



## Factors predicting program fidelity and delivery of an early intervention program for first episode psychosis in rural Australia

Richard O’Kearney<sup>1</sup>, Graham Garland<sup>2</sup>, Mark Welch<sup>3</sup>, Len Kanowski<sup>2</sup> and Sylvia Fitzgerald<sup>2</sup>

1. School of Psychology, The Australian National University, Canberra, ACT, Australia

2. Southern Area Health Service, Queanbeyan, New South Wales, Australia

3. Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada

### Abstract

This study evaluated the sustainability of the Southern Area First Episode (SAFE) program - an early intervention for psychosis service modified to a specialist-within-generalist-team approach for a rural mental health service. The study also aimed to identify the factors that influence the fidelity of program delivery. A retrospective audit of the files of all people between the age of 15 and 25 years seen by three clinical teams was undertaken two years after the program was implemented. At audit, 43 of the 225 files reviewed were considered suitable for SAFE although only a quarter of these were identified as early intervention clients at assessment. There was considerable variability in delivery of the early intervention practices to suitable clients. Rates of delivery of the medical aspects of care ranged from 61% to 81% while less standard care components of early intervention such as psycho-education, cognitive-behavioural intervention and outcome monitoring ranged from 20% to 33%. An assessment diagnosis of a psychotic disorder predicted the number of early intervention components delivered, but age, gender, phase of illness and severity were not predictive. Registration on SAFE was the strongest predictor of overall program fidelity. The results indicate that the specialist-within-generalist-team approach can be an effective model of early intervention for psychosis in settings where dedicated specialist teams are not appropriate, provided that prominent service identification processes and advocacy to ensure the ongoing visibility of the program are in place.

### Keywords

*service evaluation, early intervention, psychosis, transportability, rural mental health*

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### Introduction

There is growing evidence that specific early intervention programs and services for people in a first episode or the early years of a psychotic illness can be more useful than standard care and can prevent the progression from the prodromal phase to an acute psychosis (McGorry, Yung, Phillips et al., 2002; Sanbrook, Harris, Parada &

Young, 2003). A leading example of efficacious early intervention for first episode psychosis in Australia, and internationally, is the Early Psychosis Prevention and Intervention Centre (EPPIC) program (Edwards & McGorry 2002). While the EPPIC program has also been shown to be economically viable (Mihalopoulos, McGorry & Carter, 1999) and there is understandable advocacy for dissemination of

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**Contact:** Richard O’Kearney Ph.D., Director of Clinical Training, School of Psychology, The Australian National University, Canberra, ACT 0200, Australia [Richard.OKearney@anu.edu.au](mailto:Richard.OKearney@anu.edu.au)

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early intervention programs for psychosis (McGorry & Yung, 2003), several factors besides cost and efficacy influence the successful transportation and dissemination of effective interventions into practice contexts.

These factors include practitioner characteristics such as specialized training and type of profession, client characteristics such as age and gender, service delivery characteristics such as location, duration and frequency of sessions, variables such as work load flexibility and organisational structure, and service system variables such as priorities for prevention and early intervention work and staff retention strategies (Schoenwald & Hoagwood, 2001). For example, potentially important factors such as clinician turnover, allegiance to the treatment model, hours of operation affecting availability of clients' families, and clinician workload, may vary considerably in the diverse settings where the intervention is designed to be used. Schoenwald and Hoagwood (2001) argue strongly for an evidence-based approach to identifying the role of these variables, with data from specific transportability projects informing adjustments locally and more widely as the results of these studies are communicated. They also highlight the risk of premature adoption of programs which 'ill fit clients, practitioners, provider agencies or service systems' and risk 'poisoning the waters among these groups, not only for the treatment in question but also for any empirically validated treatment' (Schoenwald & Hoagwood, 2001:1192).

A key feature of EPPIC and other early interventions is psycho-education and behavioural approaches to working with the clients and their families. While these approaches have demonstrated value (Cormac, Jones, Campbell & Silveria da Mota Neto, 2003; Pekkala & Merinder, 2003), the data about their take up and use, generally by mental health clinicians, are very disappointing (Amenson & Liberman, 2001). For example, fewer than 10% of families of outpatients with schizophrenia receive support or education (Sherman, 2003). Such findings should temper expectation about the success of unexamined dissemination of efficacious specialised programs. Addressing the local factors which act as obstacles to providing psycho-education and other effective

interventions is challenging but necessary if early intervention is to improve outcomes for people presenting with psychotic disorders.

The Southern Area First Episode (SAFE) program modified the EPPIC model (Edwards & McGorry, 2002) to a rural area to adjust for the relatively infrequent presentation of first episode schizophrenia and related psychotic disorders, fewer staff overall, and fewer still with specialist early intervention training or experience. While based substantially on the EPPIC early intervention model, the SAFE program differed from EPPIC, which provides services through a specialist team, by adopting a specialist-within-generalist-team approach. In this approach all clinicians are trained in the components of effective early intervention. In addition, two selected members of each clinical team are further trained as specialists in early intervention for psychosis to provide early intervention services and to assist other staff in the appropriate management of young people presenting with psychotic illness. Like other team members these specialists also carry out general clinical responsibilities.

While the SAFE program was an Area wide innovation, its day-to-day delivery was managed separately within three sectors that make up the Southern Area Health Service. It was the responsibility of the sector management to ensure that specialist clinicians were identified and in place, that staff attended ongoing training and made use of the academic outreach, supervision and other SAFE resources, and that effective administrative procedures were established. The three sectors were geographically distinct and involved different management teams and consequently different organisational structure, culture and climate.

This study examines whether the SAFE early intervention protocol, which adapted an efficacious early intervention model for implementation in a rural area, can be delivered as it was designed over a sustained period. It also aims to identify the factors that impact on the fidelity of SAFE implementation. Specifically, two questions about fidelity are examined: How sensitive are teams in detecting people who may benefit from early intervention for schizophrenia and other psychoses? And how well are early intervention practices implemented? The study

attempts to identify implementation obstacles by identifying who has done what well and which client and management factors influenced adherence to the SAFE program.

## **Method**

### ***Program components***

The SAFE program consists of:

- Training all staff in SAFE early intervention protocol and procedures based on EPPIC;
- Identifying two SAFE specialists within each team;
- Establishing an Area wide early intervention network;
- Producing and disseminating SAFE procedure manuals and resource materials;
- Supervisory outreach by early intervention specialist psychiatrist; and
- Ongoing early intervention in psychosis training and supervisory support to new staff from a local specialist.

The aim of the program was to deliver an early intervention protocol which facilitated the following recommended practices and procedures: client engagement, family engagement, general practitioner involvement, risk assessment, physical examination, psychiatrist review, taking a drug history, appropriate medication protocol, psycho-education for the client, psycho-education for the family, cognitive-behavioural therapy, relapse prevention, active follow-up, diagnostic testing such as electrolytes, erythrocyte sedimentation rate, full blood count, and outcomes measures such as the Scale for the Assessment of Negative Symptoms (SANS), British Psychiatric Rating Scale (BPRS) and Beck Depression Inventory (BDI).

### ***Measures***

The study involved a retrospective file audit 24 months after the SAFE program had been adopted in all sectors. An Area wide SAFE reference group consisting of all SAFE specialist clinicians, the senior clinician from each sector, an Area wide manager and academic support was formed. The reference group developed the SAFE File Audit checklist (available on request). The checklist included two sections; the first evaluated client demographic and clinical information at assessment and the second section

assessed file evidence of adherence to SAFE protocol practices and principles.

A concurrent survey of all clinicians (N=66) in the Area was also undertaken to assess the number of clinicians who had completed the SAFE training, the number in each professional category, self rated confidence in identifying an appropriate client and in effectively providing the components of the SAFE protocol, and self-reported utilization of outreach and local specialist supervision and support.

### ***Sampling***

One community-based clinical team from each sector was selected for the audit. Teams were matched in terms of client load so that about equal numbers of files from each site were audited. Together the three teams represented approximately 25% of the Area's community based workforce, carrying about 25% of its community-based workload. All files of people between the ages of 15 and 25 inclusive that were active at any time in the two years after the implementation of the SAFE program were reviewed.

### ***Procedure***

Three senior clinicians (Clinical Nurse Consultants, CNCs) who were trained in the SAFE early intervention protocol reviewed the file independently to identify whether the client met the criteria for suitability for the SAFE program. All three judges needed to agree on SAFE identification to consider the client as suitable for SAFE for the purposes of the file review. Consensus on cases where one or more judge was uncertain of the suitability of the client was determined by discussion. The files of clients identified by the judges as SAFE appropriate were subsequently reviewed by one of the CNCs using the audit checklist. The judge noted demographic information (age, gender) and clinical information (assessment diagnosis of schizophrenia or related psychotic disorder/other diagnosis/diagnosis deferred, length of contact with service) provided in the file. They also categorised the phase of illness (acute/prodromal) and its complexity (complex/not complex) based on the description of the client's symptoms at assessment, and noted the presence or absence of evidence of the SAFE protocol practices and procedures listed above.

## Results

### *Clinician survey results*

Responses to the survey of clinicians regarding their earlier intervention for psychosis practice were used to understand how the three teams differed. There was no difference between the teams in their mix of types of mental health professions. There were clear differences between the teams in the utilisation of the educational, supervisory and support structures provided by SAFE. A significantly larger proportion of Team 3 clinicians reported use of within-team specialist supervision (79% versus 42%,  $\chi^2 = 3.72$ ,  $p < .05$ ) and experience in management of SAFE clients (56% versus 30%,  $\chi^2 = 4.43$ ,  $p < .05$ ) than clinicians in the other two teams. There was also substantial but not significantly differing rates of completion of SAFE training (67% versus 50%,  $\chi^2 = 1.86$ , n.s.) and use of formal outreach supervision (43% versus 16%;  $\chi^2 = 2.00$ , n.s.) favouring Team 3 compared to the other teams. However, the confidence rating for use of various practices did not differ between Team 3 and the other teams although there was a trend for Team 3 to report higher levels of confidence in delivering psycho-education to the client ( $t(23) = 1.41$ ,  $p < .09$ ) and CBT ( $t(23) = 1.46$ ,  $p < .08$ ).

### *Audit results*

A total of 225 files were reviewed with about equal numbers from each of the three teams ( $n=70$ , 81 and 74 respectively). The three judges agreed for 77% of clients who they identified as potentially having a first episode psychotic disorder and for 91% of clients who they identified as not first episode. Of those where discussion was necessary 40% were considered suitable for the SAFE program.

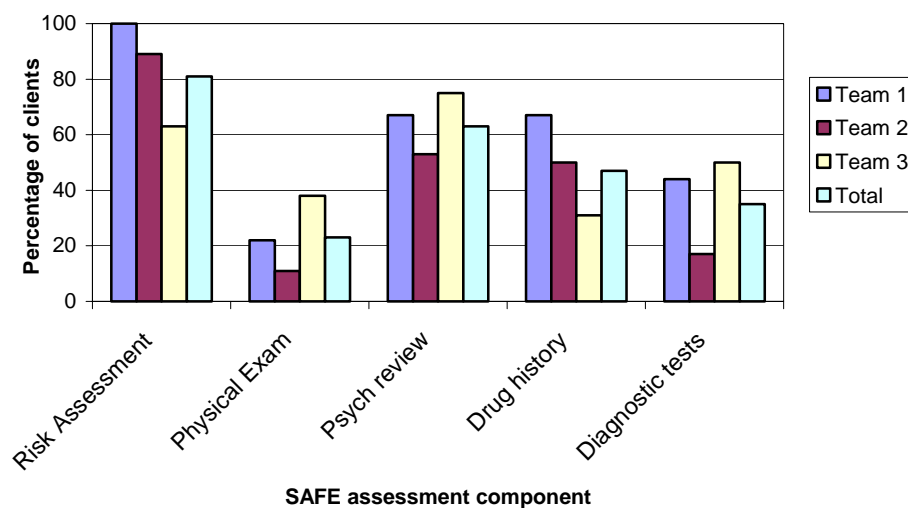
Forty three clients (28 males and 15 females) were identified as potentially first episode clients by the three CNCs. Ages ranged from 15 to 25 years (mean = 20.6, s.d. = 2.7). This rate represents a prevalence of 19 per one thousand in the 15 to 25 year age group of people presenting to a community mental health service. At assessment, 19 clients were diagnosed with a psychotic disorder, 15 with another diagnosis, and for 9 the diagnosis was missing. At presentation, 32 were in the acute phase and 11

in the prodromal phase of illness. Average length of contact was 25.7 weeks (s.d. = 33.9).

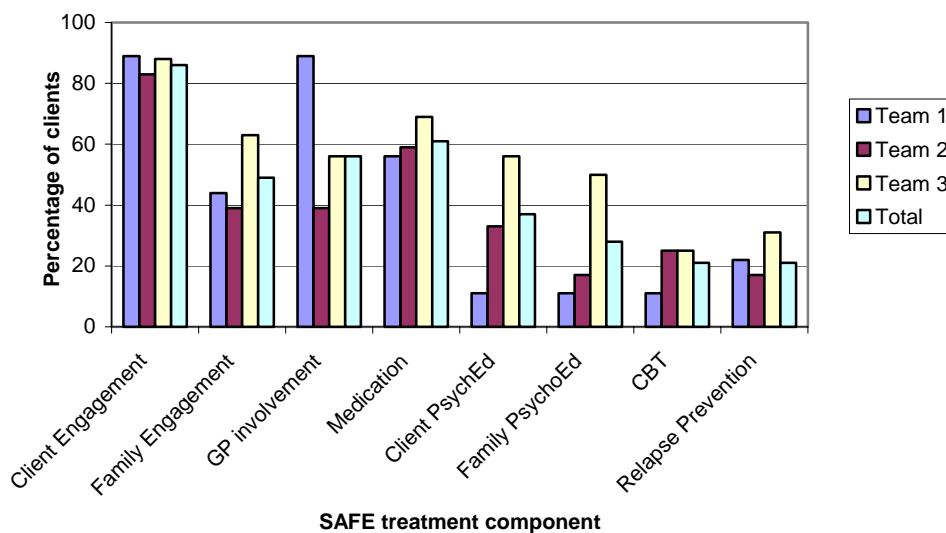
For 10 of the 43 files there was clear evidence that the clinician has identified the client as suitable for the SAFE protocol. The teams varied significantly in their sensitivity to detecting and registering a first episode client for the early intervention program (0/9 for Team 1, 1/18 for Team 2, 9/16 for Team 3,  $\chi^2 = 12.98$ ;  $p < .01$ ).

Figure 1 presents the percentage of files for each team and overall with evidence of the delivery or implementation of the early intervention assessment practices (Figure 1a) and early intervention treatment practices (Figure 1b). Overall, there was frequent provision of risk assessment (81%), psychiatrist review (63%) and appropriate medication protocol (61%) and evidence of engagement with client (86%) consistent with the SAFE early intervention practices. However, other SAFE components were delivered infrequently with rates of 23% for physical examination, 37% for client psycho-education, 28% for family psycho-education, 21% for cognitive-behavioural therapy and 21% for relapse prevention. The overall rates of use of outcome measures such as the BPRS, SANS and BDI ranged from 16% to 23%. Substantial variability was evident in the rates of delivery of various components between teams. There were significant differences between Teams 1 and 2 on GP involvement (89% versus 39%,  $\chi^2 = 6.02$ ;  $p < .05$ ), between Teams 2 and 3 on family psycho-education (17% versus 50%,  $\chi^2 = 4.3$ ;  $p < .05$ ), and between Teams 1 and 3 on risk assessment (100% versus 63%,  $\chi^2 = 4.44$ ;  $p < .05$ ), psycho-education with the client (11% versus 56%,  $\chi^2 = 4.89$ ;  $p < .05$ ) and the family (11% versus 50%,  $\chi^2 = 3.78$ ;  $p < .05$ ).

In order to examine which factors influenced adherence to the early intervention practices we first looked at which practices were significantly more frequent depending on client factors (assessment diagnosis, phase of illness) and management factors (team and registration on SAFE program). Table 1 lists the practices which significantly differed by diagnosis, phase of illness, and registration. Clients with a diagnosis of schizophrenia or related psychotic disorder were more likely to receive a psychiatrist's review, appropriate medication and diagnostic



(a) Percentage of clients with evidence of each SAFE assessment component



(b) Percentage of clients with evidence of each SAFE treatment component

**Figure 1. Percentage of clients overall and for each Team with evidence of the SAFE (a) assessment and (b) treatment components**

tests than those with deferred or other diagnosis. Clients judged by the CNCs to be in an acute phase were more likely to receive appropriate medication, a physical examination and diagnostic tests than those judged as prodromal. None of the other SAFE components differed according to diagnosis or phase of illness. Clients with evidence of registration on the SAFE program were particularly more likely

than client without such evidence to have their families engaged, have psycho-education for themselves and their family, receive CBT and have outcomes monitored and also were more likely to be engaged, have a psychiatrist’s review, have their GP involved, a physical examination, the appropriate medication regime and diagnostic tests.

**Table 1. Significantly differing practices by assessment diagnosis, phase and registration (p<.05 except \* where p<.01)**

<b>By Diagnosis</b>	<b>Psychotic disorder %</b>	<b>Other %</b>
Psychiatrist review	79	40
Medication Protocol	85	33
Diagnostic testing	42	20
Active follow-up	82	20
<b>By Phase</b>	<b>Acute %</b>	<b>Prodromal %</b>
Medication Protocol	74	27
Diagnostic testing	44	9
Physical exam	31	0
<b>By Registration</b>	<b>Registered %</b>	<b>Not registered %</b>
Client engagement	100	81
Family engagement	91	*34
GP involved	82	47
Physical Exam	46	16
Psychiatrist review	91	55
Medication Protocol	91	52
Psychoeduc'n - client	82	*22
Psychoeduc'n - family	64	*16
CBT	55	*10
Outcomes measures	63-81	*0-3

A total score on the delivery of the SAFE components was calculated by summing the occurrence of each practice (excluding relapse planning and active follow-up, both of which were highly dependent on the length of engagement with the service). This provided a total early intervention practice (TEIP) score ranging from 0 to 12 for each file. The bivariate correlations showed that TEIP was associated with age, diagnosis, and SAFE registration, but not with gender, phase, complexity and team. To investigate which of these interrelated variables had the most impact on early intervention practice, regression analyses were undertaken. Table 2 presents the results of these analyses and shows that together the complexity of illness, its phase, the gender and age of the client, and the treating team did not provide significant prediction of variability in TEIP ( $R^2 = .022$ ). Adding the client’s diagnosis did not significantly improve the total amount of variability in TEIP accounted for ( $R^2$  change = .139,  $F(1,19)$ , n.s.). However, registration on the SAFE program adds significantly and strongly to the prediction of TEIP ( $R^2$  change = .373,  $F(1,18) = 13.75$ ,  $p<.01$ ) once the

**Table 2. Regression analysis predicting total early intervention practice (TEIP) score from complexity, team, phase, gender, age, diagnosis, SAFE registration with unique contribution by (a) SAFE registration and (b) Diagnosis.**

**(a) Unique contribution of SAFE registration to prediction of TEIP score**

Model	R	R Square	Change Statistics				
			R Square Change	F Change	df1	df2	Sig. F Change
1	.144	.021	.021	.112	4	21	.977
2	.148	.022	.001	.020	1	20	.890
3	.373	.139	.117	2.592	1	19	.124
4	.716	.512	.373	13.747	1	18	.002

Model 1: complexity, team, phase, gender  
 Model 2: complexity, team, phase, gender, **age**  
 Model 3: complexity, team, phase, gender, age, **diagnosis**  
 Model 4: complexity, team, phase, gender, age, diagnosis, **SAFE registration**

**(b) Unique contribution of diagnosis to prediction of TEIP score**

Model	R	R Square	Change Statistics				
			R Square Change	F Change	df1	df2	Sig. F Change
1	.144	.021	.021	.112	4	21	.977
2	.148	.022	.001	.020	1	20	.890
3	.610	.372	.350	10.603	1	19	.004
4	.716	.512	.140	5.156	1	18	.036

Model 1: complexity, team, phase, gender  
 Model 2: complexity, team, phase, gender, **age**  
 Model 3: complexity, team, phase, gender, age, **SAFE registration**  
 Model 4: complexity, team, phase, gender, age, SAFE registration, **diagnosis**

effects of the other factors are taken into account (total  $R^2 = .512$ ). Diagnosis makes a unique but weaker contribution ( $R^2$  change = .14,  $F(1,18) = 5.16$ ,  $p < .05$ ) to the prediction of TEIP when the effects of the other factors including SAFE registration are considered.

Because of the strong impact of SAFE registration on predicting practice we lastly examined which factors were associated with being registered on the program. Clients seen by Team 3 were significantly more likely to be registered ( $\chi^2 = 12.9$ ,  $p < .01$ ) and there was a trend for the registration of younger clients ( $t(41) = 1.48$ ,  $p < .07$ ), but there were no associations with registration for diagnosis, severity, phase, or gender.

## Discussion

The results of the current study show that two years after the implementation of an early intervention program in a rural area there is considerable variability in how well delivery of the components of the program is sustained. Practices which vary most from standard clinical management such as psycho-education for the client and his or her family, relapse planning and monitoring of psychological outcomes, showed the lowest rates of sustained delivery while the more usual medical aspects of care were sustained at good rates. In addition, clinicians were accurately recognising 1 in 4 clients who might potentially benefit from early intervention.

These results are not out of keeping with other reports of transportability and sustainability of early intervention practices (Amenson & Liberman, 2001). What is important and unique in the current results is the finding that much higher rates of service delivery are obtainable in a rural practice context and that variability in outcomes for delivery of effective early intervention practices are associated with specific management and clinical factors. Importantly, in the current study management factors are most influential in accounting for this variability. Clients who were 'formally' registered for the program were substantially and significantly more likely to receive early intervention services than non-registered clients. In particular they were more likely to receive the non-standard practices such as psycho-education, family psycho-education, and outcome

monitoring. An early provisional diagnosis of schizophrenia or related psychotic disorder and younger age also predicted better early intervention practices for the more medically focused components.

In the current study, registration was related to a number of other indices that mark sustained use of the early intervention protocol, particularly maintenance of a trained workforce and use of educational and supervisory resources. Overall, these findings suggest that the practice of formal registration on the early intervention program within a generalist setting highlights both particular services for the client as well as a set of supported practices that become acceptable and expected by clinicians and management. In some respects this formal procedure may serve a similar function to having a dedicated specialist early intervention team to which identified clients are referred. The registration process activates or prompts the clinician to deliver specific practices and also directs them to use their training and to the various supervisory and support structures. In view of the relatively infrequent presentation of first episode clients in rural areas, it is crucial to have an administrative process like registration that orientates clinicians to available early intervention protocols, processes, resources and supports. Anecdotally, the early intervention process was further prompted and made visible by a vigorous and dedicated local champion and advocate for the program for Team 3. In addition, practices in this team seemed to be more generally organised to allow time for clinicians to deliver the time-intensive early intervention practices such as psycho-education. Overall, the current study indicates that the specialist-within-generalist-team approach can be an effective model of early intervention for psychosis in settings where dedicated specialist teams are not appropriate, provided that prominent service identification processes and advocacy to ensure the ongoing visibility of the program are in place.

There were a number of local implications from the current findings. Team 3's rates of identification of appropriate clients and its rates of delivery of program components provided achievable benchmarks for other teams in the area. Recommendations arising from the evaluation included adjusting the current

program to add a formal procedure such as registration as early as possible in the assessment process, enlisting local champions or advocates with clearly defined role and responsibilities, monitoring service delivery under the program throughout the Area, providing booster training for psycho-education and cognitive-behavioural therapy, and examining existing local work practice to allow more time to deliver early interventions components. An initial review of program fidelity (Welch & Garland, 2003) after applying these adjustments, using data from the routine monitoring put in place, suggests improvement in rates of delivery for program components across the area. For example, GP involvement increased from 56% to 94%, and psycho-education for families of clients from 28% to 95%. Whether these rates can be sustained over an extended period remains to be tested. The SAFE program approach ensures that sustainability data will continue to inform program adjustments.

From a wider perspective, the results suggest that sustainability of an efficacious early intervention program is achievable in rural areas. It also shows that successful dissemination of any modified program will involve the development of local service systems and procedures alongside structures for training, outreach supervision, local supervision and support for clinicians. The results reinforce Schoenwald and Hoagwood's (2001) argument that implementation of efficacious treatments needs to be evidence-based and that local data should both benchmark and inform alterations to important service and clinical factors to optimise the fidelity of treatment delivery.

The current results need to be considered within the context of the study's limitations. These include the exclusive use of file material to indicate practice adherence, the small number of identified clients, the lack of consideration of clients entering and exiting the service rapidly not allowing time for practice delivery, and its disregard for the clients' clinical outcomes. Future evaluation could also be extended to include possible changes over time to examine factors influencing loss of sustainability and other important management variables such as rates of staff turnover. Despite these limitations, the study represents an initial and valuable

attempt to examine the dissemination of an efficacious model of early intervention for psychosis in a real-life and challenging practice context. Overall, the results suggest that such a specialist-within-generalist-team model can be useful in a rural setting where dedicated early intervention for psychosis teams are not practical or cost effective. The study also demonstrates how an evidence-based approach to transporting and disseminating effective early intervention programs for psychosis might enhance and sustain the quality of service delivery.

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