

International experts‘ meeting

# General information

**Date:** 19. 10. 2021, 1:00 - 4:30 pm

**Place:** Online

**Participants:** Merete Nordentoft, Anita Riecher-Rössler, Robert Leon Jørgensen, Petr Winkler, Lucie Kondrátová, Ondřej Krupčík, Hana Tomášková, Marie Kuklová, Pavel Říčan

# programme

**Updates on the project activities**

**Quantitative evaluation** (preliminary findings, evaluation design)

**Qualitative evaluation and fidelity assessment** (preliminary findings)

**EI teams’ sustainability** (discussion)

# Basic information about THE VIZDOM PROJECT

**VIZDOM project – statistics**

* The overall number of clients supported by ED/EI teams (since April 2019): 484/600 clients, 273/200 family members, 629 detection contacts
* The number of new clients hasn´t increased during COVID-19.
* In last 6 months, the number of family members coming to the service has increased

*Discussion*

**Dropout index**: Half of the clients did not want to continue the collaboration for the following reasons: involuntary hospitalization, stigma in the family etc. Although the proportion of clients who dropped out for these listed reasons was small, it is still important to pay attention to this phenomenon. The following steps can be undertaken to lower the overall dropout rate:

* Investigate whether the team has sufficient skills.
* Adjust the intensity of contact with each client to his needs (i.e. the frequency of contact may be lowered in case the client´s overall mental state and well-being are improving). Low-risk clients may have the tendency to drop out in case the ED/EI team contacts them regularly. It is thus important to investigate the severity of the symptoms that the client is exhibiting.
* Observe the severity of the symptoms in those clients who did not provide the ED/EI teams with their informed consent (IC). These recommendations will be mentioned in the program manual.

**Data collection is possible only for clients who signed the IC**

* Anonymous clients: Many clients who contacted the ED/EI teams did not sign the informed consent as result of their paranoia etc. Hence, it was not possible to collect data from these clients. Services were provided to them for approximately 2 months – enabled the researchers to collect data from them.

**Caseload:**

* 3 FTEs per team (3 teams in total = 9 FTEs) – the caseload is 1:4 (4 clients to 1 FTE). The caseload is low. The informed consent can be a serious barrier for some of the clients. The same applies to high rate of stigma in the country.
* The teams’ members have capacity for new clients, detection activities and dissemination. Opposite situation is in Denmark – there are a lot of new clients.

**How to make the the EI service more attractive?**

* Clear status of the team. EI teams operation within the project are not under social system, nor health system (limitation of the project).
* Organize workshops for institutions and psychiatrists who work in the region, establish collaboration with them. In the project, we contacted psychiatrist individually and tried to explain them what the EI service offers. In Switzerland, all doctors (GPs) are closed off on Friday afternoon at this time education programs they get some credits for may be offered to them. Dissemination at professional symposia; advanced education; interactive worskhops.

**Recognize the barriers**

* Internal barriers: it may be the case that the clients are in other community services, but they may not be referred to the early intervention services. This is mainly the case for DUP.
* External barriers: The problem could also be caused by high rate of stigma. Another explanation is to do with the development and implementation of other community mental health services (i.e. Community Mental Health Centres). This suggests that many potential clients could end up in the Community Mental Health Centres. However, if the ED/EI teams become a part of the Community Mental Health Centres, the teams may lose their special focus.
* The future ED/EI teams should focus more on referral sources.

# Evaluation

**PRE-POST DESIGN**

* Pre-post design is based on an internal database that contains data on: provided services (by category) and client information (socdem and clinical data)
* Clinical assessment (PANSS, GAF, HoNOS, AQoL, CSRI) is administered every six months after entering the service
* N decreases due to dropout and incompleteness (missing values, short time in service)

*Discussion*

* **Dropout analysis**: Is there a systematic difference between those who completed the second measurement compared to those who only completed the first measurement? The research team will look into the baseline values.

**COHORT DESIGN**

* Based on national health registers (register of provided health services). Cases (EI clients) will be followed in registers based on their unique ID, control groups will be selected based on the pre-defined criteria.
* Outcomes: inpatient days, consumption of mental health services, overall functioning, quality of life
* Limitations: low number of cases (approx. 25) with a permission to search the register

*Discussion*

* Evaluation of “at risk” mental state group (forms a small group). Do a separate qualitative study with this target group.
* Cohort design will be focused on those treated for psychosis for first time; the cohort will be divided into three branches. (1) ED/EI clients; (2) Community mental health centre’s clients; (3) patients in outpatient care
* propensity score matching (PSM) recommended

# Project Evaluation: Qualitative Analysis

**Introduction**

* 3 sets of interviews were conducted with: ED/EI teams, Stakeholders, and Clients

**ED/EI teams**

* Data collection: 3 focus groups conducted, each included three team members
* Data analysis: Open coding (2 coders)
* Main results:
	+ Challenging collaboration with health professionals (i.e. psychiatrists or GPs), useful and effective collaboration with schools and community services.
	+ Suggestions for the implementation of other services (i.e. group psychoeducation for children and adolescents) or diagnosis methods (i.e. differential diagnosis) within the FEP program.
	+ Evaluation of the team structure (e.g. benefits: multidisciplinarity, limitations: small team).
	+ Utility and feasibility of the use of questionnaires in practice.
		- Advantages of using the questionnaires in practice (e.g. help to map the client´s situation)
		- Limitations of using the questionnaires in practice (e.g. difficulty in scheduling the initial assessment because of the client´s poor mental state).

*Discussion*

* **Differential diagnosis**.
	+ Instrument for comorbidities (i.e. depression, addiction, autism). It is important that we diagnose emerging psychosis with the instruments.
	+ The research team decided to include both affective and non-affective psychotic disorders. The research team needs to find out what the proportion of clients with affective psychotic disorders is.
	+ It would be ideal to investigate the following: Substance abuse, depression or autism.
	+ The following instrument should be considered: Present State Examination.

**STAKEHOLDERS**

* Data collection: 23 semi-structured interviews conducted
* Data analysis: Open coding (2 coders)
* Main results:
	+ Case studies during which ED/EI teams assisted with providing direct care to clients (e.g. assisting a client with delusions).
	+ The positive effect of the teams´ existence on the stakeholders´ workload (e.g. help to diagnose clients exhibiting symptoms of mental illness and find relevant service provider).
	+ Advantages of the service provision by the teams (e.g. not based in psychiatric institutions, less stigmatising for the clients, flexibility in where the initial meeting is held, collaboration with schools).
	+ Recommendations regarding the provision of services (e.g. increase team members´ FTE, expand the personnel by hiring members of different expertise).
	+ Recommendations regarding establishing collaboration with other stakeholders (e.g. establish collaboration with larger institutions and police. Target stakeholders through their professional societies (e.g. Czech-Moravian Psychological Society) and compulsory seminars (e.g. Institute of Postgraduate Medical Education).

*Discussion*

* A strategy towards the general public peers. The experts suggested to have a more public appeal. This would generate more clients.

# Fidelity ASSESSMENT

**Introduction to FEPS-FS 1.0**

* FEPS-FS scale is used to assess the degree to which First Episode Psychosis Services (FEPS) deliver evidence-based practices.
* Consists of 35 components, 5-point Likert scale
* Results
* 17-23/35 components were rated as not implemented depending on the team (components measuring the delivery of evidence-based psychosocial services – component 28.)
* 12-18/35 components were rated as satisfactory (varied across the teams). (components measuring structural and pharmacological aspects – component 20.)
* Areas for improvement were identified

*Discussion*

1. What is your experience with measuring fidelity in ED/EI teams?
* MN finds the use of fidelity scales useful. Fidelity assessments improved the quality of early intervention services.
1. What is the adequate frequency of fidelity measurement?
	* A short version of the fidelity assessment will be conducted by the research team in early 2022.
2. Is measuring fidelity associated with the financing of the service?
	* In majority of cases, the program developers initiated such response to protect the services.

# Sustainability

**ED/EI teams sustainability**

* **What did we manage to negotiate?**
	+ EI recognised as a health service (codes used for mental health centres)
	+ Specific scales (such as DUP and CAARMS) recognised as a health service code in the reimbursement system
	+ Majority of current clients may continue to use ED/EI services after the end of the pilot project
		- Pilsen: EI as an independent subteam of CMHC
		- Blansko: EI as a subteam of youth outreach team
* **What are the challenges?**
	+ Hesitancy to support implementation of specialised services at the time when the network of general MH services is underdeveloped
	+ Motivation of (health) professionals to enter community teams
	+ Financing a psychiatrist in a community outreach team (social service)
	+ Financing non-health workers in health services and vice versa
	+ Direct access to medical devices (EEG, MRI, PET)
	+ Prague-team sustainability

*Discussion*

* It is important for psychiatrist to be a part of each ED/EI team – necessary for differential diagnosis, prescription of medication etc.
* Future of psychiatric institutions: Specialised teams that can visit the clients hospitalised in psychiatric hospitals.
* **What are the next steps?**
	+ Specific scales (such as DUP and CAARMS) involved in the system of reimbursement (now included in the register without being reimbursed)
	+ Continuous training for ED/EI teams
	+ Provision of support to new teams being developed

**Invitation to the international workshop on ED/EI services in CZ** – June / May in Prague

Recorded by: Marie Kuklová and Hana Tomášková