Assertive Outreach and Treatment: A European Agenda

Prof. dr. J. van Os
Caring for mentally ill people

Jim van Os, Jan Neeleman

Despite legislation to harmonise mental health practice throughout Europe and convergence in systems of training there remains an extraordinary diversity in psychiatric practice in Europe. Approaches to tackling substance misuse vary among nations; statistics on psychiatric morbidity are affected by different approaches to diagnosis and treatment of psychiatric disorders; attitudes towards mental illness show definite international differences. Everywhere, though, mental health care for patients with psychotic illnesses is a “cinderella service,” and there is a general move towards care falling increasingly on the family and the community.

Box 2—Mental illness programmes in Europe

WHO/ EURO: strategies for reducing suicidal behaviour: multicentre study on parasuicide and collaboration in developing preventive programmes on suicide

WHO/ EURO: the development of model approaches to stress management in the community to assist high risk groups such as migrants and displaced persons

EC Handicapped People in the European Community Living Independently in an Open Society (HELIOS): organised cooperation in the field of vocational re-
The European AO Situation
Evolving Knowledge

Context Effects vs "Neglect as usual":

- Symptomatic recovery
- Social recovery
- Personal recovery

Responder Subgroups
Evolving Knowledge: “Neglect as Usual” Effect

Cochrane Database 2000:
Currently, for those with schizophrenia willing to receive CBT, access to this treatment approach is associated with a substantially reduced risk of relapse.

Cochrane Database 2004:
Currently, trial-based data supporting the wide use of CBT for people with schizophrenia or other psychotic illnesses are far from conclusive. More trials are justified, especially in comparison with a lower grade supportive approach.

Cochrane Database 2011:
Trial-based evidence suggests no clear and convincing advantage for cognitive behavioural therapy over other and sometimes much less sophisticated therapies for people with schizophrenia.
Intensive CM for severe mental illness

“It is not clear.....what gain ICM provides on top of a less formal non-ICM approach”.

Cochrane review, Dieterich et al, 2010
Antidepressant Drug Effects and Depression Severity
A Patient-Level Meta-analysis

Jay C. Fournier, MA
Robert J. DeRubeis, PhD
Steven D. Hollon, PhD

Context: Antidepressant medications represent the best established treatment for major depressive disorder, but there is little evidence that they have a specific pharmacological effect relative to pill placebo for patients with less severe depression.
Service Context: Assertive Outreach and Bed Use

Bed Use

- Pioneering trials, Institutionalised SC
- Recent trials, Community based SC

AO
SC
Are we asking the right questions?
What Patients Want..........

“I want to be able to do things that other people do, like have a boyfriend and a job …”

Vocational functioning

“I want to have friends”

Social functioning

“I want to be able to cook and eat when I want”

Life skills

“I want to live in my own place not a hostel”

Independent living

“I want to be a person, not a diagnosis”

Personal recovery
What the AO “Model” Wants (IFACT)

- Staff/patient ratio
- Team size
- Psychiatrist, and nurse on team
- Team is primary service provider
- Own office
- Shared case load
- Daily team meetings
- Team leader sees patients
- 24 hour coverage
- Time unlimited services
- In vivo contacts
- Low % office contacts
- Number of contacts / month

Job
Friends
Skills
Independence
Participation
AO Dimensions

Admission prevention

Crisis management, medication-based symptom reduction

Team organisation

Social Participation

Empowerment and Social participation

Treatment content

?
AO vs. Standard Care (LEO): Uptake of Interventions

Craig et al, BMJ, 2004

The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis

Tom K J Craig, Philippa Garety, Paddy Power, Nikola Rahaman, Susannah Colbert, Miriam Fornells-Ambrojo and Graham Dunn
Public Mental Health Model – or not?

Country A

Rolls Royce vs. NAU

Population AO Need

Non-AO 1

Non-AO 2

Non-AO 3

Non-AO 4

Assertive Outreach

Country B

Replacing NAU

Certified for form AND content (CCAF)
## FACT in the Netherlands

<table>
<thead>
<tr>
<th>Case Load</th>
<th>FACT (NL)</th>
<th>AO (UK practice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Team Case Load</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>In Vivo Contact</td>
<td>80%</td>
<td>33%</td>
</tr>
<tr>
<td>Assertive</td>
<td>yes</td>
<td>to a certain extent</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>100%</td>
<td>50 - 64%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>100%</td>
<td>20 - 50%</td>
</tr>
<tr>
<td>Integrated Health/Social Care</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Vocational, SA Specialist</td>
<td>100%</td>
<td>0 - 10%</td>
</tr>
<tr>
<td>Specific Treatment (voc rehab, subst abuse, CBT, etc.)</td>
<td>yes (moderately implemented)</td>
<td>no</td>
</tr>
<tr>
<td>Research Focus</td>
<td>functioning</td>
<td>hospital use</td>
</tr>
<tr>
<td>Team Work, Shared Caseload</td>
<td>yes</td>
<td>yes</td>
</tr>
</tbody>
</table>

### Assertive Community Treatment in the Netherlands: Outcome and Model Fidelity

Maaike D van Vugt, MSc¹; Hans Kroon, PhD²; Philippe A E G Delespaun, PhD³; Fred G Dreef, MD⁴; Annet Nugter, PhD⁵; Bert-Jan Roosenschoon, MSc⁶; Jaap van Weegh, PhD⁷; Jeroen B Zoeteman, MD⁴; Cornelis L Mulder, MD, PhD⁸
(F)ACT Evaluated by Psychiatric Case Registers in the Netherlands

“Traditional” ACT

Function-ACT

MN, Utrecht

Rijnmond Rotterdam,

Marjan Dukker, later today
(F)ACT in the Netherlands: Traditional Outcomes

- More outpatient contacts
- More continuity of care
- Rise in costs
- Cost effectiveness not yet demonstrated

Drukker et al, in preparation
The cumulative needs for care monitor: a unique monitoring system in the south of the Netherlands

Marjan Drukker · Maarten Bak · Joost à Campo · Ger Driessen · Jim Van Os · Philippe Delespaul
Remission: higher with Assertive Outreach?

Pre-assertive outreach
1998–2001

No remission

19%
probability

Remission

OR=2.21 (1.03 – 4.78)

Post-assertive outreach
2002–2005

No remission

31%
probability

Remission

Bak M et al. SSPE 2007
FACT and Treatment Uptake

Drukker et al, in preparation
AO Dimensions

“Admission Prevention”

Crisis management, medication-based symptom reduction

Team organisation

Social Participation

Empowerment and Social participation

Treatment content
Values & Concepts Underlying Treatment

ENVIRONMENT AND SCHIZOPHRENIA

Stigmatization as an Environmental Risk in Schizophrenia: A User Perspective

Catherine van Zelst¹,²

¹²Department of Psychiatry and Neuropsychology, South Limburg Mental Health Research and Teaching Network, EURON, Maastricht University Medical Centre, 6200 MD Maastricht, The Netherlands

public stigma, self-stigma, and label avoidance⁷—may have profoundly defeating consequences for the individual with a psychotic disorder.⁸–¹¹ Ritsher and Phelan¹² suggest that the harmful effects of stigma may work through the internal perceptions, beliefs, and emotions of the stigmatized person, even above and beyond the effects of direct discrimi-
Victimization Stigmatization Cycle

Victimisation → Self-stigma → Care dependence

Van Zelst et al, 2009
### Trauma and Psychosis

Varese & Smeets et al, submitted

#### Table

<table>
<thead>
<tr>
<th>Study ID</th>
<th>Odds Ratio (95% CI)</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCHORT STUDY (prospective)</td>
<td></td>
<td></td>
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<tr>
<td>Arsenault et al, 2010</td>
<td>3.65 (2.65, 5.50)</td>
<td>4.64</td>
</tr>
<tr>
<td>Cutler et al, 2011</td>
<td>2.10 (1.40, 3.15)</td>
<td>4.72</td>
</tr>
<tr>
<td>Janssen et al, 2004</td>
<td>13.00 (2.70, 65.67)</td>
<td>2.01</td>
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<tr>
<td>Molkenyo et al, 1996</td>
<td>1.25 (0.59, 2.72)</td>
<td>3.33</td>
</tr>
<tr>
<td>Schreier et al, 2003</td>
<td>1.54 (1.54, 2.44)</td>
<td>6.28</td>
</tr>
<tr>
<td>Sprouwen et al, 2006</td>
<td>2.19 (1.00, 4.30)</td>
<td>3.30</td>
</tr>
<tr>
<td>Subtotal (I-squared = 74.0%, p = 0.002)</td>
<td>2.52 (1.89, 3.76)</td>
<td>23.49</td>
</tr>
<tr>
<td>EPIDEMIOLOGICAL (cross-sectional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bebbington et al, 2011</td>
<td>2.74 (1.40, 5.36)</td>
<td>3.71</td>
</tr>
<tr>
<td>Harvey et al, 2010</td>
<td>5.20 (1.80, 16.00)</td>
<td>2.18</td>
</tr>
<tr>
<td>Kim &amp; Kim, 2005</td>
<td>2.76 (1.74, 4.36)</td>
<td>4.51</td>
</tr>
<tr>
<td>Ross &amp; Joshi, 1992</td>
<td>0.61 (4.51, 20.47)</td>
<td>3.40</td>
</tr>
<tr>
<td>Shevin et al, 2008</td>
<td>4.53 (2.45, 8.39)</td>
<td>3.92</td>
</tr>
<tr>
<td>Shevin et al, 2010</td>
<td>2.79 (2.10, 3.72)</td>
<td>5.13</td>
</tr>
<tr>
<td>Whittington et al, 2005</td>
<td>1.86 (1.45, 2.36)</td>
<td>5.23</td>
</tr>
<tr>
<td>Subtotal (I-squared = 74.1%, p = 0.001)</td>
<td>3.28 (2.28, 4.70)</td>
<td>28.07</td>
</tr>
<tr>
<td>CASE-CONTROL STUDY</td>
<td></td>
<td></td>
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<tr>
<td>Agid et al, 1999</td>
<td>3.05 (1.52, 5.94)</td>
<td>2.14</td>
</tr>
<tr>
<td>Cohen et al, 2011</td>
<td>3.08 (1.57, 6.12)</td>
<td>4.69</td>
</tr>
<tr>
<td>Conroy et al, 1995 (female)</td>
<td>1.71 (0.52, 5.65)</td>
<td>2.14</td>
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<tr>
<td>Conroy et al, 1995 (male)</td>
<td>1.40 (0.45, 4.37)</td>
<td>2.27</td>
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<tr>
<td>Dastman et al, 2011</td>
<td>3.08 (1.89, 5.02)</td>
<td>4.41</td>
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<tr>
<td>Dell’Eba et al, 2003</td>
<td>4.14 (1.49, 11.47)</td>
<td>2.57</td>
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<tr>
<td>Evans, 2011</td>
<td>4.40 (1.89, 11.44)</td>
<td>2.75</td>
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<tr>
<td>Fisher et al, 2010</td>
<td>1.57 (1.06, 2.33)</td>
<td>4.76</td>
</tr>
<tr>
<td>Friedman &amp; Harrison, 1984</td>
<td>3.76 (1.72, 8.35)</td>
<td>1.27</td>
</tr>
<tr>
<td>Furukawa et al, 1996</td>
<td>0.22 (0.10, 0.47)</td>
<td>3.41</td>
</tr>
<tr>
<td>Giblin et al, 2004</td>
<td>3.20 (0.49, 20.81)</td>
<td>1.13</td>
</tr>
<tr>
<td>Heins et al, 2011</td>
<td>4.35 (1.79, 9.26)</td>
<td>4.58</td>
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<tr>
<td>Husted et al, 2010</td>
<td>2.66 (1.08, 6.37)</td>
<td>3.04</td>
</tr>
<tr>
<td>Rubino et al, 2009</td>
<td>8.57 (3.88, 19.20)</td>
<td>3.64</td>
</tr>
<tr>
<td>Varese et al, 2011</td>
<td>8.12 (2.92, 22.53)</td>
<td>2.57</td>
</tr>
<tr>
<td>Weber et al, 2003</td>
<td>3.44 (1.77, 6.64)</td>
<td>2.86</td>
</tr>
<tr>
<td>Subtotal (I-squared = 79.5%, p = 0.000)</td>
<td>2.71 (1.78, 4.41)</td>
<td>48.84</td>
</tr>
<tr>
<td>Overall (I-squared = 76.1%, p = 0.000)</td>
<td>2.81 (2.25, 3.14)</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**NOTE:** Weights are from random effects analysis.
(Family) Stereotype Awareness

DCS = Devaluation of Consumers Scale
DCFS = Devaluation of Consumers Families Scale

van Zelst et al, in preparation
Randomized Controlled Trial: Psycho-education coping skills training vs. Newspaper reading group

Goal: Evaluating the effectiveness of a new psycho-education coping skills training

Sample: People in FACT with one or more psychotic episodes, age 18-65. (N=140)

Evaluation: Baseline, post-treatment & follow-up

Outcome variables: Quality of life, social functioning and care needs

van Zelst et al, in preparation
Existential Recovery:
User-run Recovery Programmes

\[ P \leq P \]

PEOPLE SUPPORTING PEOPLE
Dutch National RCT of User-run Recovery Program

Early Starters (status: no TREE)  
N = 81

Present at baseline  
N = 163

Late Starters group (status: no TREE)  
N = 82

Early Starters (status: TREE)  
N = 67

Follow-up at 12m (T1)  
N = 139

Late Starters group (status: no TREE)  
N = 72

Early Starters (status: TREE)  
N = 59

Follow-up at 24m (T2) completed

Late Starters (status: TREE)  
N = 64

Boevink, Kroon, van Vugt, Delespaul, van Os, submitted
TREETREE (HEE): Toward Recovery, Empowerment and Experiential Expertise

- Fortnightly recovery self-help working groups (1 year)
- A one-day ‘recovery’ training course
- Training course *Starting with Recovery*

Run by renumerated experts by experience
User-run Recovery Programme

Boevink, Kroon, van Vugt, Delespaul, van Os, submitted
Psychiatric Rehabilitation: Evidence?

**Intervention Protocol**

Rehabilitation programmes for schizophrenia

Samer Makhoul¹, Clive E Adams², Vijender Balain³

Editorial Group: Cochrane Schizophrenia Group

Published Online: 17 MAR 2010

Assessed as up-to-date: 4 MAY 2008

DOI: 10.1002/14651858.CD007301

Copyright © 2010 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
Dutch National RCT of the Boston Psychiatric Rehabilitation approach

- 423 Patients Informed
- 267 Patients excluded
- 156 Randomly allocated
  - PR (n=80)
  - CC (n=76)

Swildens, van Busschbach, Michon, Kroon, Koeter, Wiersma & van Os, in press
**Boston Psychiatric Rehabilitation Approach**

- **Diagnosis:** helping patients gain insight into their future goals in the rehabilitation areas of work/study, social contacts and living environment, and into the skills and resources needed to attain these goals

- **Planning:** describing the necessary interventions, such as skill training and resource coordination

- **Intervention:** carrying out these interventions

Swildens, van Busschbach, Michon, Kroon, Koeter, Wiersma & van Os, in press
Psychiatric Rehabilitation (PR) vs Control Condition (CC)

NNT=5

Obtained Goal

Societal Participation

Living Independently

Proportion

0%

12 months 24 months

Swildens, van Busschbach, Michon, Kroon, Koeter, Wiersma & van Os, in press
Mobile Self-management: Situated Therapeutics

Philippe Delespaul, Inez Myin-Germeys, Marieke Wichers
Core Vulnerability/Resilience Targets

Illness episode 1

Major life stress

Illness episode 2

Reward reactivity

Stress-reactivity

Van Os et al, Nature, 2010
Psymate Person-Context Interactions

ESM procedure

Day 1 | Day 2 | Day 3 | Day 4 | Day 5

7.30

beep beep beep beep beep beep beep beep beep beep beep beep beep beep

22.30

A single ESM day

Ik voel me

Enthousiast

Helemaal niet

1 2 3 4 5 6 7

Emotional response

Daily life context

(Un)pleasant situation

Assessment of daily life person-context interactions
From Implicit to Explicit

Implicit  →  Explicit

affect

Environment

Lancet, 2011
Linking Affect and Psychosis

Psychosis

Mood

Motivation

Reward

Negative affect

Stress

Paranoia

Anxiety

Time
Studying Paranoia Episodes

Episode = uninterrupted series of occurrence of paranoia $\geq 3$

Thewissen et al. Br J Clin Psych 2010
Paranoia in daily life: onset of episode

n=155

Anxiety
Down
Anger
Self-esteem

Medication Side Effects

Emotional Experience and Estimates of D₂ Receptor Occupancy in Psychotic Patients Treated With Haloperidol, Risperidone, or Olanzapine: An Experience Sampling Study

Johan Lataster, MSc; Jim van Os, MD, PhD; Lieuwe de Haan, MD, PhD; Viviane Thewissen, PhD; Maarten Bak, MD, PhD; Tineke Lataster, PhD; Mariëlle Lardinois, PhD; Philippe A. E. G. Delespaul, PhD; and Inez Myin-Germeys, PhD
Mindfulness Training Increases Momentary Positive Emotions and Reward Experience in Adults Vulnerable to Depression: A Randomized Controlled Trial

Nicole Geschwind, Frenk Peeters, and Marjan Drukker
Maastricht University Medical Centre

Jim van Os
Maastricht University Medical Centre and King’s College
London

Marieke Wichers
Maastricht University Medical Centre
A Focus on Resilience

Momentary PA transfer

PA (t) → PA (t+1)

90 min

beep

PA → PA

beep

PA → PA

90 min

beep

PA → PA

beep

PA → PA
Reward Cycle: Negative symptoms

Experience of positive affect

Incentive

Motivation

Reward-directed behaviour

Wichers et al, in press
AO Dimensions: not one without the other

“Admission Prevention”

Crisis management, medication-based symptom reduction

Team organisation

Social Participation

Empowerment and Social participation

Treatment content

?
Fin
How Does Altered Mood Induce Psychosis?

Ingrid Kramer et al, Psychol Med, 2011
During a paranoid episode

Thewissen et al. Br J Clin Psych 2010
Web-based Feedback: From Implicit to Explicit

Implicit → Explicit

Salience

Environment
ESM: Measures of Affect

- **Intensity**
- **Psychiatry**

![Graph showing measures of affect over time](image-url)
ESM Time Relationships

Anxiety

Paranoia
ESM Time Relationships

Paranoia

Anxiety

Time
# ACT and FACT in the Netherlands

<table>
<thead>
<tr>
<th>ACT (35)</th>
<th>FACT (130)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT intensive care</td>
<td>ACT intensive + Individual extended</td>
</tr>
<tr>
<td>20% most severely affected</td>
<td>Entire SMI population in area</td>
</tr>
<tr>
<td>100 patients / team</td>
<td>220-250 patients / team</td>
</tr>
<tr>
<td>Caseload 1:10</td>
<td>Caseload 1:20</td>
</tr>
<tr>
<td>Psychiatrist 1/100</td>
<td>Psychiatrist 1/200</td>
</tr>
<tr>
<td>Psychologist: not required</td>
<td>Psychologist: 0.8/200</td>
</tr>
<tr>
<td>Job Coach /Expert by Exp: no</td>
<td>Expert by experience: 0.8/200</td>
</tr>
<tr>
<td>All patients daily discussed</td>
<td>20%-30% daily discussed</td>
</tr>
<tr>
<td>Contact frequency 3-4x / week</td>
<td>If required up to 4x / week possible</td>
</tr>
<tr>
<td>Job Coach: not required</td>
<td>Job Coach: 0.6/200</td>
</tr>
</tbody>
</table>
Prevalence Mental Disorders – 20%
Capacity Mental Health Services – 4% population
No clear demarcation between “common mental disorder” and “severe mental illness”
Assertive Outreach needed by many

How to Introduce Assertive Outreach?
The relationship between neurocognition and social cognition with functional outcomes in schizophrenia: A meta-analysis

Anne-Kathrin J. Fett\textsuperscript{a,c,d}, Wolfgang Viechtbauer\textsuperscript{b}, Maria-de-Gracia Dominguez\textsuperscript{a}, David L. Penn\textsuperscript{e}, Jim van Os\textsuperscript{a,d}, Lydia Krabbendam\textsuperscript{c,d,*}

\textsuperscript{a} Department of Psychiatry and Neuropsychology, School of Mental Health and Neuroscience, Maastricht University, Maastricht, The Netherlands
\textsuperscript{b} Department of Methodology and Statistics, School for Public Health and Primary Care, Maastricht University, Maastricht, The Netherlands
\textsuperscript{c} Centre for Brain & Learning, Faculty of Psychology and Education, VU University Amsterdam, Amsterdam, The Netherlands
\textsuperscript{d} Department of Psychosis Studies, Institute of Psychiatry, London, United Kingdom
\textsuperscript{e} Department of Psychology, University of North Carolina Chapel Hill, United States
## Social Cognition Predicts Community Functioning

<table>
<thead>
<tr>
<th>Social cognitive domain</th>
<th>Neurocognitive domain</th>
<th>$k$</th>
<th>Diff</th>
<th>$P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory of mind</td>
<td>Reasoning &amp; problem solving</td>
<td>19</td>
<td>0.32</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Processing speed</td>
<td>9</td>
<td>0.24</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>Attention &amp; vigilance</td>
<td>12</td>
<td>0.36</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>Working memory</td>
<td>10</td>
<td>0.29</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>Verbal learning &amp; memory</td>
<td>19</td>
<td>0.24</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>Visual learning &amp; memory</td>
<td>8</td>
<td>0.31</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>Verbal comprehension</td>
<td>4</td>
<td>0.31</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Verbal fluency</td>
<td>9</td>
<td>0.19</td>
<td>0.20</td>
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<tr>
<td></td>
<td>Overall neurocognition</td>
<td>11</td>
<td>0.24</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Fett et al, Neuroscience and Biobehavioral Reviews, 2010
Non-hierarchical goals

Personal recovery

Symptomatic recovery

Social recovery
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Assertive community treatment teams&lt;sup&gt;16&lt;/sup&gt;</th>
<th>Community mental health teams&lt;sup&gt;17&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total team case load</td>
<td>80 to 100</td>
<td>300 to 350</td>
</tr>
<tr>
<td>Maximum individual case load</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>Availability</td>
<td>Extended hours (0800 to 2000 every day)</td>
<td>Office hours only (0900 to 1700 Mon-Fri)</td>
</tr>
<tr>
<td>Locations for appointments</td>
<td>Not office based (“in vivo”): meet client at home, in cafes, parks, etc</td>
<td>Office based appointments and home visits</td>
</tr>
<tr>
<td>Contact with clients</td>
<td>Assertive engagement: multiple attempts, flexible and various approaches (for example, befriending, offering practical support, leisure activities)</td>
<td>Offer appointments at office or make home visits</td>
</tr>
<tr>
<td>Commitment to care</td>
<td>“No drop-out” policy: continue to try to engage in long term care</td>
<td>Discharge if unable to make or maintain contact</td>
</tr>
<tr>
<td>Case work style</td>
<td>Team approach—all team members work with all clients</td>
<td>Case management—little “sharing” of work with clients between team members</td>
</tr>
<tr>
<td>Frequency of team meetings</td>
<td>Frequent (up to daily) to discuss clients and daily plans</td>
<td>Weekly</td>
</tr>
<tr>
<td>Source of skills</td>
<td>Team rather than outside agencies as far as possible</td>
<td>“Brokerage”: referral to outside agencies for advice (for example, social security benefits, housing)</td>
</tr>
</tbody>
</table>
D-STIGMI: Study design

Questionnaires & interviews
Optional: PsyMate (ESM)

Intervention:
Psycho-education or
Newspaper reading group

10 weekly sessions of 1-1.5 hours

Questionnaires & interviews

2 months after intervention

Questionnaires & interviews
Optional: PsyMate (ESM)

van Zelst et al, in preparation
D-STIGMI: Feasibility

- **Inclusion**: People have to commit themselves to the study for 5-6 months, including the intervention of 10 weeks.

- **Expectations**: Depending on the type of intervention people will actively learn how to cope with stigma (Psycho-education) or other skills (Newspaper reading group), while they may be interested in learning the first.

- **Logistics**: Enough trainers (both health care professionals and experts by experience), resources, time and locations needed.

- There is **enthusiasm and acknowledgement of the need** for attention for stigma, from participants, trainers and mental health professionals.
AO and Outcomes

Increased treatment exposure

AO

? 

Personal recovery

Symptomatic recovery

Social recovery
Are Treatments Available?
“It is not clear…..what gain ICM provides on top of a less formal non-ICM approach. We do not think that more trials comparing current ICM with standard care are justified, but currently we know of no review comparing non-ICM with standard care.”

Satisfaction
Continuity of care

Cochrane review, Dieterich et al, 2010
Cognitive Enhancement Therapy for Schizophrenia

Effects of a 2-Year Randomized Trial on Cognition and Behavior

Gerard E. Hogarty, MSW; Samuel Flesher, PhD; Richard Ulrich, MS; Mary Carter, PhD; Deborah Greenwald, PhD; Michael Pogue-Geile, PhD; Matcheri Kechavan, MD; Susan Cooley, MSN; Ann Louise DiBarry, MSN; Ann Garrett, PhD; Haranath Parepally, MD; Rebecca Zoretich, MSEd

Arch Gen Psychiatry, 2004
Plasticity: Cognitive Remediation

Hogarty GE et al. Arch Gen Psychiatry 2004;61:866-76.
Psychiatric beds - Western Europe

Psychiatric hospital beds per 100000

Source: WHO
Assertive Outreach Early Intervention

“There is some support....but further trials would be desirable, and there is a question of whether gains are maintained.”

Cochrane Review, Marshall & Rathbone, 2011
Where There Is No Data……

RCT

Rest of Life

Onset

Death

Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies

P. Cuijpers¹,²*, T. Donker¹,², A. van Straten¹,², J. Li³ and G. Andersson⁴,⁵

¹ Department of Clinical Psychology, VU University Amsterdam, The Netherlands
² EMGO Institute for Health and Care Research, VU University Amsterdam and VU University Medical Center, The Netherlands
³ Institute of Psychology, Chinese Academy of Sciences, Beijing, People’s Republic of China
⁴ Department of Behavioural Sciences and Learning, Swedish Institute for Disability Research, Linköping University, Sweden
⁵ Department of Clinical Neuroscience, Psychiatry Section, Karolinska Institutet, Stockholm, Sweden
Treatment Psychosis

Lataster et al, 2011

- Psychosis
- Negative Affect
- Positive Affect

Mean ESM Likert-Scores (range 0-7)

- before treatment switch to aripiprazole
- 1-2 weeks after treatment switch to aripiprazole
ESM Time Relationships

Time

PA

Activity

Time
ESM Time Relationships

Company X

NA
ESM Time Relationships

Self-esteem

Psychosis

Time
Momentary Approaches GxE: Environmentally Reactive Phenotypes

Year 1 | Year 2 | Year 3 | Year 4

Stress

Hour 1 | Hour 2 | Hour 3 | Hour 4
“PsyMate”: Experience Sampling Method

www.PsyMate.eu
Situated Therapy

- Patient makes own diagnosis
- Patient assesses change
- Implicit (dysfunctional) patterns of experience made explicit
- Learning about experience in reaction to daily life circumstances
MindMaastricht RCT

Sample: 130 participants with residual symptoms of depression, not currently depressed

6 days Experience Sampling

Mindfulness Training

Control

6 days Experience Sampling

FU 6 months
FU 12 months

"Inoculation" by Physical Exercise: Within-Study Replication Twin Design

Twin sample: n=504 (252 complete pairs)

(Wichers, Peeters, Lothman, Simons et al, in press)
Situated Therapeutics
Self-Management
Somatic Outcomes: AP Monitor

Bak et al, submitted

Met.Syndr.

DM-II

Men

Women

Met.Syndr. DM-II

Men

Women

BELANGRIJK!

- stuur dit formulier in en stuur de bloeddrukwaarden laterin
- stuur met dit formulier ook een ingevuld Zorgmonitor interview mee

Ingevuld: stuur naar Maria Van Duijl, PM 3/370; Postbus 6230 3700 AF Maasbracht; AP+1@CMCM 2006
Patients do not attribute satisfaction with services to somatic outcomes

Delespaul et al, submitted
Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials

D. Lynch¹, K. R. Laws² and P. J. McKenna³,⁴*  
¹ Stobhill Hospital, Glasgow, UK  
² School of Psychology, University of Hertfordshire, Hatfield, UK  
³ Benito Menni CASM, Barcelona, Spain  
⁴ CIBERSAM, Spain
Genome-wide association study identifies five new schizophrenia loci

The Schizophrenia Psychiatric Genome-Wide Association Study (GWAS) Consortium¹
Recovery: Illness plasticity
(illness changeability in response to treatment)


15-year follow-up of first episodes
2 out of 3 had relapse

15-year follow-up

% Response after each relapse
Van Os & Kapur, Lancet, 2009
Plasticity: Hippocampal Volume and Aerobic Exercise

There is more to treatment than symptoms

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<th>Patients who worked at least 1 day (%)</th>
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IPS = Individual Placement & Support

Burns et al, Lancet, 2007