months, they are screened by TREAT. If the young person is still experiencing on-going psychotic symptoms then a case review is scheduled whereby recommendations are made on how to ameliorate the symptoms. TREAT consists of a panel of senior Consultant Psychiatrists, Psychologists and other clinicians of various disciplines who have significant experience in the field of psychosis.

In the meeting that I sat in on, most recommendations were in relation to a change in medication.

Working with clients who have complex needs can be very challenging for any clinician but I felt that this was an excellent system which offered immense support to the individual OCM’s and ensured that the client received the best available treatments.

Personal Assessment+ Crisis Evaluation (PACE) – A Team for Young People who are at risk of developing Psychosis

My meeting with the PACE Team took place in their weekly 2 hour meeting in which referrals, reviews and discharges are discussed. Prior to this meeting I briefly met John Stratford the PACE Team Leader and Social Worker by profession. John gave me an overview of how and what PACE entailed. John explained to me that PACE work with young people who are at risk from developing a psychotic illness. As well as medication, they can offer Case Management, in-depth assessment or Psychological Therapies which I understood was mainly CBT. John explained to me that PACE works with young people for up to 6 months unlike the remainder of OYH CCTs where the time scale is up to 2 years. The rationale for this was that it was anticipated that by 6 months, the young person’s psychotic symptoms would have been ameliorated, their general function significantly improved and the young person would be more knowledgeable and skilful in coping with symptoms. However, if the developing psychosis develops into a ‘full blown’ psychotic illness The PACE Team can continue to work with the young person but, still only up to 6 months. This is referred to as EPPIC C Cases. There appear to be several advantages to keeping a young person in PACE whose psychosis has developed into a full blown psychosis. Some of the advantages identified to me were:

1: Continuity of care

2: Strong therapeutic relationships, trust and engagement have been established with the person and it is considered that starting the process over again would be too stressful for the young person
3: Installation of hope - keeping the young person in PACE can install hope for the young person and their family by the belief that this is something that can be contained by PACE. Whereas, if they are referred onto an EPPIC CCT the young person might think that something more serious must be wrong with them.

The benefits of intervening early with a young person experiencing psychosis is, I believe, highlighted in the following case synopsis, presented at the PACE meeting that I attended.

Mary (not her real name) is a 16 year old girl who had been both physically and sexually abused. Her relationships with one of her parents and school were very difficult. She met PACE criteria by having auditory, command and visual hallucinations that had posed a risk to her. However, after being with PACE for 6 months not only had her psychotic symptoms reduced significantly but she was more confident in her own abilities, had a more understanding relationship with the parent and had started a new school, which she liked. As a result of this progress she was discharged from PACE and OYH.

While there are many advantages of keeping a young person in PACE, EPPIC C cases such as the one highlighted above, account for 15% of PACE's total case load. This can subsequently affect individual OCM's case loads, potentially leading to them having high numbers of clients to manage.

**CBT session in PACE**

After my meeting with John Stratford and sitting in on the PACE meeting I was fortunate to be able to observe a CBT session with a young man. The young man in question was diagnosed as having Post Traumatic Stress Disorder (PTSD) after witnessing very traumatic experiences. The PTSD resulted in him having psychotic symptoms which were triggered every time he became stressed. He cited recent examples of school exams and anxiety over a physical health issue which led him to become stressed then psychotic. Part of the stress reaction just prior to him becoming psychotic was that he experienced panic attacks and depression. On commencement of the session the young man was asked what he perceived as his most pressing problem which he then identified as the panic attacks and depression. CBT in conjunction with psycho-education was how the PACE OCM subsequently addressed the young man’s issues. This, I thought, was not only in keeping with being client centred, but also reflected a basic premise of CBT whereby the approach taken is a collaborative one. The hypothesis was that once the young man’s problems were addressed, it would contribute to a reduction in the young man’s stress and subsequent psychotic symptoms. The young man believed that this process was already taking effect. He stated that since
commencing psycho-education and beginning to address the panic attacks and depression he was much more able to think clearly (psychosis was interfering with cognition functioning) and as a result able to achieve some of his goals.

My observations in this session, as in other clinical sessions which I sat in on, were that there was no magical ingredient used exclusively by OYH staff other than what would be deemed best practice anywhere else. For me this was reassuring that what I was trying to achieve back in Scotland with regards to CBT for first episode psychosis, was in effect, similar to the world leaders in the field.

HYPE (Helping Young People Early) Team for Young People with Borderline Personality Disorder - Meeting with Emma Burke

A third Community Care Team (CCT) is HYPE. HYPE was founded in 1998 but became fully operational in 2000. Initially it catered for young people with Borderline Personality Disorder (BPD) from the ages of 15-18 but this was subsequently extended to include clients up to 25 years old. Within this age range it is estimated that there is a 22% prevalence of BPD, with the ratio of women to men being 2:1. As BPD emerges during a critical period of the young person’s life, it can have devastating effects upon the development of personality and general function. It can be seen therefore, why it is imperative that interventions are timely.

Emma Burke, who is a Consultant Clinical Psychologist, manages the HYPE Team, which consists of 5 wte clinicians. Emma explained to me that on average each full time clinician has a case load of 15 young people. Emma also informed me that usually white young women presented to HYPE, but in recent times more young women of Oriental origin have been presenting. This obviously reflects the growing cultural diversity in Melbourne’s population. It was my understanding that providing therapeutic interventions and case management was combined and delivered by one person. This was not only for sound financial reasons but also to enhance continuity of care, therapeutic relationships and helped target real life situations as they arose. I also got the impression that similar to other teams within OYH, HYPE had a strong team ethos providing excellent support to OCMs.

One of the main modes of intervention in the Highlands, for people with BPD, is Dialectical Behavioural Therapy (DBT). Emma informed me that in OYH, Assertive Case Management and Cognitive Analytical Therapy (CAT) are the main therapeutic interventions. CAT, like CBT is a collaborative psychotherapeutic approach but has a particular focus on problematic relationships patterns that have become habitual. As in CBT, thoughts, emotions and the subsequent behavioural responses are also targeted. As the author has little experience of treating BPD, he does not feel qualified to comment on the merits of either approach.
Emma informed me that clients receive 16 sessions of CAT. I asked her if she thought that this was enough. She replied that after 16 sessions many young people using the service did not require Adult Services once they reached adulthood. However, she did go on to say that this might be due to a natural tendency of the symptoms of BPD to resolve once a person reaches adulthood, as opposed to early intervention and treatment.

**Mood and Anxiety Team**

Near the end of my time with OYH I had a brief opportunity to sit in on a Mood and Anxiety Team Meeting but unfortunately was not able to meet up with individual clinicians. I believe OYH’s evolution away from purely working with people with psychosis is reflected in this team. As the name suggests, this team deals with youth who predominantly have anxiety and mood disorders.

Similar to other clinical meetings that I attended, this team met up weekly to discuss referrals, reviews and discharges. In this meeting a young woman, referred by one of her parents, was discussed. She had been given a diagnosis of BPD by a private psychiatrist but did not meet the criteria for HYPE when assessed by them. She responded well to both, biological and psychosocial treatment for low mood, and as a result was discharged from OYH services.

**Meeting with Johanne Rouse from Mood and Anxiety Team to discuss CBT**

Later, after I attended the Mood and Anxiety Team meeting I had an opportunity to discuss how CBT was implemented by Jo. Jo an OT by profession had temporarily transferred to the Mood and Anxiety Team to provide cover for someone who was on maternity leave. Jo explained to me that she had a particular interest in CBT and used her OT skills to be creative in implementing it. She explained to me that she might use art or poetry in constructing a formulation, if this meant that the client could relate to it and understand it better. Jo also explained that initially she would focus on the behavioural component of CBT. She would focus on going for a walk with a client or a coffee, drive, anything really that took her and the client away from OYH at Parkville and normalised the contact. This, she believes, was beneficial in helping her develop a therapeutic relationship with the client. Once engaged, Jo aims to work with the client for up to 14 sessions using CBT.

Once again, by speaking to Jo as I had with others, it emphasised for me that there were many similarities in the way my colleagues and I addressed similar issues. Perhaps the main difference was that Jo uses different mediums to help her construct a case formulation, which I thought was an excellent idea and one that I will be incorporating into my practice.
Psychosocial Recovery Group Program

House 22-Home to the Psychosocial Group Program

On a beautiful balmy Melbourne morning, which some locals believed cold, I was introduced to, and received a very warm welcome from, my mentor Gina Woodhead. I had briefly met Gina the previous week when I was in the process of buying lunch. Gina introduced herself from the other side of the counter where she was involved in helping to run the catering group and asked if I would be interested in coming along to the choir practice after lunch, how could I refuse? However due to chronic laryngitis, my new found Antipodean friends, were spared from pain!

Gina is a very energetic, vibrant 100% committed OT who never appears to tire. You might be forgiven for thinking that due to her enthusiasm Gina was a new graduate but, Gina is in fact a very experienced OT manager and veteran EPPIC stalwart. Gina also manages the Psychosocial Group Program. Gina explained that young people recovering from psychosis often have difficulties with general confidence, socialising and life roles. As such the group program was designed to meet these needs. To help her be ‘more in tune’ with the youth culture and, to help her engage the young people in the groups, Gina spent a considerable amount of her own time familiarising herself with what is current in Melbourne youth culture. I had previously been informed that there was a huge emphasis on group work at OYH with all of the CCT’s referring into the group program and that it was viewed as an important intervention in its own right and most definitely, was not, just an adjunct to medication. This importance is reflected in the Australian Clinical Guidelines for Early Psychosis (2010) and by Professor Patrick McGorry the founder of EPPIC by ascribing the same importance to psychosocial recovery as symptom reduction.

The group program is run by a Multidisciplinary Team which includes Occupational Therapists, a Social Worker and Teachers who facilitated 16 groups per week. This differed somewhat to my experience in NHS Highland where Technical Instructors facilitate the majority of activity based groups. Some of the Therapists who were involved in the Group Program also worked as case managers in EPPIC, PACE or the Mood and Anxiety Team. This approach, whereby clinicians worked in two teams I
believed greatly enhanced general communication about a young person between the respective teams. This was very evident when I sat in on team reviews for a young person.

In my opinion, any therapeutic group program should be there to meet a specific need, as opposed to a set program where people have to fit in. In the psychosocial group program the former was, I observed, very much the norm. Not only was this the norm but the range of meaningful activities available which the young people could engage in were many and varied (see appendix A for description of groups). In addition the group program was reviewed often. All groups had a written protocol which specified among other items, objectives of the group, content and format and referral processes.

Most of the groups were activity based, which for me reflected not only the Therapists’ belief in the importance of being active, but also the influence of the Occupational Therapists within it. A further observation made was that in my experience of working in mental health, a traditional group title reflected the overt purpose of the group ie the walking, music or art ‘group’ etc. When I asked the young people about the groups they were involved in and the names given to the group they thought they were ‘cool’. When I asked them how they thought they would feel if all the groups they attended had the suffix of ‘group’ (breakfast group, music group etc) to choose from, they unanimously stated that it sounded quite institutionalised. The names given to the psychosocial groups at OYH, in my view, certainly reflected ‘normality’ and mainstream youth culture.

I believe with their mix of professional skills the various disciplines involved in the group program also helped to bring uniqueness to the way the groups were facilitated. Whilst most of the groups were activity based,’ Schools In’, which was run on Tuesday, Thursday and Friday afternoons by Teachers and Support Staff from the Travancore service was one of the exceptions.

I had asked Gina if I could have as much contact with the young service users as possible, as I believed they would give me the real, ‘low down’ on how it really was for them at OYH. As such, Gina very kindly arranged for me to spend time in a horticultural group project and have a day working in ‘Catering’.

Horticultural Project Greenhouse
‘Catering’, as the name suggests aims to give the young person experience not only in catering per se, but also develop confidence in social and work environments. Travancore (will be discussed later) can also help the young person work towards formal qualifications in catering and hospitality. ‘Catering’ also takes responsibility for producing the main meals for that day for the staff at OYH.

My day in catering commenced at 9.00 am when I met up with the other Clinicians and Young People involved in the group. I was paired up with a young man and we were given the task of producing a vegetable curry for the staff restaurant. My stress levels had suddenly increased two fold and I found it helpful to discuss this with the young man I was working with. He was instrumental in alleviating my fears and after 3 hours of following recipes and cooking en masse we believe we had produced a very tasty curry. The ‘proof of the pudding’ as they say, or in this case ‘the curry’, was in the eating, and by the end of lunch time we had sold every curry.

My time in the group gave me ample opportunity to talk to young people about OYH and without exception every one of them praised it very highly. Such was the high esteem that they held it in, that very few of them wanted to leave. Although everyone had a different reason why they valued OYH so much, the general consensus was that it gave them ‘hope for the future’ and made them feel ‘normal’.

With colleagues from the catering group at the end of day

Psychosocial Recovery Services Clinical Review Meeting

This meeting takes place every Tuesday afternoon and Referrals to the Group Program, Three Monthly Reviews of people’s goals and Discharges are discussed. The particular Tuesday afternoon I sat in on the meeting, 13 young people were discussed. The following is a synopsis of one of the referred cases.
**Case 1**

Gina presented a young man Peter (not his real name) who had been referred to the Choir from the EPPIC A Team. Whilst Peter was in the Group Program, EPPIC would continue to work with him using Case Management and CBT. Although he was employed, he found his work very stressful and had financial difficulties. As a result of this, he had multiple suicide attempts, one of which involved a car. This initially precipitated his referral to OYH Acute Team and subsequently the EPPIC Team. He was referred to the Choir as he had an interest in music, but also because it was envisaged it could help him have more balance in his life between work and leisure. It was felt that due to being on sick leave it could also assist him in having routine and structure to his week, in the absence of his work. As Peter indicated that he was also interested in 'looking for a new direction' with regards to a career, Gina suggested that he could benefit from a referral to the ‘Vocational Rehabilitation Consultant’ Gina Chinnery.

**Pathway of Care for Peter**

A clear Pathway of Care was evident.

a) Referral and Entry Point to the Acute Team (Initially at the Inpatient Unit at Fotscray).

b) Referral to the Youth Access Team (YAT) for assessment.

c) Referral to EPPIC and Family Peer Support Worker contact with Parents.

d) Referral to the Psychosocial Group Program.

e) Referral to Vocational Rehabilitation Worker.

I believe the above case demonstrated excellent pathways of care. This, I believe, was facilitated by very good communication at all levels. I also believe it reflected a truly holistic approach encompassing biological and psychosocial models of care. Further, the interventions offered to the young man were client centred and meaningful, thereby putting him truly at the centre of these interventions. Overall I believe it emphasised how efficient OYH actually is.
Family Peer Support

Ray Anastasi, Gina Woodhead and Susan Peach

Gina introduced me to two of the four Family Support Workers, Ray Anastasi and Susan Peach. Family Peer Support’s main aim, Ray said, was to ‘provide support for families with young people diagnosed with schizophrenia’. Ray, who has been in post for 10 years and Susan 3 weeks, both know the heartbreak of having a child with schizophrenia. Ray described to me what it was like in those ‘early days’ for him and his wife, when they learned that their son was diagnosed with schizophrenia. A whole gambit of emotions from denial to despair and anger ensued, but eventually Ray and his wife managed to come to terms with their son’s diagnosis. Ray subsequently changed careers and started to work as a family peer support worker, initially voluntarily but now as a paid member of staff. Ray informed me that this move from volunteer to paid employee reflected OYH’s view of how important Family Peer Support work is. This is a view also supported by the Australian Clinical Guidelines for Early Psychosis 2010, The Acute Phase of Early Psychosis 2004 and Implementing Early Intervention in Psychosis 2002. Ray explained to me that once a young person enters into the EPPIC system and is allocated an OCM, Family Peer Support are also notified or ‘requested’, not referred. This ‘request’ consists of the client’s name and contact name and telephone number of their main carer. On average, Family Peer Support will wait 5-10 days prior to contacting the young person’s carer. This is to ensure that there are no problems which might be exacerbated or compounded by contacting the carer. Ray said that after making the initial contact and emphasising that it is about how the parent is coping; most people welcomed the opportunity for support, especially from someone who knows what it feels like.

OYH have just published a new Family Peer support Manual titled Training Family Peer Support Workers in an Early Intervention Mental Health Service - Facilitator’s Training Guide (2012). By the end of my meeting with Ray and Susan, I could not help but be both moved and enthused by their passion and commitment to their vocation, for that was exactly how I believed they perceived their role.
Meeting with Gina Chinnery Vocational Rehabilitation Consultant

Gina, who had been in post for 7 years, is a full time vocational rehabilitation consultant and, offers Individual Placement Support (IPS) at OYH. IPS which is a focussed form of intervention to help people with chronic Mental Health issues gain employment in the Open Labour Market was developed in response to Unemployment being the largest contributor to indirect costs of Psychosis (Killackey et al 2008). For example, according to The Scotland Institute 2012, these indirect costs for an individual with Schizophrenia were £60,000 per year per person, while in England the cost of lost productivity of people with schizophrenia owing to unemployment, absence from work and premature mortality in 2004-2005 reached 3.4 billion, while the cost of lost productivity of carers was 32 million (NICE Guidelines 2010). To understand more fully what it is like to have a mental health problem and be seeking employment I would like to suggest that the reader read the Highland User Group Employment Report 1997.

Gina went on to explain that her manager Eoin Kilackey went out to Canada several years ago to study IPS and was so impressed that on his return lobbied for it to be part of the OYH psychosocial program. After positive findings from a Research Project (Killackey et al 2008) he managed to get funding to employ Gina.

Gina works with the clients, for example, creating Curriculum Vitae (CVs), assertive job seeking and general support around employment issues. Gina informed me that in order to give the young person 'ownership' they are encouraged to be involved optimally at all stages of the process of job seeking.

Currently, Gina works with a case load in the region of 20-25 clients and is able to offer 6 months support to a young person. However, she believes being able to follow them up after 6 months would be significantly more beneficial for them as she could help support them optimally on their career pathways.

Gina also went on to say that IPS has been so successful, that the Australian Government has recommended that any new Early Intervention in Psychosis Service in Australia should have an IPS worker.

Hearing first-hand how important people viewed IPS; I found it re-assuring for my own area of work that we secured funding for an IPS worker who has now been in post for about 6 months.
Meeting with Melissa Thurley - Platform and Peer Support

I met with Melissa in the Platform and Peer Support Office or, ‘chill out room’ as one young person referred to it as. As well as Melissa, there was a young woman who was currently working in Platform. Melissa commenced the meeting by informing me that the office could also be used as a waiting room for any young person attending OYH at Parkville but did not want to sit in the main waiting room. At this point, I stated that I thought that if I was a young person and attending OYH she would find me in the Platform/Peer Support Office which had a relaxed informal ambience to it. The young woman sitting in with us agreed.

The Platform Team

Platform is open to any client past or present who wants to help develop the services at OYH. The premise being that it is the young person who knows what has worked and not worked for them. There is also a strong focus on educating the general public about mental health. Some of the projects of Platform are as follows:

- Newsletters
- Sitting in on interview panels to select new staff
- Designing Information Packages
- Assisting in Research Projects
- Talking to school students about mental health

Peer Support

I initially heard about Peer Support from a young man that I worked alongside in the catering group. He had informed me that he wanted to be involved as a Peer Support worker, to give something back to OYH and help others, like he was helped when he first came into OYH. Melissa informed me that Peer Support workers are young people who have been in OYH and who have experienced what it is like to have a mental illness. Peer support workers support other young people who come into the service. They do this by sharing their own story or recovery journey through mental illness, with new service users. For example, they shared what helped them cope with their experiences or illness but also what was not so helpful. Peer Support Workers also visit the inpatient unit at Fotscray. This was where the young man I referred to earlier first met Peer Support Workers. One word which the young man used struck me as being pivotal in how important Peer Support Workers are in the eyes of young service users, this was ‘Hope’. The young man stated that the Peer Support Workers gave him ‘Hope’ for the future, which was something he felt that he did not have when first admitted to the IPU. Like Family Peer Support Workers, Peer Support Workers are paid on a sessional basis. They are also supervised by experienced clinicians.
Once again, as so often with my time at OYH, I saw a real commitment to give and an acknowledgment of the important contribution other people, other than clinicians, give to OYH. I believe the **Australian Clinical Guidelines for Early Psychosis 2010** sums it up perfectly, when it recommends that service users be involved optimally in service development. I remember being very impressed when I saw representatives from Platform help form part of a delegation meeting up with Australian Politicians to discuss future developments at OYH. Once more, I had the strong impression that involving Service Users was most definitely not ‘tokenism’ at OYH.

I also attended the launch of a new booklet by Platform and Peer Support titled, ‘What’s next?’ This was presented by Melissa, Kathryn from the Psychosocial Group Program and two other young members of Peer Support and Platform.

**Meeting with Teachers from Travancore**

Richard, a young teacher, like many other staff at OYH, warmly welcomed me into his office to explain the role of Travancore. Travancore School is a Department of Early Education and Childhood Development School that works with Children’s Mental Health Services and Orygen Youth Health. The Travancore School provides educational services to children and young people who are current Mental Health Clients as well as liaising with schools to develop mental health programs for mainstream students *(Travancore School Booklet, 2012).*

Their mission statement is:

- To provide a safe and supportive environment which supports young people with mental health difficulties in education
- To provide pathways and options to build successful educational transitions
- To develop mental health awareness across educational communities
- To assist and support teachers in understanding and managing mental health issues with an increasing emphasis on prevention and early intervention *(Travancore School Booklet, 2012).*

As previously mentioned, Travancore play an important role in the Psychosocial Group Program, being involved in the Catering, Horticultural and ‘School’s In’ groups. Travancore can, as well as helping young people achieve a certificate in catering work, help them work towards nationally accredited certificates in horticulture. Support is also available to students aged 19 or under who have not completed their ‘year 12’ education. One young student explained to me that she was working on a ‘year 11’ module, which when completed, would enable her to complete her year at school. Another young person that I spoke to informed me that he was writing up an essay about a fund raising event that he had been involved in.
Staffing for Travancore at OYH amounted to 3 full time Teachers per week and a Teaching Assistant every day. Richard also explained to me that Travancore were State Funded as opposed to being funded by a budget from Health.

From the anecdotal evidence that I have from working with young people in the Highlands, a large percentage of them have some form of educational needs. These young people often feel embarrassed by their poor literacy or numeracy skill, which is often compounded further by the stigma of Mental Health. Young people can often feel marginalised by their self-perceived inadequacies. The effect it has upon their self-efficacy can also be substantial. I believe many of these young people, in the Highlands would benefit from having access to adult learning as part of the package of care while in hospital, similar to how they are now offered IPS in relation to employment. Young people with Mental Health issues in the Highlands have also informed me that although they would like to get into employment, several factors inhibit them. One such factor is the benefit trap, which many of them claim makes it not worth their while going out to work, as they get more money from benefits. To make it worth their while to go out and work, they claim, they need a job that is sustainable and would pay them more than benefits, and this type of work usually entails having qualifications.

Meeting with Beth Angus- Senior Psychologist and Autism Specialist

Autism is a particular area of work that I knew very little about. However the Adult Mental Health Service that I work in, are now beginning to see more people on the autistic spectrum. Beth who is a Senior Psychologist gave me some idea why there appears to more people with Autism around, when she informed me that at OYH, 11% of all clients have features of Autism co-occurring with a Mental Illness. This amounts, I believe, to approximately 88 young people who are accepted for treatment at OYH per year. Beth also informed me that the incidence of Autistic Spectrum Disorders (ASD) in the general population was 1%, which is the same for Schizophrenia. Beth also said that ASD was often misdiagnosed; one of the reasons being that it is very difficult to diagnose. Beth therefore helps in diagnosing young people with ASD and works very closely with case holders, generally helping to co-ordinate interventions. Beth is also co-author of, ‘The Clinical Practice Principles for the Management of Autism Spectrum Disorders and Psychiatric Co-morbidity in Young People 2012’.
Training

I believe that investment in good training plays a significant role in why OYH functions so well. During the first week I attended a two day workshop on Mania, entitled ‘The Highs and Lows of Mania’. In the following section, I reflect on this valuable workshop.

The Highs and Lows of Mania-A 2 Day Workshop

I had been informed that both speakers, Dr Craig MacNeil, a clinical psychologist and author of an excellent book on Cognitive Therapy for Bipolar Disorder, and Professor Michael Berk, a world renowned expert in the field, were both excellent speakers and I wasn’t disappointed. Not only did I learn a considerable amount about the negative effects of this devastating mental illness which gives it a 4th place rating from the Lancet 2011, when it comes to overall Global Burden for young people aged 10-24 but, also what this actually entails. It effectively entails a young person losing out on average 12 years of normal health, 14 years of work productivity and 9 years of life expectancy. This group also has a 15% suicide rate, which is one of the highest rates associated with any mental illness.

Craig informed us that there had been less psychological research conducted into Mania than any other major psychiatric diagnosis. It is therefore hardly surprising that I had always thought that the combinations of psychological and social interventions were but an adjunct in this area of Mental Health. However, according to the research presented by Dr Craig MacNeil, Psychosocial Interventions should be an integral component of overall treatment for Bipolar Disorder as is currently the case with other Psychotic Illnesses. Given that after 2 years, 97% of people with Bipolar disorder can have symptom recovery, but only 38% regain functional recovery, one might begin to understand how debilitating this illness actually is and why we need to target it using Psychosocial Interventions in conjunction with medication.

Craig who is an author of a book on Cognitive Behavioural Therapy for Bipolar Disorder went on to discuss why it was imperative to have Psychosocial Interventions. He highlighted how effective these were in delaying or preventing relapses in Bipolar Illness at any stage of the illness. I believe this to be a very salient point and one which I plan to discuss with both my Occupational Therapy and Cognitive Behavioural Therapy colleagues. Perhaps one of the most important points for me however, was how difficult and under diagnosed Bipolar Disorder is in young people. It is, Craig informed us, often mistaken for Antisocial Personality Disorder in young men and Border Line Personality Disorder in young women. Given that suicide is considerably higher with Bipolar Disorder than these other two mental illneses, one can perhaps appreciate why I thought the need for better diagnosis of Bipolar Disorder to be one of the most significant points of the whole 2 day workshop. Once again it is something that I will be discussing with colleagues and also the Highland User Group who are a very proactive group of Service Users.
**Comprehensive Assessment of At Risk Mental State (CAARMS)**

During my time at EPPIC I also attended a workshop on the CAARMS. This workshop was facilitated by Kristen a self-confessed ‘geek’ on the CAARMS. Kristen is a Senior Occupational Therapist and like many of my encounters with OYH staff, I was immediately impressed by his passion for his work and knowledge in the area. I had heard of the CAARMS but had never had an opportunity to work with it. Kirsten who works in The PACE Team explained to our group that the prodromal period of psychosis offered an opportunity to intervene at an early stage. This he went on to explain was why the CAARMS was developed. The CAARMS consists of seven areas, these are:

1: Positive symptoms

2: Cognitive change attention/concentration

3: Emotional disturbance

4: Negative symptoms

5: Behavioural change

6: Mood/physical change

7: General psychopathology

Taken together, these seven categories assess both the Psychopathology indicative of imminent development of a First Episode of Psychosis and to determine if an individual meets criteria associated with being at Ultra High Risk (UHR) of developing First Episode Psychosis.

Kirsten also explained that prior to using the CAARMS; an assessment using the Social and Occupational Functioning Assessment Scale (SOFAS) is required. The SOFAS which assesses a person’s Social and Occupational functioning indicates if a person has had a drop in function compared to their norm in the past year. If this difference is 30% or more then the person has an increased chance of developing a First Episode of Psychosis. This would now initiate the use of the CAARMS.
International Early Psychosis Association (IEPA) 2012 Conference Update

On my arrival in Melbourne and OYH, Simon Dodd had informed me that he had just arrived back from the IEPA Conference in San Francisco. I attended presentations from returned OYH Delegates who shared with us what they had both presented and learned at an update to the conference held at OYH’s Parkville Campus. They had recorded 85% of all the presentations at the conference, which amounted to a staggering 65 hours of filming! There had also been 30 poster presentations. Below are my salient learning points and reflections on some of the updates.

Feedback on Paper on Vocational Rehabilitation

Associate Professor Eoin Killackey and Gina Chinnery spoke about the presentation of a paper on Vocational Rehabilitation. The presentation on the concept of Individual Placement Support (IPS) had met with significant interest at the conference. Perhaps one reason why it did get so much attention was due to the excellent outcomes which surpassed the first study in this area. The paper demonstrated that not only did a significant amount of young people who were seen by OYH and used IPS gain employment but so did the Treatment As Usual (TAU) group who used IPS compared to the earlier study. Associate Professor Eoin Killackey postulated that several factors played a role in the TAU group having such good outcomes with regards to employment. Two of these were that the young people had access to the Psychosocial Group Program which places considerable emphasis on developing skills which could be transferrable to employment situations and OCMs in CCTs being more aware of the importance of employment and supporting the young person to gain it. During the update, the overall importance of Employment and Mental Health was emphasised by Professor Patrick McGorry when he stated that, ‘Mental Health is the largest threat to the GDP of nations’.

Meeting with Professor Eoin Killackey

I had an opportunity to talk directly to Associate Professor Eoin Killackey one of the San Francisco Conference delegates. I asked Eoin about what he thought might be the prevalence of First Episode Psychosis in the Highlands based on the population statistics of 275,000. He said that he thought there might be approximately 40-60 new cases every year. However I believe this is based on figures which suggest that approximately ¼ of the population falls within the age range of 15-24. Even though some of these cases would fall within the remit of Child and Adolescent Mental Health Services in the Highlands, which like other parts of UK remain separate from Adult Services, it is envisaged that the majority would be within the age range for our Adult Services.
Cognitive Therapy v Medication for People with Schizophrenia

We also heard one of the presentations recorded in San Francisco from a paper by Morrison et al 2011. While not feeling suitably qualified enough to comment, I did never the less find the presentation very interesting and thought provoking. The study basically analysed whether Cognitive Therapy, which traditionally has been delivered in conjunction with medication for Schizophrenia, was as effective in the absence of medication. The conclusions to this study suggested that Cognitive Therapy was indeed effective without medication and that it was also much more acceptable to many people who have a diagnosis of Schizophrenia.

Professor McGorry on OYH and EPPIC

The main point I took from Professor McGorry’s presentation was about the need for Early Intervention in Psychosis and suggested that it was unacceptable not to have an Early Intervention Policy. He spoke about how no one would question early intervention in areas such as cancer or heart disease and yet early intervention in psychosis still meets the question ‘Why have it?’. He further rationalised the need for Early Intervention by highlighting the effects major mental illnesses have upon a country’s economy. This he stated was due to the major mental illnesses such as schizophrenia having their onset at a time in a person’s life when they otherwise might be at their most productive.

The crux of his talk for me however, was very simple yet profound. It was when he spoke about Early Intervention in Psychosis not being ‘Rocket Science’ and thereby supporting my observations all the way through my Fellowship that there was no magical or mythical ingredients to OYH’s excellent practice in this area. He strongly alluded to any good Clinician working in Mental Health being able to undertake this type of work. His second point which also left its mark on me, was when he stated with reference to having Early Intervention Strategies, ‘one size does not fit all’. This I understood to mean that to have an effective Early Intervention in Psychosis Team and Strategy it did not have to mirror OYH and EPPIC. The capacity and resources of an organisation as well as its Geography could well dictate a structure very different to OYH and EPPIC. Examples of this are; a)the Early Treatment and Identification of Psychosis Project (TIPS) in Norway; b)Early Intervention Service (EIS) in Birmingham; c)Early Psychosis Program (EPP) in Canada; d)Prevention and Early Intervention Program for Psychosis (PEPP) Canada, Edwards and McGorry (2002).
Meeting with Murray Ashby-Treasurer of WCMT Victoria Branch-New Research

In the first week of my Fellowship I contacted Murray the treasurer of the Victoria Branch of The Winston Churchill Memorial Trust. Murray very kindly agreed to meet up with me at the Botanical Gardens over a 'long black coffee'. Murray and I spoke about our shared interest in Psychosis and offered to arrange a visit to the Researchers at the Alfred Hospital in Melbourne. I later visited the hospital with Murray who introduced me to Dr Neil Thomas a Consultant Psychologist who very kindly, in turn introduced me to the research staff. I learned about two research projects. These were;

1: Woman’s health and oestrogen. This basically was a project looking at factors inherent in oestrogen, which might act as a protective mechanism for some women in relation to serious mental illnesses such as Schizophrenia.

2: I was also given information about a study using Transcranial Magnetic Stimulation or TMS, with some very interesting results, but as this research has not yet been published, I feel that I’m not at liberty to discuss it further.

Dr Neil Thomas arranged a meeting with a local Hearing Voices Network for Murray and me at Prahran a suburb in South Yarra, Melbourne. Like most of my experiences with The Hearing Voices Network, this one was positive. I was warmly welcomed with the informality I had come to associate with Australians and The wider Hearing Voices Network. One of their interesting projects that I was informed about, was the use of information technology in rural areas, to help people who hear voices access support from the Hearing Voices Network.

People from the Hearing Voices Network in Prahan invited me to attend a workshop on ‘voice dialoguing’ a technique where by the person who hears voices engages with them. I was told that it was to be facilitated by Professor Maurice Romme, Ron Coleman and Indigo Daya. This really brought home to me how small the world actually was. I went on to share with them that I had been to several workshops and lectures given by Professor Romme and Ron, and how Ron had partly been responsible for colleagues from ‘Cairdeas Cottage’ and I, setting up the Highland Hearing Voices Network many years ago. As much as I would have liked to attend, I had to turn down the offer as the dates for the workshop were after my Fellowship had ended.
Meeting with the Victoria Branch of the WCMT

Just when I thought that Murray could not be any more hospitable, he invited me along to the Victoria WCMT Christmas Diner, which I duly accepted. I had an excellent evening with members from the Victoria Branch who maintained this hospitable reputation which I had formed of Australians.

The Victoria Branch of WCMT Christmas Diner
**Conclusion**

During my first morning at OYH’s Parkville Campus, I had no real idea what to expect from the world leaders in the field of Early Intervention in Psychosis. I had read so much about EPPIC, OYH, Professor McGorry and the groundbreaking work in Early Intervention in Psychosis. My imagination somehow managed to conjure up an organisation that was staffed by Mental Health Super Heroes. What I found instead, were passionate and committed clinicians who believed wholeheartedly in the ethos of Early Intervention in Psychosis and who operate within a supportive, well-structured system in which ongoing professional development was strongly evident. Which by the end of my Fellowship I felt was beginning to understand.

The overall premise for the work being undertaken at OYH and EPPIC was, according to Professor McGorry, ‘not rocket science’. Rocket science it may not have been but science it certainly was. It was the science, in the form of cutting edge research in the field of Early Intervention in Psychosis and other major Mental Illnesses, at OYH that allowed the clinical staff to implement findings from it, to produce outcomes that the world of Early Intervention in Psychosis work has embraced.

This research would probably never have taken place had it not been for people who were far sighted and passionate about this area of mental health and ‘stuck their head up above the parapet’ of conventionality 20 years ago. Through this research not only has it produced strategies and interventions but it has created an ethos that most Clinicians are proud to be part of. It has also raised the awareness of the importance of Early Intervention in Psychosis to a wider audience. This has been achieved by reaching out to the wider community, schools, youth groups and the like, by word of mouth from clinicians, the media and by service user involvement, such as Platform and Peer Support.

OYH has also demonstrated that by working in partnership with people and staff members who understand what it means to have a family member with a severe mental illness, they are taking a truly holistic approach. Another aspect which reflects this holistic way of thinking about an individual, their environment and their place within it is the emphasis which OYH places on employment and education. By taking this approach not only is OYH helping to address relevant issues for the individual but helping to address the wider issue of costs to the economy of the nation from Mental Health.

I believe the recognition by OYH of the importance of Psychological and Social Interventions is much more than just tokenism and is reflected in the importance given to the Psychosocial Program at OYH. This shift away from a purely Biomedical approach to a more balanced one encompassing Psychosocial Interventions has also been acknowledged by the **Australian Guidelines for Early Intervention in Psychosis.** This excellent document with its staged managed approach and
interventions for specific stages of Psychosis ensures that treatment is standardised as much as possible.

Throughout my time with OYH I was aware of very well defined care pathways for young people, commencing with YAT or the IPU through to the CCT’s and Psychosocial Group program. These pathways which reflected OYH’s evolution from purely Early Intervention in Psychosis to early intervention in other Mental Illnesses was supported by regular and open communication.

Of course as Michael Novak states, ‘to know one’s self is to disbelieve utopia’. After 6 weeks with OYH I was left with no illusions that the staff certainly did not think of themselves as anything special, nor did they believe that they worked in a utopian Mental Health Service. Like many places, staff complained of staff shortages unmanageable case load sizes and the physical environment not being conducive to what they were trying to achieve. Their actual knowledge and skill base while being honed for a specific area of work was, in my opinion not that dissimilar to, the skills that many of my colleagues have in NHS Highland.

I asked myself ‘Were all of my objectives met by OYH?’ I would have liked to have spent more time with individual Cognitive Behavioural Therapists specifically working with CBT for psychotic symptoms. Perhaps I would have liked to spend more time with the CCT’s also and observed more clinical sessions. I have to remember however that I only had 6 weeks and that in many instances it was not always conducive to the Young Person for an ‘outsider’ to sit in on clinical sessions. I had an excellent mentor in Gina Woodhead who worked incredibly hard along with Simon Dodd to give me as many opportunities as possible in 6 short weeks. Overall I had a fantastic 6 weeks, a once in a life time opportunity. Now it is up to me and NHS Highland to meet the remainder of my objectives and give young people in the Highlands who are diagnosed with Psychotic Illnesses the same opportunities, dreams and aspirations as their peers.
Recommendations

Research/Audit - I have spoken to senior clinicians and researchers at OYH and also in the UK in the field of EIP, about the prevalence of First Episode Psychosis amongst Young People in the 15-24 age range in the Highlands. They estimated the numbers were between 40 -60 young people per year. This is also in keeping with statistics for the Highlands from the Institute of Statistical Data (ISD) for Scotland. If we were considering some form of early intervention policy for the Highlands then an up to date audit to obtain precise numbers of FEP would be necessary.

Raising Awareness - To help raise the awareness to the Public, GP’s, Schools, Colleges and other referrers of the importance of recognising and intervening early in psychosis, we could use a public health initiative, using various forms of media. For example, using NHS Newsletter, leaflets in GP Surgeries, hospitals, Highland User Group, the wider Highland media, talks to schools and colleges. This could take a similar form to the Scottish Governments 'Psychiatric First Aid' initiative several years ago. With regards to raising awareness with GP’s and other referrers clinical assessment tools used in EIP such as the SOFAS and CAARMS could be introduced.

Integrated Care Pathways (ICP’s) – The ICP for Schizophrenia in the Highlands, which is a work in progress, should have a subsection referring to a strategy for Early Intervention in Psychosis. A clear pathway of care needs to be identified within this. Guidelines outlining a staged approach similar to The Australian Clinical Guidelines to guide Clinicians on Assessment and Interventions should be developed.

Use of existing Resources - A feasibility study to determine if a small Multidisciplinary Team, specialising in Early Intervention for Psychosis should be set up to respond to any referrals. Team members could take it in turn to be the point of contact for Referrals and screen the Referrals in a similar manner that the YAT Team does. They could also give advice about Early Intervention to Clinical Teams or individual Staff in outlying areas. As Professor McGorry stated, ‘One size does not fit all’. In this economic climate we may have to use what resources and capacity we have to address the local need, something is always going to be better than nothing in this situation.

Early Intervention in Psychosis Champions - Similar to the ‘cleanliness champions’ programme that NHS Highland started several years ago, we should have EIP Champions. This could be achieved by bringing together a cohort of clinicians throughout NHS Highland who are interested in developing early intervention in psychosis. They could then facilitate specific workshops, lectures to staff, GP’s and Community Mental Health Teams. Special Interest Groups could be set up with a view to developing skills in this area further. If this initiative was adopted it would
also result in having clinicians strategically placed to act as advisor and link person on EIP to their clinical teams.

**Student Education** – *I plan to liaise with Learning Centres to highlight the importance of Early Intervention in Psychosis and other major Mental Illnesses.* Discuss with these learning centres the importance of *introducing EIP into mental health student training* (students I currently discuss this with highlight the paucity of awareness of the importance of EIP in their training). *Involve students in EIP Special Interest Groups.*

**Psychosocial Group Program** – *In order to appeal to a younger client group, a revamp of existing group programs and their titles is necessary.* This would also entail *looking at more meaningful activities specifically for young men, as they make up the largest group of people presenting with First Episode Psychosis.*

**Service User Involvement** - *Provide a forum, perhaps in tandem with HUG, whereby service users would have their say on what works for them, what doesn’t and what they think would be beneficial in Early Intervention Treatment in Psychosis. Explore the development of Client Peer Support and explore potential of using more Service Users in the Group Program.*

**CBT for Psychosis** - Currently in the NHS Highlands area, I am only aware of perhaps one or two clinicians with a special interest in CBT for Psychosis. *More Therapists, formal training and supervision for CBT for Psychosis are required to deliver CBT for Psychosis* which is acknowledged as best practice in Best Practice Guidelines for Schizophrenia for example SIGN Guidelines for Schizophrenia.

**Eye Movement Desensitisation and Reprocessing (EMDR) for Trauma Related Psychosis** - Recently there has been a cohort of clinicians in NHS Highland trained in this therapy to treat Trauma. Through my own Professional Development I have become aware that this form of Therapy has also been used in treating Trauma Related Psychosis. *Therefore, as with CBT for psychosis, it is my opinion that we could use this form of Therapy to treat Trauma Related Psychosis.*

**Family Peer Support** - The withdrawal of funding from the Schizophrenia Fellowship left a void for many families who have a family member with schizophrenia. Who does a parent with a young daughter or son diagnosed with a first episode of psychosis have to speak too, other than perhaps a clinician about what is happening. *Having a Volunteer or paid Family Peer Support Worker would be very beneficial for families as has been demonstrated by OYH.*

**Educational Needs** - An Individual Placement Support (IPS) Worker has been funded for one year to determine if this is beneficial to young unemployed people with mental health problems in the Highlands. OYH demonstrated that outcomes
surrounding employment can be enhanced not only by IPS, but by clinicians highlighting employment with the client. With regards to education, the anecdotal evidence from my own clinical work and from speaking to staff and clients at OYH is that *Young People’s educational needs are not necessarily given the same priority as employment*. To address this we could have better links with established education providers such as, community link at Inverness College and the workers educational association, whilst also looking to other educational providers.
References

1: Australian Clinical Guidelines for Early Psychosis 2nd Edition (2010); Orygen Youth Health Research Centre; info@eppic.org.au.


3: Cook, R. Dr; (2012); The Scotland Institute; The Personal Social and Economic costs of Social Exclusion in Scotland; p: 21.


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8: Killackey, E, (2010); All in a day's work: Opportunities and challenges for vocational interventions in early intervention settings. Early Intervention in Psychiatry; 4.


10: Lloyd, C. Basset, J. Samara, P. (2000); Rehabilitation Programs for Early Psychosis British Journal of Occupational Therapy; 63 (2).


13: Orygen Youth Health (2012); What’s next? A guide to all the ins and outs you need to know about discharge from Orygen.


Appendix A

Group Program

Monday
O-Zone: Clients decide what they want to do, ranging from ‘chilling out’ to cooking lunch and playing the Wii with friends.

Schools In: Here, young people can work towards The Victorian Certificate of applied learning, which is described as a ‘hands on’ practical approach to achieving important life and work skills. Support from Travancore School Teachers and support staff is available.

Tuesday
Studio 35: For anyone interested in music with a view to working towards creating one’s own music in a recording studio.
Schools In: See above.

Wednesday:
Catering: For anyone wishing to learn how to cook and make ‘real’ coffees in a real café setting, working as a team. There is also an opportunity to work towards a qualification in kitchen operations.
Art Space: This group provides an opportunity for people to explore their creative side.
One Voice: A unique, engaging contemporary choir, aimed at bringing together, staff, young people and families. This group is led by one of Melbourne’s top choir leaders.
Gym: Using a wide range of sports to get fit, such as, cricket, volleyball, badminton, soccer and basketball.

Thursday
Outdoor Adventure: An opportunity to engage in exciting challenges using ‘the Great Outdoors’. Some of the activities on offer are, canoeing, rock climbing and cycling.
Mind Muscles: Mindfulness meditation to help live in the ‘here and now’.
Horticulture: To help develop interests in horticulture and learn how to operate and maintain garden tools. Clients can work towards a Nationally Accredited Horticulture Certificate.
Schools In: See above.
Finding Your Feet: A group focussing on getting out and socialising with others whilst becoming aware of one’s own strengths. The group also decides what they want to do in the group session.
Safe: Learning how to manage strong emotions.

Friday
Schools In: See above.
Free Style: A self-directed activity based group aimed at overall confidence building.