

International experts‘ meeting

# General information

Date: 13 – 14/11/2018

Place: NÚDZ, Klecany

# programme

**Wednesday. November 13th, 2019**

10 – 12 am Opening

* Summary of project activities
* EI target group

1 – 4 pm Presentations of 3 EI teams

* Early Detection strategies
* Early Intervention for people with an at-risk mental state (ARMS)
* Case reports

**Thursday. November 14th, 2019**

10 – 12 am Evaluation Design

* Cohort study of DUP
* Micro-costing study

1 – 3 pm Sustainability

* EI in the context of MHC reform
* Discussion

# programme

**Opening. Introduction of the participants**

**Summary of the VIZDOM project activities**

ED/EI training

* There are specificities in FEP and ARMS groups, therefore specialised sections in ED activities for both groups should be a part of the training (ARR)
* Targeted ED activities for people with ARMS should be introduced within the training (with a focus on GPs, internet, screening instruments) (ARR)
* Important to distinguish between ED and EI phase, do ED carefully before EI and unify ED and EI processes across teams (ARR)
* Crucial is to define who is the target group for detection (public or professionals such as GPs) (RJ)
* In Switzerland, there are two separate teams: ED team is located in the hospital and EI team in the community – there is still stigma connected with hospital environment -> ED team is now located in community
* ED is not simply transferable from abroad, and they have to be region-specific (OA & ARR). In the Czech Republic, it is not possible to do big media info campaigns before there are sufficient services. We have to build services first (MP). PW: It is complicated dilemma
* How to work with private psychiatrists -> explain that we don’t want to take their clients but to cooperate with them (ARR)
* Psychiatry is generally influenced by big stigma, destigmatization activities: TV, radio and newspaper ads (i. e. stories of clients of ED/EI services); also leading self-help groups and intervening among minorities and specific communities (non-white people in the UK) (OA & RJ)

**EI as a registered health/social service**

* ED/EI services are not currently registered as health and/or social services (ED/EI services are provided to clients based on an informed consent)
* For the sustainability of ED/EI services in the country, the clients’ perspective must be known (should be included in the QL evaluation of project activities)
* Dis/advantages of running the service as research project – prescription of drugs (-), lower stigma (+)

**EI service and target group – PŘ**

Affective psychosis

* Denmark: today specialized team for this target group, however, at the first stage of an implementation of ED/EI were affective psychoses not eligible to receive the service
* London: eligible only when showing clearly psychotic symptoms

**Position of psychiatrist - SM**

* Discussion about incidence of FEP among women: there is second peak around age 40 -> attention should not be paid to young population only (ARR & MN)
* In Switzerland, there is a good experience with contacting outpatient psychiatrists - most of the contacts come from outpatient psychiatrists, not from GPs. ED/EI team Blansko has better experience with GPs as referrals. Recommendation to cooperate with pharmacological companies which organise symposia for GPs and private psychiatrists (ARR)
* Current multicentric studies show that fish oil (omega3acids) doesn’t work (MN)

Case studies – SM

**Position of psychologist – TD**

ARR: diagnosis as continuum psychosis – at risk – no risk X differential diagnostics revealing causes of psychosis

* Discussion about the screening instruments:
	+ CAARMS is long, in Switzerland is used BSIP (ARR); CAARMS is clear (OA)
	+ PANSS-6 – if only the 6-item version is used, then it is necessary to think carefully about them (MN)
	+ PANSS-6 is too brief for diagnosis, CAARMS should be dome as soon as possible – and then, according to the CAARMS category, the specific intervention should be provided
* Cognitive behavioural therapy
	+ May not be used for every client, but all team members should know at least basics of CBT (MN), in ED/EI team Prague is CBT usually used to motivate people that they are referred to another service (TD)
	+ Meta-analysis of effect CBT and needs-based therapy (psychotherapy is no better than needs-based therapy) (NM & ARR)
	+ Recommendation to use CBT elements rather than psychodynamic (we are not interested to find the cause of an illness)
	+ Analytical approach should NEVER be done with FEP/ARMS
* Crucial feature of an EI team is to support roles of clients (ARR)

**Detection strategies in schools – MR**

* Schools know lecturers (MR) personally, thanks to the previous cooperation on the project focusing on supported education.
* 3 forms of workshop – all-day/2hours/according to the needs of schools
* 2 lecturers – lecturer-presenter & person for f2f consultations
* Aim is to keep students with MH problems within education system
* Some schools want closer cooperation, but the team cannot do the job of school psychologist
* Difficulties with clients who do not belong into target group (students usually do not fulfil the region criteria)
* Some students do not need psychiatrists or specialized care of the team, psychoeducation provided within workshop is sufficient
* Students embrace when there is service for them, screening is not stigmatizing, but also normalizing the problems (ARR)
* Topics – how much to disclose in school about their MH problems, dealing with stigma

**Case studies**

Pilsen – Petr Lejčko

* Health experts necessary for detection – assessment of neurological basis of the problems is crucial (ARR)
* Miro Pastucha – ED/EI teams cannot prescribe medication, but the client does not have good relationship with health system
* Putting symptoms into timeline is good for diagnostics (DUP) (RJ)

Blansko

How to tell diagnosis to client and family? Using word “schizophrenia”? Telling the whole family? Using word “psychosis”, but carefully explain that antipsychotics could help to lower the symptoms the client experiences – clients tend to look for information online.

* “Do not believe the information on the internet, these are old (…). It is unfair that you feel like that but there are ways to deal with it. (…) You are master, you will decide what to do.” (ARR)
* Focus on client’s needs and wishes, never involve parents without previous confirmation of the client (ARR)

**Closing discussion**

Fish oil has no effect (doi:10.1001/jamapsychiatry.2016.2902)

Meta-analysis of EI services (doi: 10.1001/jamapsychiatry.2018.0623)

There should be guidelines for GPs focused on EI (ARR)

**Evaluation design**

Highlander

Consider implementation of categories of interventions (CBT, family interventions,…)

* Categorization of intervention types and proper reporting will help to create a fidelity of the service
* Training what intervention is what is needed (education x having a coffee together with a client)
* Multiple choice is possible (e.g. CBT + family therapy)
* Recommendation to create a checklist of what has been done)
* Psychological assessment may be done at each meeting with a client, does not have to be reported every time

Differentiate ED and EI services

* Recommendation to add the date of transition of ARMS to FEP (according to foreign experience, this may take 3 or more years to transition)

**Cohort study of DUP**

* IRAOS is the golden standard, but it is very long – it is possible to derive criteria from it (MN)
* Consensus on cut-off is crucial – how severe symptoms do we observe?
* 4 on PANSS may be higher than 6 on CAARMS -> same PANSS items as we use (criteria derived from Yung)
* Recommendation to use PANSS items with Young’s criteria (the highest criteria)
* Link the presence of symptoms to significant events (Christmas, graduation,…) – easier to remember (MN)
* Study design
	+ TIPS – ED year before collecting data about DUP (similar to our plan)
	+ Private psychiatrists do not have catchment areas, but we asked also psychiatrists from neighbouring regions (ARR)
	+ At the beginning EI is more expensive that TAU – 1 year follow up is short (OA)
	+ Relevant sociodemographic criteria of the region – wealth, employment rate, age structure, education structure, and average income (MN); these criteria can be also controlled statistically (OA); propensity score matching (MN)
	+ The proposed design is quasi-experimental, as we don’t have same control groups (MN)
	+ Similar proportions of control regions according to demographic variables. Considering demographic variables (education level, immigration rate) rather than services, in selection of the region.
* Meta-analysis about DUP prevention (doi: 10.1016/j.schres.2013.07.004) (MN)

**Discussion**

* Private psychiatrists often use less stigmatizing diagnoses (neurotic, personality disorders,…)
* Using CAARMS criteria for assessing DUP – as a retrospective measure
* We need precise criteria and cut-off for assessing DUP – is one psychotic symptom the beginning of psychosis?
* Average DUP is 4 years
* Distinguishing between DUP and DUI (untreated illness) (ARR)

Risk of the design:

* Private psychiatrists do not have catchment areas
* GDPR
* Permanent residency is not the actual one
* People from various regions in psychiatric hospitals

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

* Challenges: education of young psychiatrists, which does not cover new services -> internships abroad (program for young doctors primarily from Commonwealth countries, but it could be accessible for Czech doctors as well) (OA), these people may become local leaders in ED/EI
* Medical students should go in ED/EI research for a year or so (observing x doing clinical work)
* Choose Psychiatry Campaign in the UK focusing on recruitment of psychiatrists to clinical setting and research ([link](https://www.rcpsych.ac.uk/become-a-psychiatrist/choose-psychiatry/choose-psychiatry))
* Experts from WHO as consulting experts (MN)
* In Denmark and Norway new services have been established gradually – pilot projects first, than national guidelines and plans (MN & RJ)
* It is better to have EI services separate from service for chronic patients – in community buildings etc.
* Good practice – mutual meetings of ARMS and FEP clients – they can recognize severity of the problems (ARR)

**EI teams as a part of wards in general hospitals**

* General hospital (psychiatric wards) allows differential diagnosis (including neuro monitoring)
* 26 psychiatric wards in general hospitals in the Czech Republic, university hospitals could be more opened to change
* Sustainability of EI team Blansko? The closest psychiatric ward is in Brno, services should be “under one roof”
* UK – ED/EI is a part of health care, efficient when its health-social service, ED services in university hospitals, which are open to new approaches
* Crisis beds at ED/EI department (in Switzerland up to 4 nights)
* In Switzerland staff in psychiatric hospitals is very conservative -> EI teams as part of general hospitals
* Division of health and social care does not work (because of bureaucracy etc.), in the UK, the social work is funded by social budget, but via health budget (OA)
* Celebrities and politicians can be ambassadors in promotion of mental health care reform (OA & ARR)
* In terms of sustainability is a key factor to determine who is going to pay for the services (insurance companies?)
* Higher attachment to medical system is desirable (recommendation to start negotiations with insurance companies)

**Other suggestions**

* At the next meeting, one day for lecturing for ED/EI teams (morning ED by ARR, afternoon EI by MN) – update about current state of art, recommendations, guideline
* Education video for EI guidelines from the USA (NAVIGATE & RAISE) (MN)

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