

International experts‘ meeting

# General information

Date: 5 – 6/11/2018

Place: NÚDZ, Klecany

# programme

Current state of MHC reform in the Czech Republic

Introduction of the VIZDOM project

Structure of the training for EI teams

Target group of EI services

Early Detection strategies

Evaluation Design

Discussion

# programme

**Introduction of NIMH (PW)**

**Introduction of the guests**

**Current state of MHC reform in the Czech Republic (PW presentation)**

Process of getting funding from EU for bridging period could be inspirational for other countries

**Introduction of the VIZDOM project (LK presentation)**

Proper labelling of service

non-stigmatizing – part of youth centres, “mental health” teams

“social” vs. “medical” team

**ED vs. EI**

Early detection may be much bigger part of workload of teams -> careful about time balance of ED and EI -> splitting of ED and EI services can be the option, but continuity in personnel involved is crucial

Bigger role of psychiatrist and psychologist in early detection (diagnostics/assessment), although nurses and social workers can do screening, education and contacts with other stakeholders

Not all people in contact are eligible for EI service (90% estimate) -> need of services for these clients

**Training of teams (PŘ presentation)**

Training is focused more on FEP than UHR -> consider adding screening for UHR, evidence based intervention for UHR – CBT for UHR, needs based approach - family, communication, educational and employment support

Consider adding relapse prevention – education about triggers, warning signs, crisis plans, long-term self-management tools.

Supervision during the ED/ EI work is crucial

**Assessment**

Diagnostic interview is crucial, standardized tools are only part of it

UHR – criteria by Yung -> CAARMS (alternatively SIPS or BSIP = Basel Screening Instrument)

FEP - PANSS

Assessment could be stepwise -> a) Selfscreen Prodrome filled in by patient, b) short risk checklist for GPs, nurses, social workers, school psychologists etc. – e. g. Basel Risk Checklist or PG16 (it needs regular meetings with them), then c) screening psychiatrist/psychologist with BSIP (Basel Screening Instrument) or CAARMS or SIPS/SCPS

PANSS 6 (short version for 15 minutes); inter-scorer reliability needs to be discussed

There is need for supervision – someone with clinical experience for supervision of UHR, otherwise assessment could be only instrumental

**Target group**

**FEP x UHR**

FEP and UHR should be considered separately – UHR is less specific, FEP does not contain functional criterion (social decline should be included only for UHR)

But it is necessary to be inclusive at the beginning – calling the service “Early intervention for mental health”, screen people and consider who can benefit from the EI service – it is cherrypicking, but possibly the best solution

**Age**

Work with older people is different, but almost 15% (10% of men and 20% of women) diagnosed with F2 get first diagnosed after age 40. It was strongly recommended to provide support to population up to 60 years of age.

Time in care

People taken into the service should be no more than 3 years in previous treatment for psychosis.

But in the beginning there will be people with *years* of problems but without any contact to services before

**Definition of DUP**

Simple but accurate definition is crucial both for work of teams and research, e.g. “first appearance of a psychotic symptom until first contact with specialised service” assed with the BSIP, Basel Screening Interview for Psychosis (Riecher-Rössler et al. 2008) or SKID interview (psychosis modul), , assessing history of clients via structured interview

But assessment shouldn’t be time consuming – months of DUP as reasonable precision

To define DUI (duration of untreated illness) good estimate is just question: “When did you start feeling different?” (see Basel Instrument for Psychosis, BIP, Riecher-Rössler et al. 2015) with life scale with life events (marriage, end of school,…) – there is a version for clients and and a version for relatives.

In Norway reporting DUP is mandatory for all services – designated people going through client reports

If reporting DUP would be mandatory for all services in Czech Republic with financial incentive, there may be problem with validity -> raising awareness about importance of proper DUP assessment

**Substance use**

Excluded only when problems are associated only with substance usage (but it needs careful consideration) -> Consensus with perspective of Czech expert board, as discussed before

For sure people using cannabis alongside with their mental health problems have to be included.

**Diagnoses**

FEP: Criteria for transition to psychosis according to Yung et al. 1998 are fulfilled (assessment either with BSIP or with CAARMS or SPIPS

UHR: Criteria according to Yung et al. 1998 are fulfilled (assessment either with BSIP or with CAARMS or SPIPS/SCPS

**Early detection strategies**

Consider also focus on general population - radio, newspapers, brochures – more as anti-stigma campaign (mental illness is like any other illness), raising awareness in communities – stalls in malls, presentations in community centres (among minorities)

**GPs and other stakeholders**

Repeated information and personal meetings for GPs, building reputation and trust is (was) gradual process in every country

Education of other stakeholders is crucial, it depends on system – who is the first contact for people with problems (schools, other educational systems for young people, GPs, private psychiatrists,…)

Pharma companies sometimes organize education – they hope they can sell medication

Normalization of mental health is behind cooperation with GPs – antistigma campaign; labelling the team “mental health team” instead of “EI team”

**Evaluation design**

Control regions - FEP patients in control regions in various facilities (hospitals, community mental health centres) can be actively engaged by research team– but this activity itself actually reduce DUP as well

Permanent/current residency is problematic: only people with permanent residency in catchment area could be included – but providing support would not be restricted

Consider including client satisfaction by interviews and focus groups, although it could be strongly culturally dependent. It could be empowering for clients as well

Feedback about research results for teams and patients is very important

Collecting data can be burden for “front line” workers, but It must be seen as necessary part of the service - highly functioning teams are usually interested in measures, for their own feedback and improvement

1. Pre-post design (DUP at the beginning of ED provision x DUP at the end of the project)
2. DUP in health care registers
3. CMHC in 3 regions as a control group

**Medication**

Strong recommendation that medication should be prescribed by team psychiatrist, prescription negotiation is part of the relationship with client -> EI as medical service, pushing clients to social care seems strange when social problems are not the main/underlying problems.

Dependent also on the system – in GP driven systems they can prescribe medication. But fragmentation of services can be difficult for clients themselves

**Early medication**

CBT, psychosocial interventions, family therapy groups, fish oil, techniques for stress reduction, or anxiolytics rather than antipsychotics

But it is very different in UHR and FEP –> careful regular look on transition signs -> clinician decides if person can cope without medication

**General Discussion (following international board meeting)**

Registration of medical service is necessary – need to negotiate it again

Considering the Implementation of CBT for early intervention into the training

Inclusion of self management into the training.

Considering also pretest/posttest design of the evaluation – DUP among clients at the beginning of the service provision vs. at the end when the service is established

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