

International expert workshop 2022

# General information

Date: 1.-2.6.2022

Place: Online: Webex, YouTube:

<https://www.youtube.com/playlist?list=PLfyvhRW-nhdZB9FjYxG1d-WbDU6Eojrxv>

Braunův dům (Karlovo nám. 671/24, Nové Město, Prague 1)

# Participants

In person: 30

Webex: 35

YouTube: 40

# AGENDA

**Wednesday: June 1st, 2022**

9:00-17:00

* Welcome and introduction (9:00-9:45)
* VIZDOM project: Experiences, evaluation & sustainability (9:45-13:00)
* Implementation of ED/EI teams in Switzerland (13:45-14:45)
  + Development and implementation of the first early detection and intervention service in Switzerland
* Implementation of ED/EI teams in Denmark (14:45-15:45)
  + Early intervention services in Denmark – from research to practice
* Implementation of ED/EI teams in England (16:00-17:00)
  + Implementation of ED/EI teams in psychosis teams in England

**Thursday: June 2nd, 2022**

8:30-13:30

* Implementation of ED/EI teams in Canada (8:30-9:30)
  + First Episode Psychosis Services Fidelity Scale: Improving Quality and Outcome of Patient Care
* Implementation of ED/EI teams in France (9:30-10:30)
  + Implementing early intervention and early vocational recovery services within an already existing psychiatric health care system: the greater Lyon experience
* Implementation of ED/EI teams in Norway (10:45-11:45)
  + Shared experiences from an early detection and early intervention team in Norway
* Implementation of ED/EI teams in Latvia (11:45-12:45)
  + Good things take time: The experience and ongoing process of implementing early intervention program for patients in first episode psychosis in Latvia

# SUMMARY

**DAY 1.**

**Session 1.**

**VIZDOM project: Experiences, evaluation & sustainability**

Objectives of the project:

* Analysis of Czech and international experiences with the early detection (ED) and early intervention (EI) services
* Development of training in ED and EI based on best international practice
* 3 specialized multidisciplinary teams trained in providing ED and EI services
* Provide ED and EI services to 600 people in 3 regions in Czechia under regular supervision and sharing of experiences among the teams

Project goals:

* Improve the quality of life of people in early stages of serious mental ilness by implementing ED/EI teams in three regions
* Continuously monitor and evaluate activities during the project (2018–2022)
* Based on the acquired experiences, formulate recommendations in order to support the development and implementation of future ED/EI services in Czechia as part of the mental health reform

Networking and promotion strategy:

* Leaflet, articles (e.g. newspapers; magazines)
* Online advertisements (e.g. Google Ads)
* Direct contact with stakeholders in target regions (e.g. mental health care services; social care; educational system; authorities)

Clients: Inclusion criteria

* Age (i.e. 16-60 years old)
* Defined target region
* Diagnosis:
  + ARMS
  + First episode psychosis (F2)
  + Clients treated for psychosis for no more than 3 years

Clients: Exclusion criteria

* Clients with addiction to drugs who are referred to other specialised services
* Clients in treatment who are not enrolled in any specialised service
* Clients with organic disorder – psychosis is not their primary concern

Screening tools

* **PANSS–6 = P**ositive **A**nd **N**egative **S**yndrome **S**cale **6**
* **CAARMS-B = C**omprehensive **A**ssessment of **A**t **R**isk **M**ental **S**tate (brief version)
* **DUP** = **D**uration of **U**ntreated **P**sychosis screening tool

Evaluation of the VIZDOM project

* The following factors are measured:
  + Improvements in Global and social **functioning** of the clients; **Quality of life** of the clients; Level of **symptoms**; **SES**
  + Reduction in the number of **bed days (i. e. psychiatric hospital)**
* Evaluation tools: **GAF** (Global Assessment of Functioning Scale); **HoNOS** (Health of the Nation Outcome Scales); **PANSS-6** (Positive and Negative Syndrome Scale); **AQoL** (The Assessment of Quality of Life); **CSRI** (Client Service Recipient Inventory); **CAARMS-B; DUP tool**
* Results:
  + **531 clients**, **302 family members** and **979** networking contacst was supported
  + significant improvement in **domains of functioning**, **mental health-related problems**, **symptoms** and hosp. days from 6-months perspective
  + about **80 % reduction** of hosp. days
  + about **63 % of clients in FEP** were detected within 6 months
  + cost effectiveness analysis will be performed within the next few months

Fidelity assessment

* Fidelity assessment in the VIZDOM project:
  + First Episode Psychosis Fidelity Scale (FEPS-FS 1.0) was used
  + 2 trials (1st trial was conducted in November of 2020; 2nd trial was conducted in January of 2022)
  + No significant differences between trial 1. and trial 2.
* Areas for improvement:
  + The position of a team leader was not fixed (component 1.)
    - Further development: **Include clinical psychologists or psychiatrists**
  + Members of FEP teams do not provide services (e.g. substance use management, CBT) that they are not trained for (components 3. and 24.)
    - Further development: **Provide the FEP team access to relevant training or ensure a collaboration with specialised mental health services**
  + Low incidence rate compared to the expected annual incidence (component 9.)
    - Further development: **Establish collaboration with specialised mental health services within each region**
  + Over 80% of the clients were hospitalized prior to being accepted to the FEP program (component 13.)
    - Further development: Important to engage in activities that promote **destigmatisation and increase mental health literacy (MHL) in the general population.**
  + Limited provision of psychoeducation (component 23.)
    - Further development: Only one-on-one sessions were provided. **Train the teams in providing group psychoeducation**.
  + SE specialist nor SEd specialist were a part of the team (components 28. and 29.)
    - Further development: **Expand the team by hiring other professionals** specialised in different fields
  + Insufficient collaboration with crisis intervention services (component 32.)
    - Further development: **Increase the number of crisis intervention services across Czechia**
* Conclusion:
  + **Differences** in implementation were identified across the ED/EI teams
  + Fidelity assessment can ensure the **provision of high-quality services** and contribute to the **expansion of the early intervention services** in Czechia

Sustainability of the ED/EI teams: Pilsen

* ED/EI team as part of MHC:
  + **Target group** (no changes)
    - Age 16+
    - Served region – Pilsen
  + **Team of EI specialists:**
    - **Psychiatrist** (before attestation) with permission to do treatment
    - **General nurse** (in qualification education to be psychiatric nurse)
    - **Psychologist** without permission to do psychology medical treatment (insufficient education) – actually „social worker“
  + **Organization within the team:**
    - EI specialists
    - Meeting once a week with MHC team manager
    - EI clients
  + **More:**
    - Detection activities are done by the entire team

Sustainability of the ED/EI teams: Blansko

* **Blanensko** – some former membersstayed in the team – implementation of the know-how in other community services (e.g. use of assessment tools; detection activities)

**Session 2.**

**Implementation of ED/EI teams in Switzerland**

**Development and implementation of the first early detection and intervention service in Switzerland**

* Implementing a service for early detection of emerging psychosis
  + First ED/EI team was implemented in 1999 in Basil, Switzerland
    - The aim was to provide the clients a service that´s:
      * easy to access
      * containts specialized staff
      * oriented towards the clients´ needs
    - The public and stakeholders were informed through campaigns (e.g. talks, workshops, interviews)
      * Informed about the mental illness (e.g. signs) and its consequences if left untreated
  + Assessment tools are used to screen for the illness (e.g. risk checklist for psychoses)
    - * General psychiatric interview with the client is the first step in stepwise assessment. This is followed by the administration of the following tools: CAARMS; BSIP; SIPS/SOPS. If the client is at risk, additional assessments are conducted using mode detailed clinical interview; EEG; MRI and neurocognitive assessments.

**Implementation of ED/EI teams in Denmark**

**Early intervention services in Denmark: from research to practice**

* The Danish OPUS trial:
  + A two-site randomised clinical trial of assertive specialised psychiatric treatment
  + There was a five- and ten-year follow-up
* The OPUS team consists of 8-12 members:
  + Psychiatrist
  + Psychiatric nurse
  + Psychologist
  + Social worker
  + Occupational therapist
* Specialised assertive intervention:
  + Assertive Community Treatment
    - (staff: patient ratio1:12)
  + Psychoeducational multi family groups
  + Social skills training and other group programs
* The OPUS program has specialized activities for families that´s based on the McFarlanes model for psychoeducational multi-family groups.
  + The multi-family group consists of:
    - 4 - 6 clients and their relatives
    - The group meets for 1½ years
    - The group meets every second week for 1½- hour meetings
* Early intervention services proved to be cost-effective
* OPUS treatment can prevent relapses
  + The clients preferred OPUS program for 5 years
    - Fewer clients dropped out of of the program
* Other therapies that are currently being tested:
  + Avatar Terapi using VR
    - A psychotherapeutic intervention during which the clients can have a therapist supported dialogue with the dominant voice.
    - VR enables to make the experience immersive and thus, less artificial.

**Implementation of ED/EI teams in England**

**Implementation of ED/EI teams in psychosis teams in England**

* In total, there are 154 early intervention teams in psychosis.
  + Emerged through IRIS network: Initiative to reduce the impact of schizophrenia (1998)
  + The National Service framework emerged in 1999 along with a policy implementation guide in 2001
* Cost-effectiveness analysis: The early intervention services are cheaper in the long run. Clients spent less time hospitalised in psychiatric hospital.
* Tools used to track effectiveness of the program:
  + EIP triangulation tool – access and waits
  + EIP triangulation tool – NCAP audit

**Day 2.**

**Session 1.**

**Implementation of ED/EI teams in Canada**

**First Episode Psychosis Services Fidelity Scale: Improving Quality and Outcome of Patient Care**

* FEPS-FS: Identifies core components of an evidence-based program or intervention that assess structure and process. The scale:
  + Provides a list of objective criteria by which a program or intervention is judged to adhere to a reference standard for the intervention
  + Assesses fidelity to best practises, delivered by a team that provides treatment and care for clients with a first episode of psychosis
    - Process:20 items describe specific clinical components
    - Structure: 15 team items describe team form and function
* The scale was developed using knowledge synthesis principles
* It comprises:
  + A standardized set of components that are measured on a 5-point Likert scale (1-3 = poor fidelity; 4 = adequate fidelity; 5 = full fidelity)
  + Each assessed by a quality indicator
  + On a scale of 1- 5
  + A manual that supports reliable and valid assessments (i.e. First Episode Psychosis Services Fidelity Scale and Manual)
  + Supports comparison between programs and health systems
  + Has implicit standards which can be used in a variety ways

**Implementation of ED/EI teams in France**

**Implementing early intervention and early vocational recovery services:   
the greater Lyon experience**

* Mapping:
  + 1) Logic Model of the problem
    - Correlation between DUP and clinical outcomes, hospital treatment, and social functioning.
  + 2) Program outcomes
    - The following outcomes were considered: CBT for psychosis, physical health assessments, family interventions, wellbeing support, medication (i.e Clozapine), carer focused education & support, and education & employment support (NICE, 2016)
  + 3) Program design
    - Inspired by the Australian Early Psychosis Model (EPPIC)
  + 4) Program production (modules adapted to the context)
    - Core components from the EPPIC model were implemented.
  + 5) Program implementation
  + 6) Evaluation plan
* Team structure:
  + Head of service : psychiatrist (part time)
  + 4 Part time psychiatrists
  + 1 Team manager
  + 1 advanced practice registered nurse
  + 15 Case managers
  + Peer worker
  + Psychologist, neuropsychologist
  + Secretary
  + Clinical research assistant
  + Collaboration with the psychiatric rehabilitation unit consisting of 30 professionals
* Services provided by the team:
  + Intensive case management
  + Psychoeducation
  + Family intervention
  + Social skills
* Each client is provided an individualized recovery plan consisting of:
  + Psychotherapy
  + Peer support
  + Cognitive remediation (group & individual sessions)
  + Psychoeducation for substance use, physical activity and job coaching

**Implementation of ED/EI teams in Norway**

**Shared experiences from an early detection and early intervention team in Norway**

* TIPS project emerged in 1997
  + Norway; Rogaland + Ullevåll sector Oslo/Roskilde Danmark
  + Population 665 000
  + age 18-65
  + FE non-affective psychosis;F20-F29 ICD-10
* The information strategy was multi-focal (e.g. Ads; articles; interviews; brochures in community health centres)
* Positive effects (5 year follow-up):
  + DUP was significantly shorter
  + Less negative symptoms at 1 year follow-up
  + Less negative, depressive and cognitive symptoms
  + Lower levels of suicidality (4% vs 17% suicidal ideation and plans; 1% vs 10% suicide attempts)
* Positive effects (10 year follow-up):
  + Significantly more recovered patients in early detection area
  + More patients with full-time employment
  + No difference in positive, negative, depressive, and cognitive symptom levels

**Implementation of ED/EI teams in Latvia**

**Good things take time: The experience and ongoing process of implementing early intervention program for patients in first episode psychosis in Latvia**

* Timeline of LAT-EIP
  + 2016 - Research was done on the duration of untreated psychosis in Latvia
  + 2017 - Latvian Early intervention program was implemented
  + 2018 – First clients enrolled in the program
  + 2019 - LAT-EIP was included in the National Algorithms on first episode and schizophrenia treatment
  + 2020 – Follow-up data analyses
  + 2021 - Collaboration with Ministry of Health was established. The LAT-AIP will become a service funded by the government
* Team structure:
  + Case manager (case load up to 17)
  + Psychiatrist
  + Psychiatric visits
  + Psychoeducation
  + Psychologist
  + Acceptance and commitment therapy (ACT)
  + Social worker
  + Employment specialist
* Results:
  + Dropout rate: 79,4 % of patients finished the programme
  + Readmission: 7,4% (LAT-EIP) were readmitted (historical cohort = 36,1%)
  + Disability: 7,4% (LAT-EIP) were labeled with a mental illness (historical cohort = 34,4%)
  + Costs: There were no extra costs for implementing this programme- all resources came from reorganizing existing hospital funds and staff.

# OTHER

Recorded by: Hana Tomášková