



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.

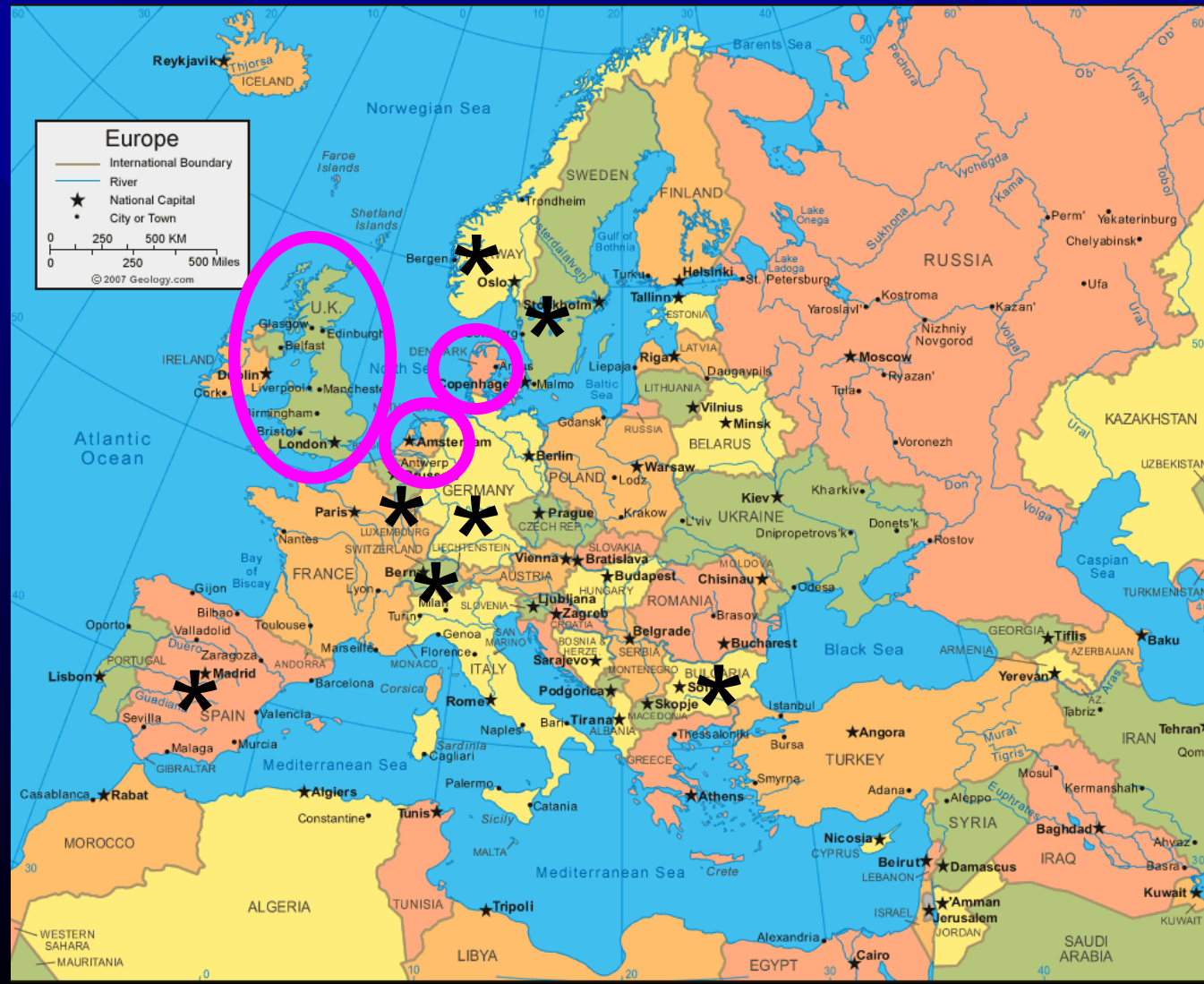
Box 2—Mental illness programmes in Europe

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

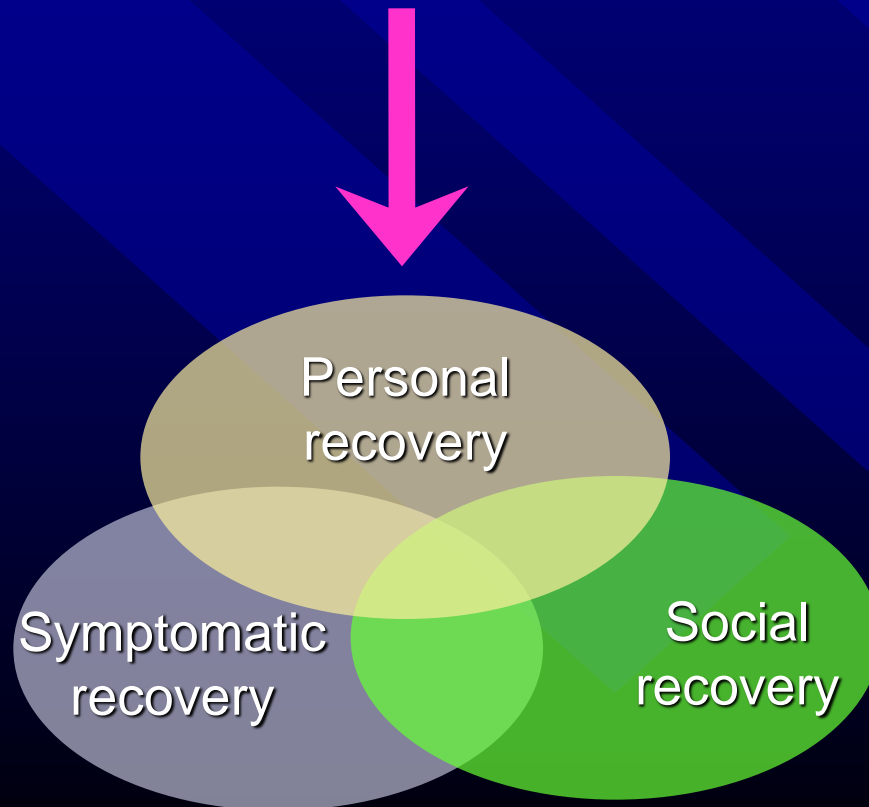
EC Handicapped People in the European Community Living Independently in an Open Society (HELIOS): organised cooperation in the field of vocational re-

The European AO Situation



Evolving Knowledge

Contextual Effects on “Neopopert subgroups”:
A Conceptual Model



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*

Responder Subgroup Effect: Severity Context

 REVIEW

JAMA, 2010

Antidepressant Drug Effects and Depression Severity

A Patient-Level Meta-analysis

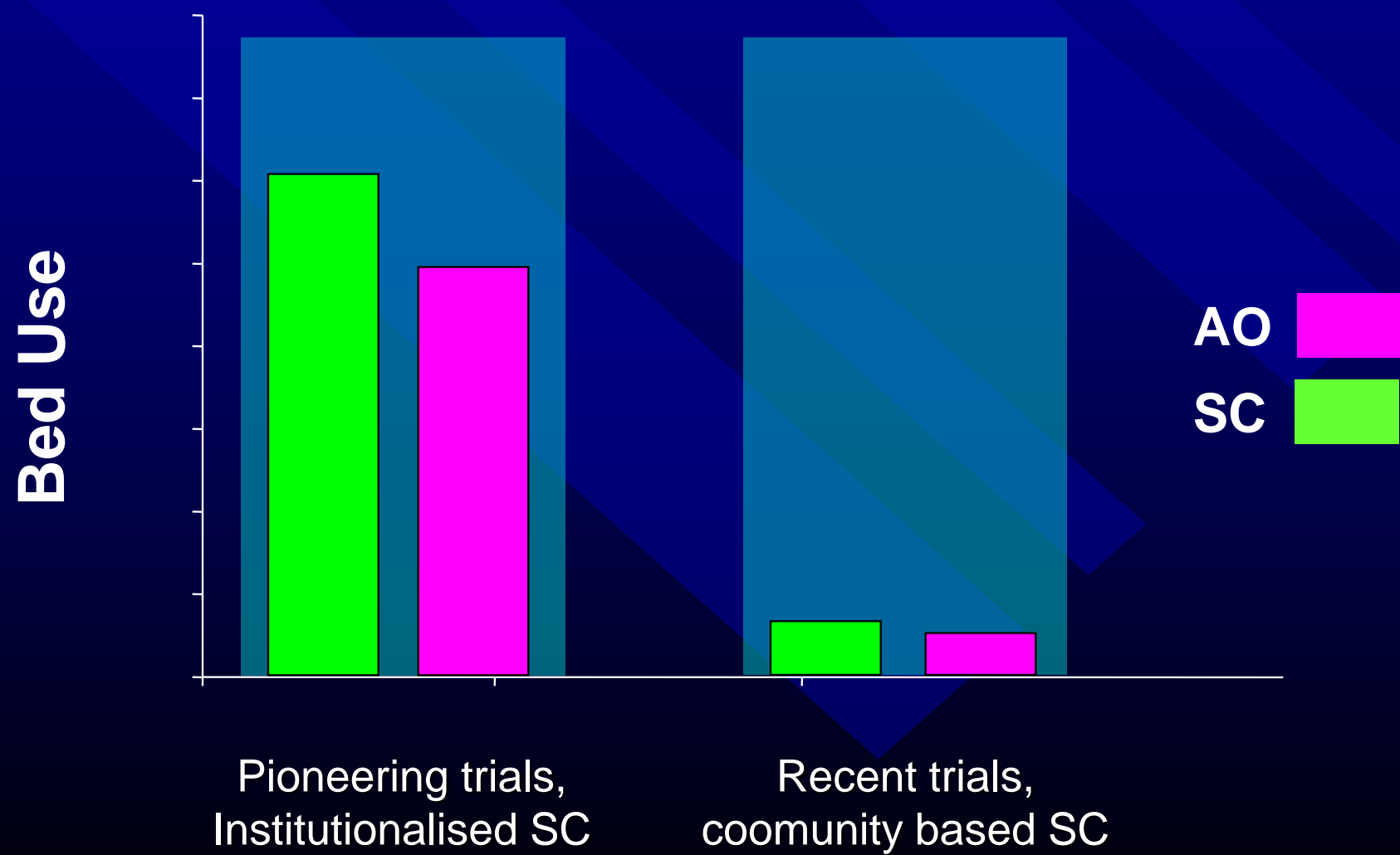
Jay C. Fournier, MA

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



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

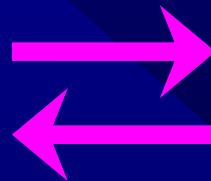
AO Dimensions

Admission prevention

Social Participation

Crisis management,
medication-based
symptom reduction

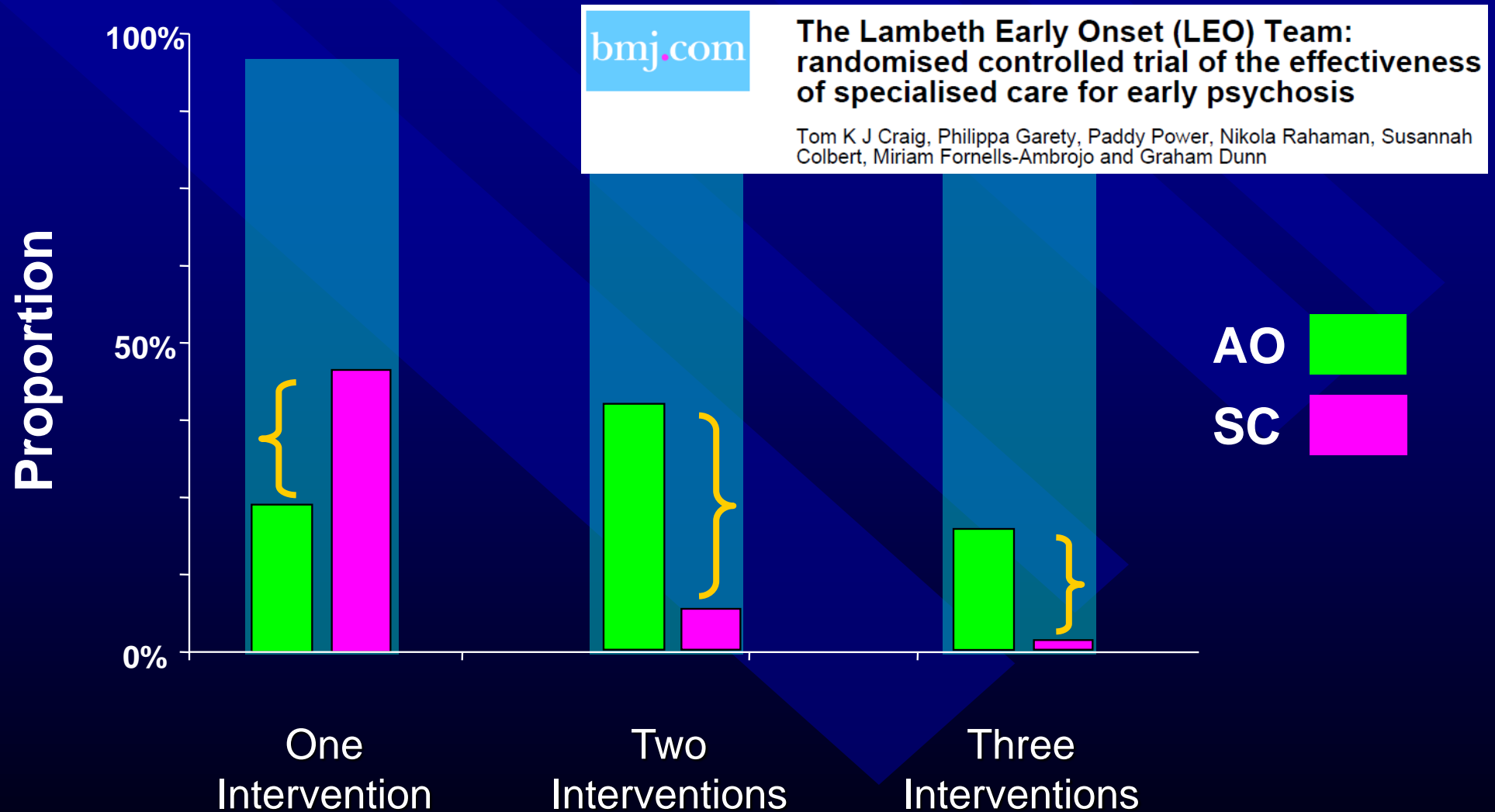
Empowerment and
Social participation



Team organisation

? Treatment content

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



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

	FACT (NL)	AO (UK practice)
case load	1:20	1:10/15
total team case load	200	100
	6M	6M

Assertive Community Treatment in the Netherlands: Outcome and Model Fidelity

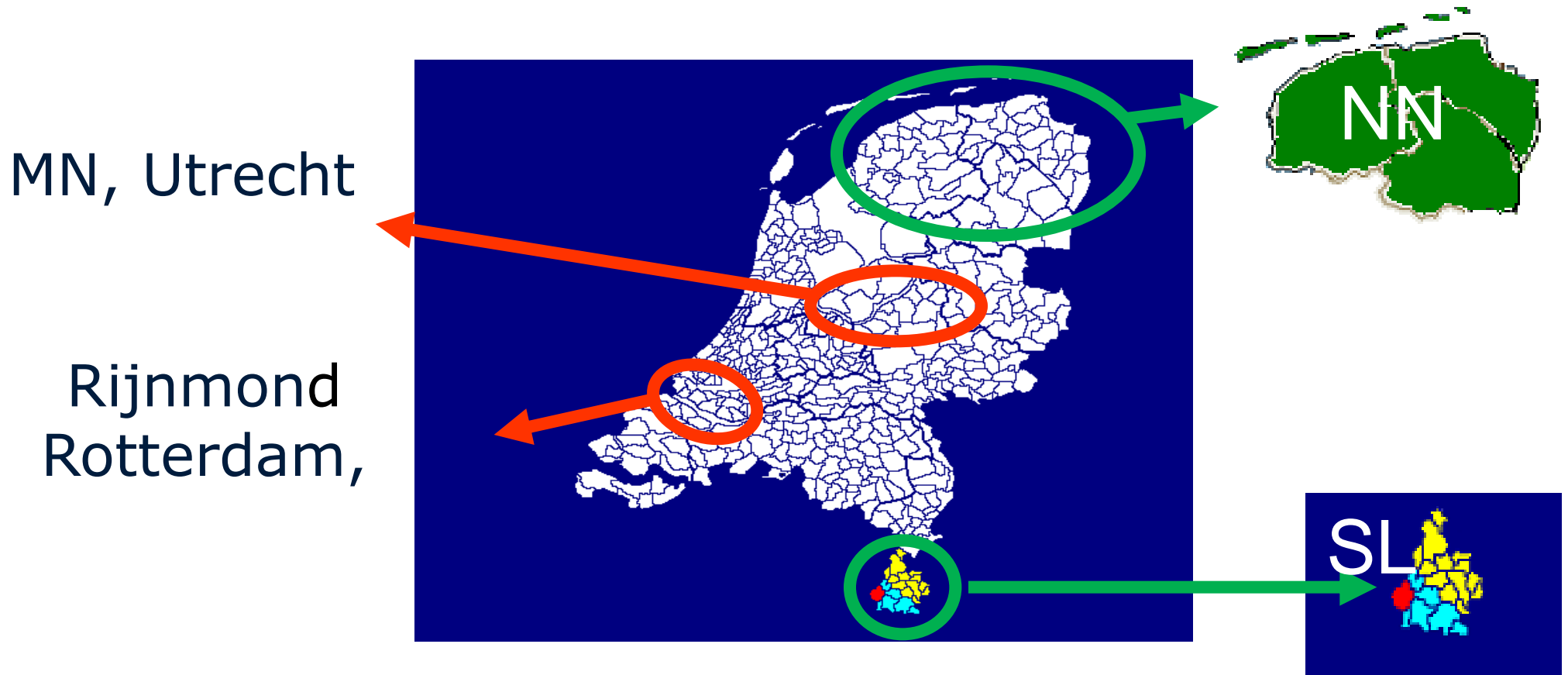
**Maaïke D van Vugt, MSc¹; Hans Kroon, PhD²; Philippe A E G Delespaul, PhD³;
Fred G Dreef, MD⁴; Annet Nugter, PhD⁵; Bert-Jan Roosenschoon, MSc⁶;
Jaap van Weeghel, PhD⁷; Jeroen B Zoeteman, MD⁴; Cornelis L Mulder, MD, PhD⁸**

specific treatment (voc rehab, subst abuse, CBT, etc.)	yes (moderately implemented)	no
research focus	functioning	hospital use
team work, shared caseload	yes	yes

(F)ACT Evaluated by Psychiatric Case Registers in the Netherlands

“Traditional” ACT

Function-ACT



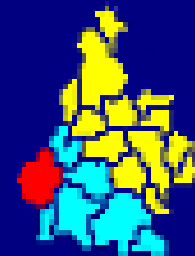
(F)ACT in the Netherlands: Traditional Outcomes

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

Treatment Content and Outcome

Soc Psychiat Epidemiol
DOI 10.1007/s00127-009-0088-3

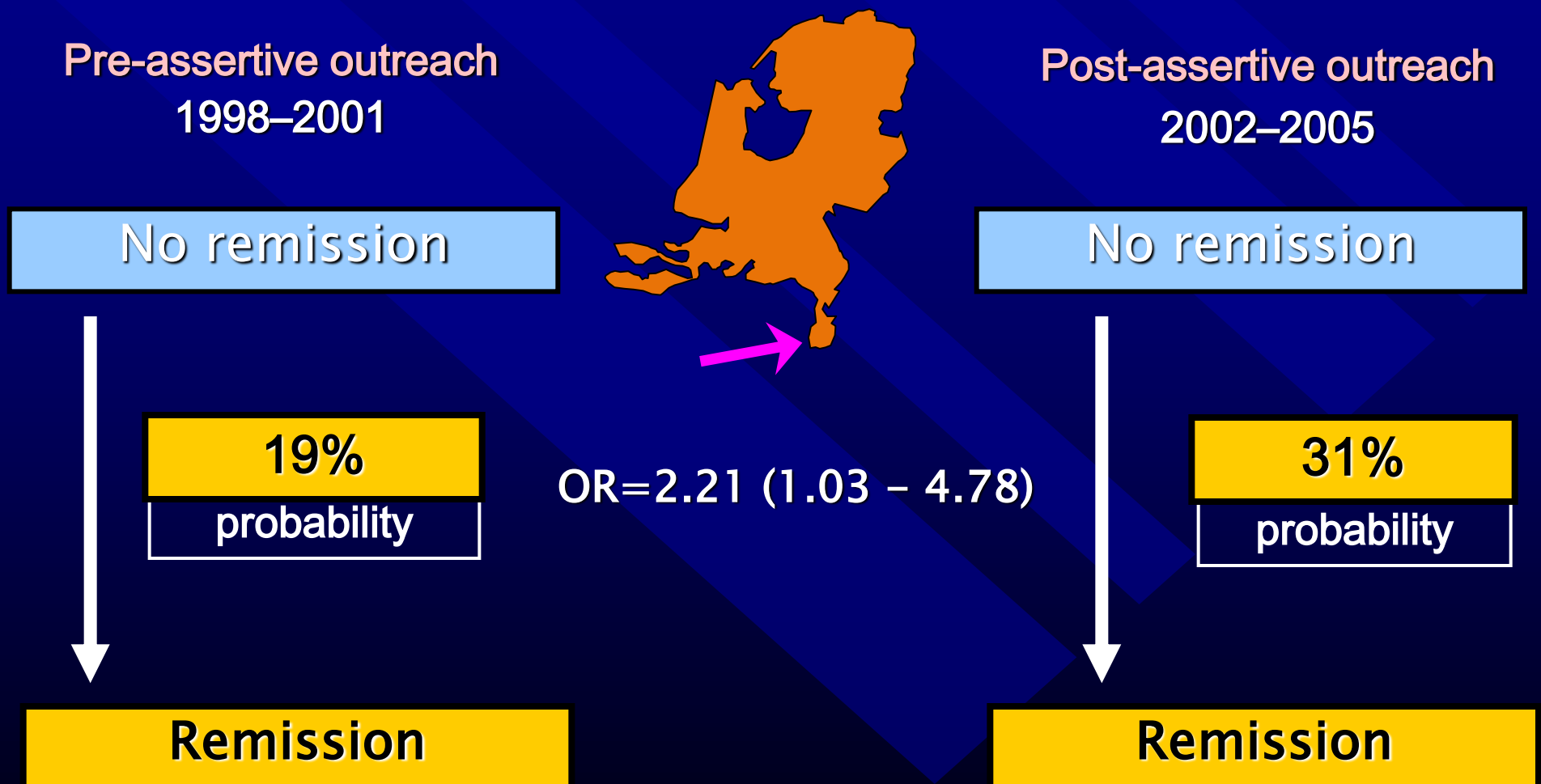
ORIGINAL PAPER



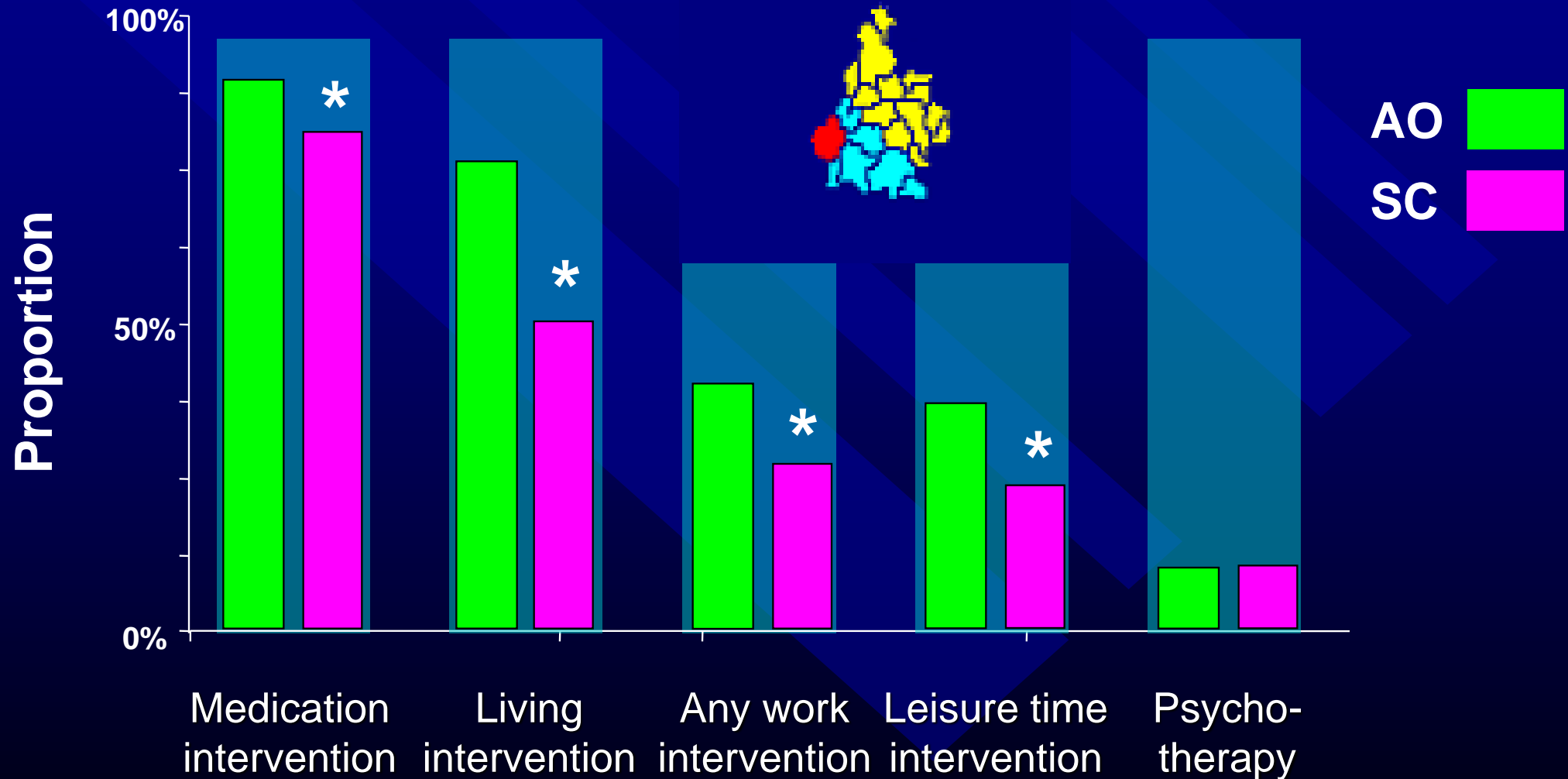
The cumulative needs for care monitor: a unique monitoring system in the south of the Netherlands

Marjan Drukker · Maarten Bak · Joost à Campo ·
Ger Driessen · Jim Van Os · Philippe Delespaul

Remission: higher with Assertive Outreach?



FACT and Treatment Uptake



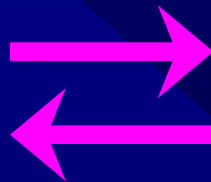
AO Dimensions

“Admission Prevention”

Crisis management,
medication-based
symptom reduction



Team organisation



Social Participation

Empowerment and
Social participation



Treatment content

Values & Concepts Underlying Treatment

Schizophrenia Bulletin vol. 35 no. 2 pp. 293–296, 2009
doi:10.1093/schbul/sbn184

ENVIRONMENT AND SCHIZOPHRENIA

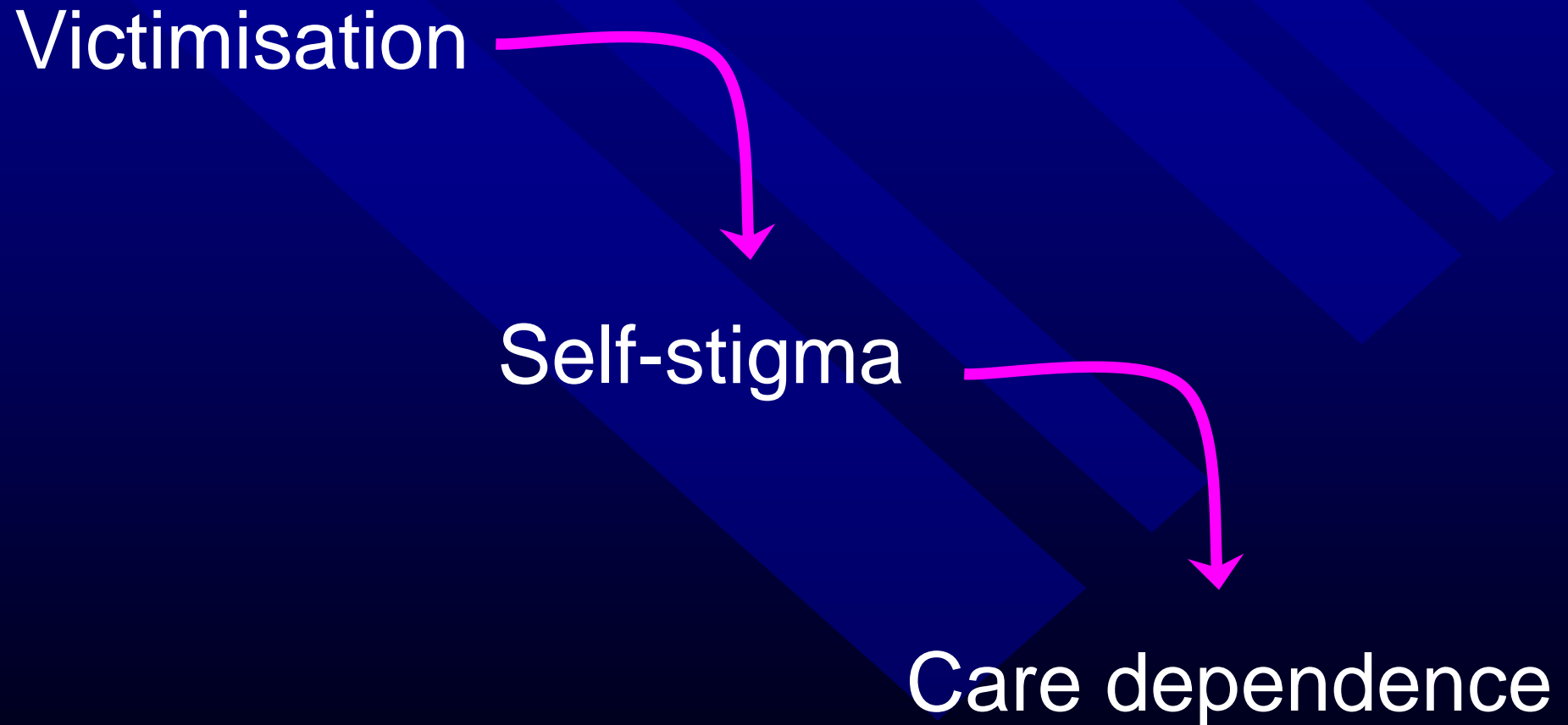
Stigmatization as an Environmental Risk in Schizophrenia: A User Perspective

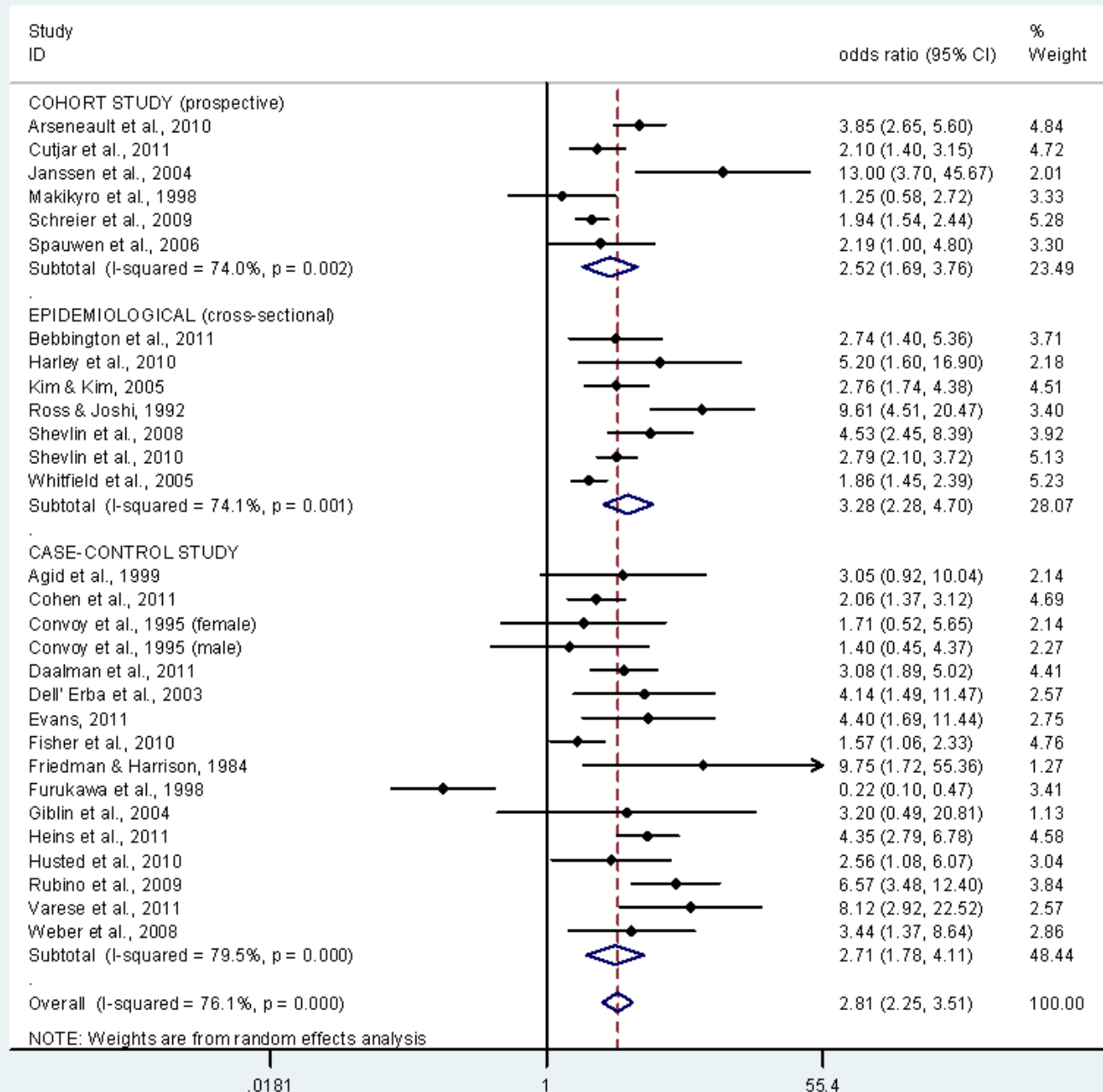
Catherine van Zelst^{1,2}

²Department 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

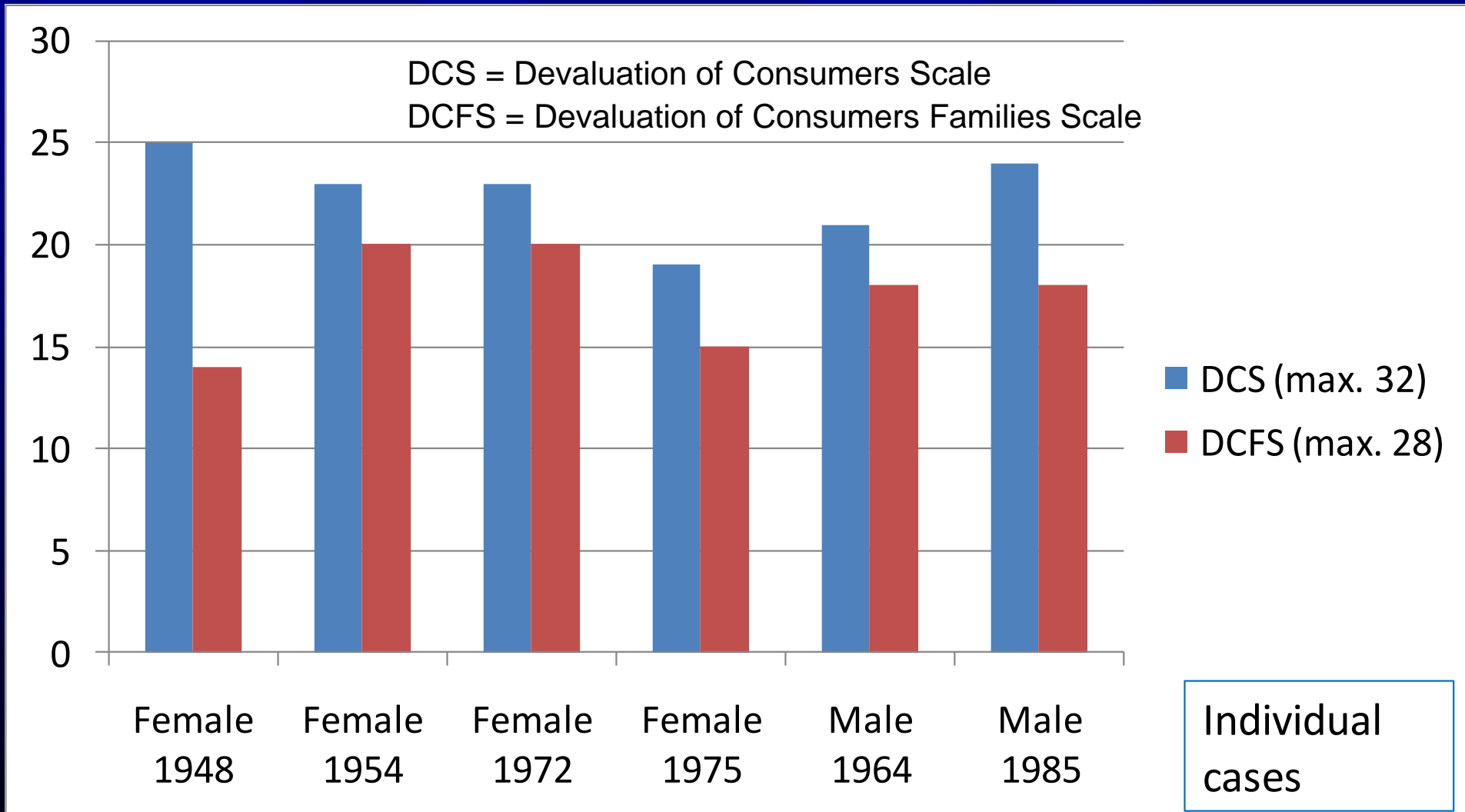




Trauma and Psychosis

Varese & Smeets
et al, submitted

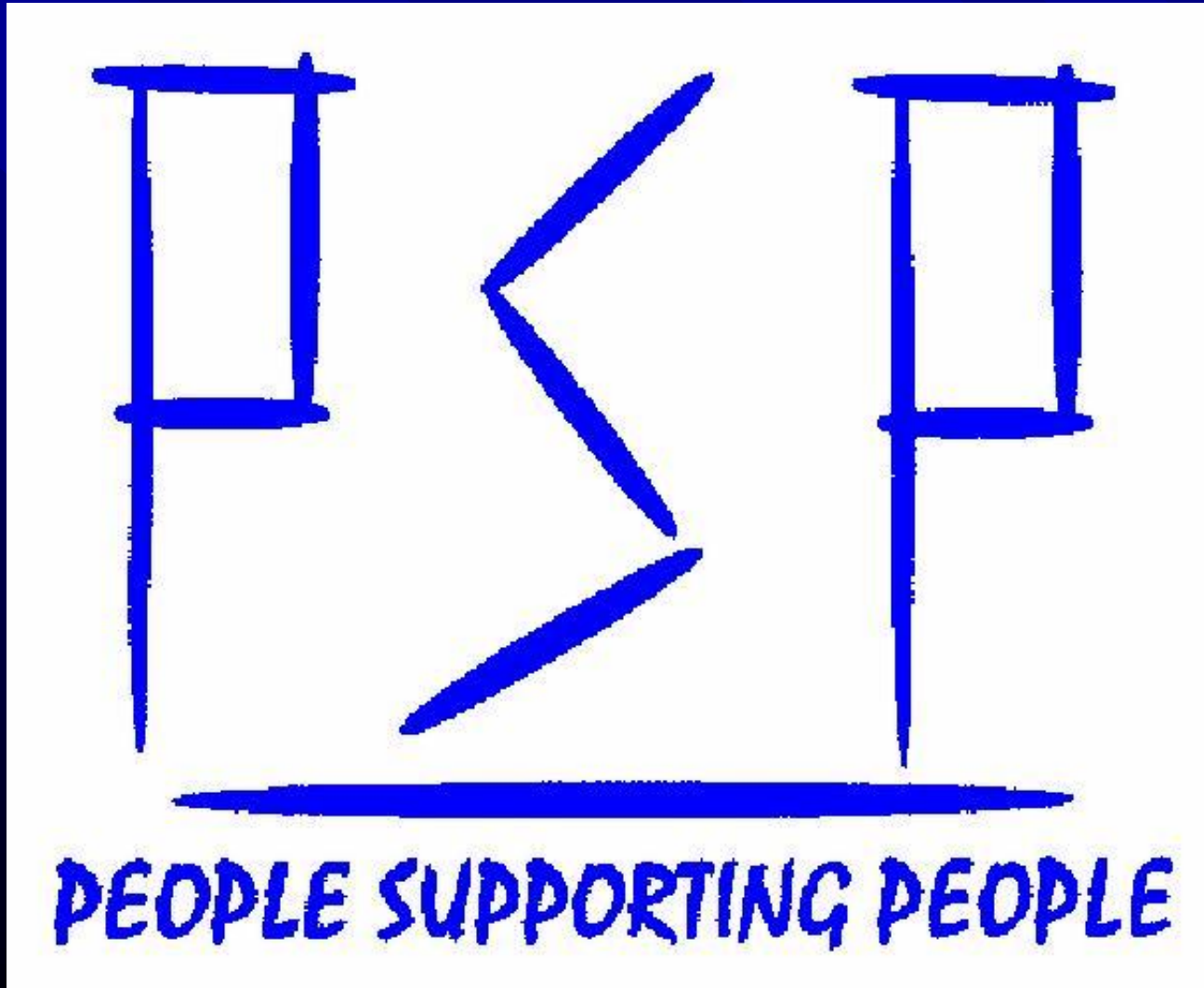
(Family) Stereotype Awareness



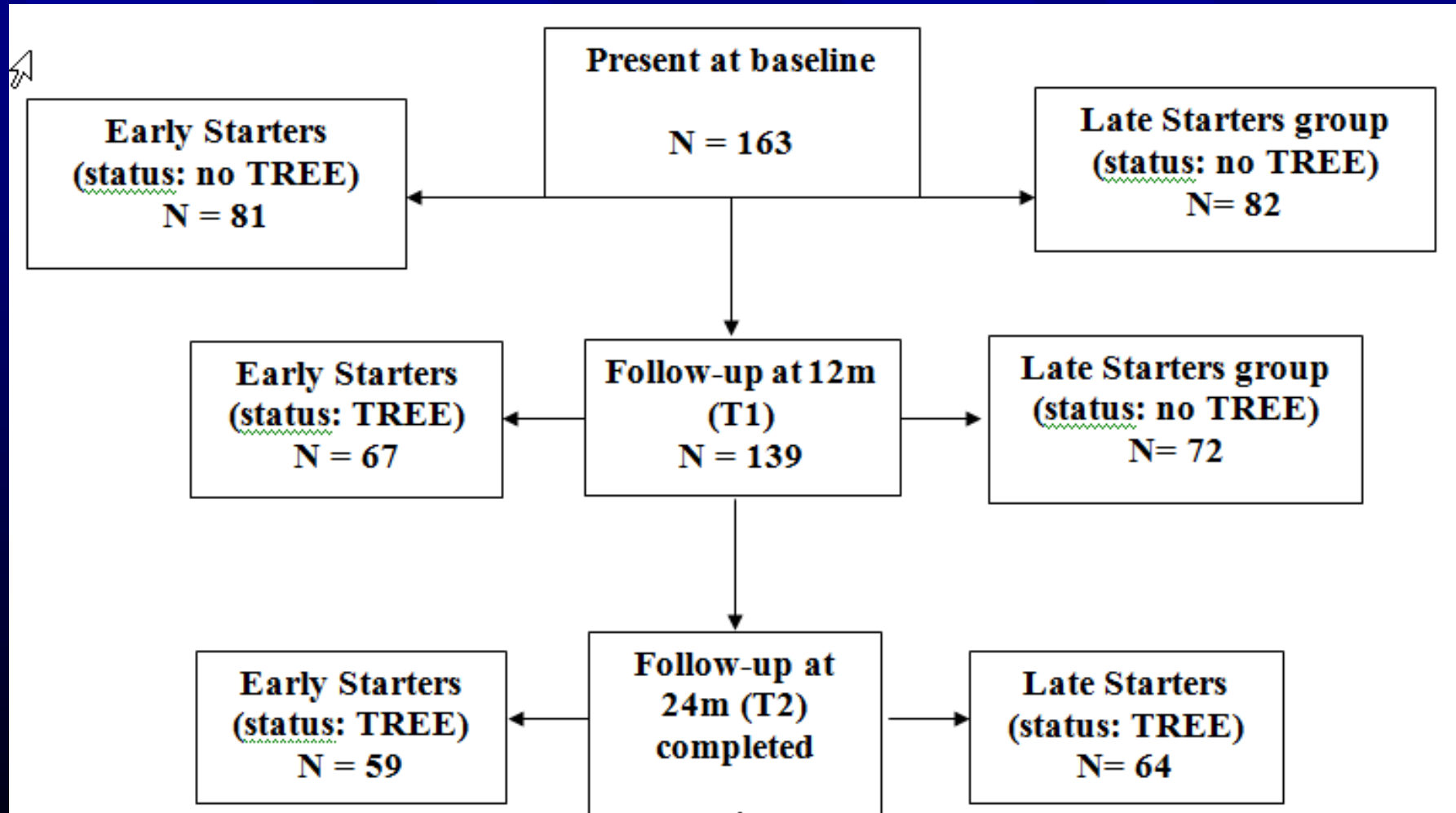
D-STIGMI: Stigma Intervention

- **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

Existential Recovery: User-run Recovery Programmes



Dutch National RCT of User-run Recovery Program

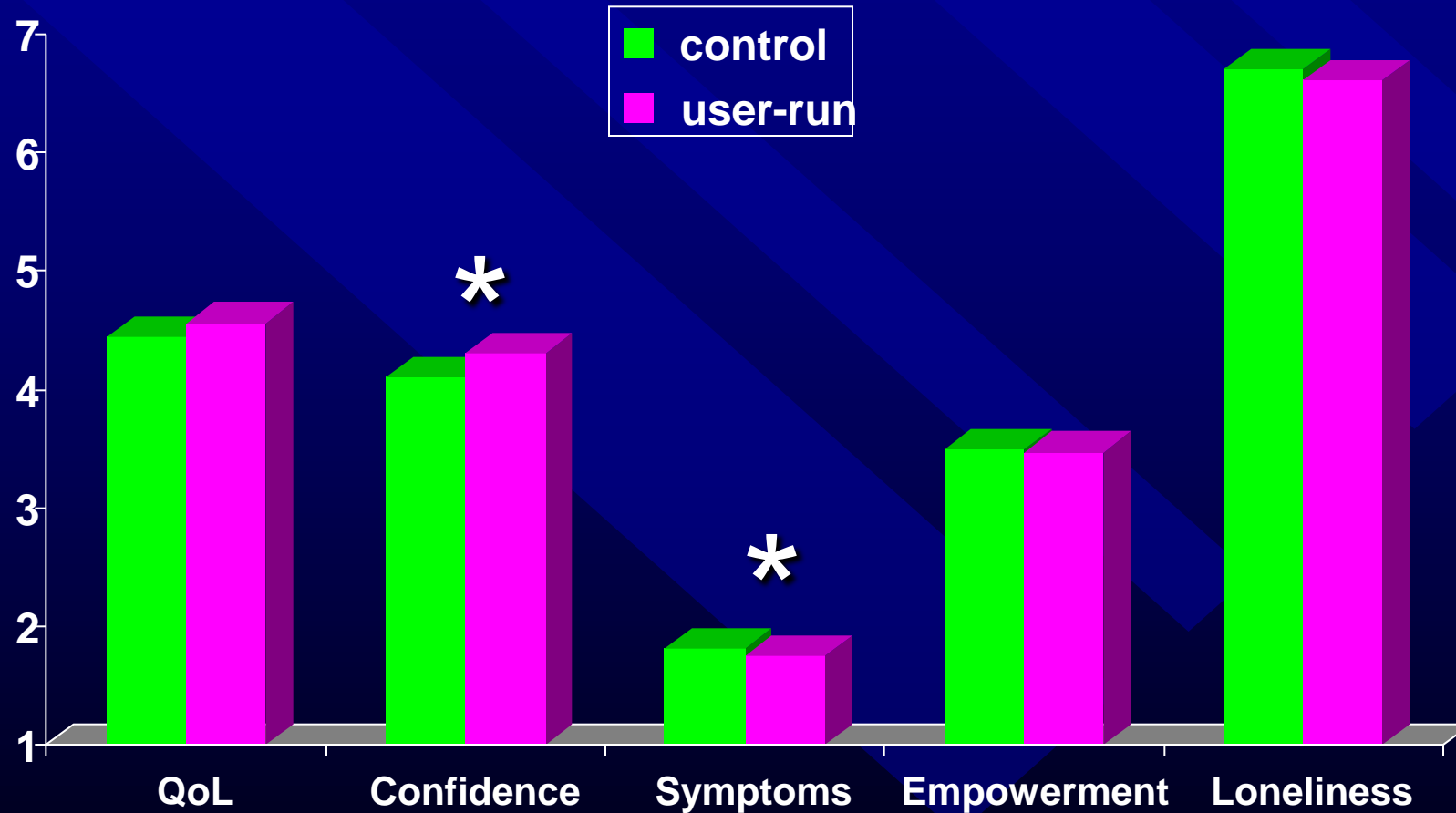


TREE (HEE): Toward Recovery, Empowerment and Experiential Expertise

- 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



Psychiatric Rehabilitation: Evidence?

Intervention Protocol

Rehabilitation programmes for schizophrenia

Samer Makhoul^{1,*}, Clive E Adams², Vijender
Balain³

Database Title

The Cochrane Library

Editorial Group: [Cochrane Schizophrenia
Group](#)

Published Online: 17 MAR 2010

Assessed as up-to-date: 4 MAY 2008

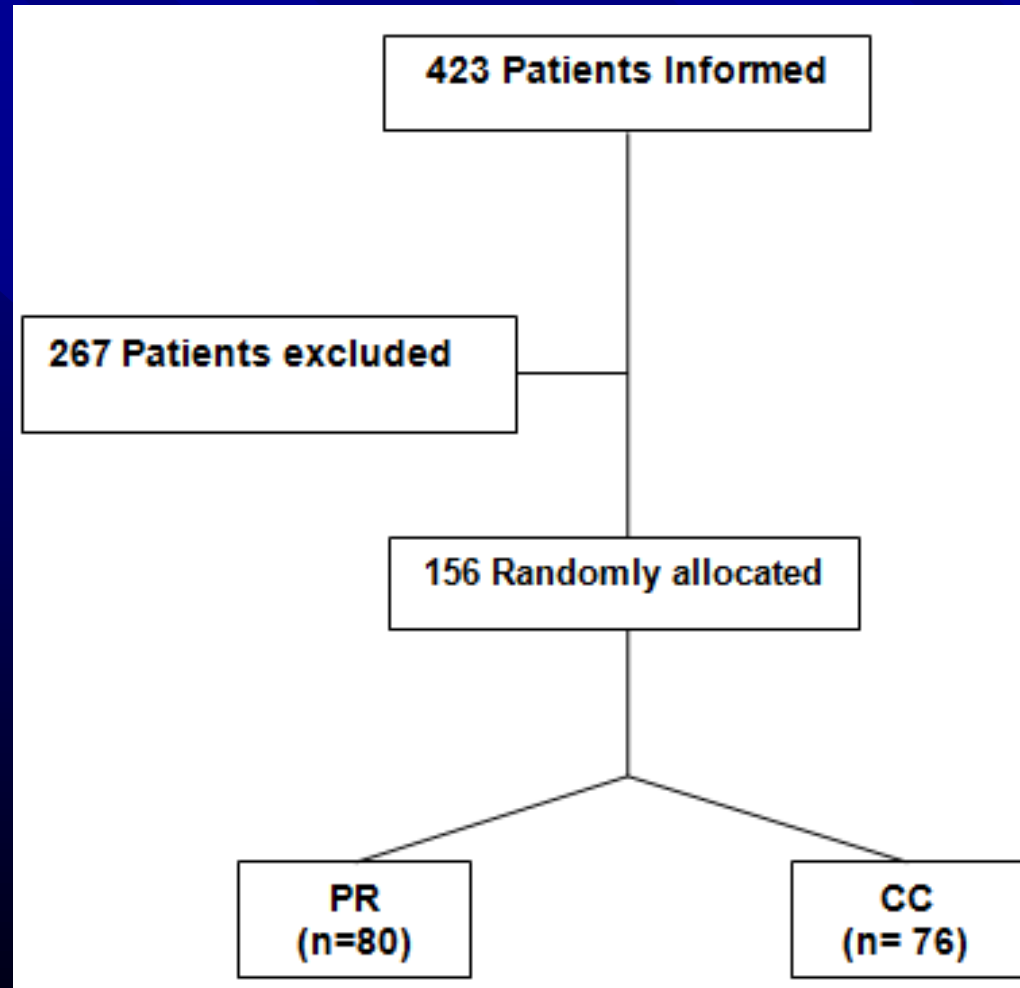
DOI: 10.1002/14651858.CD007301

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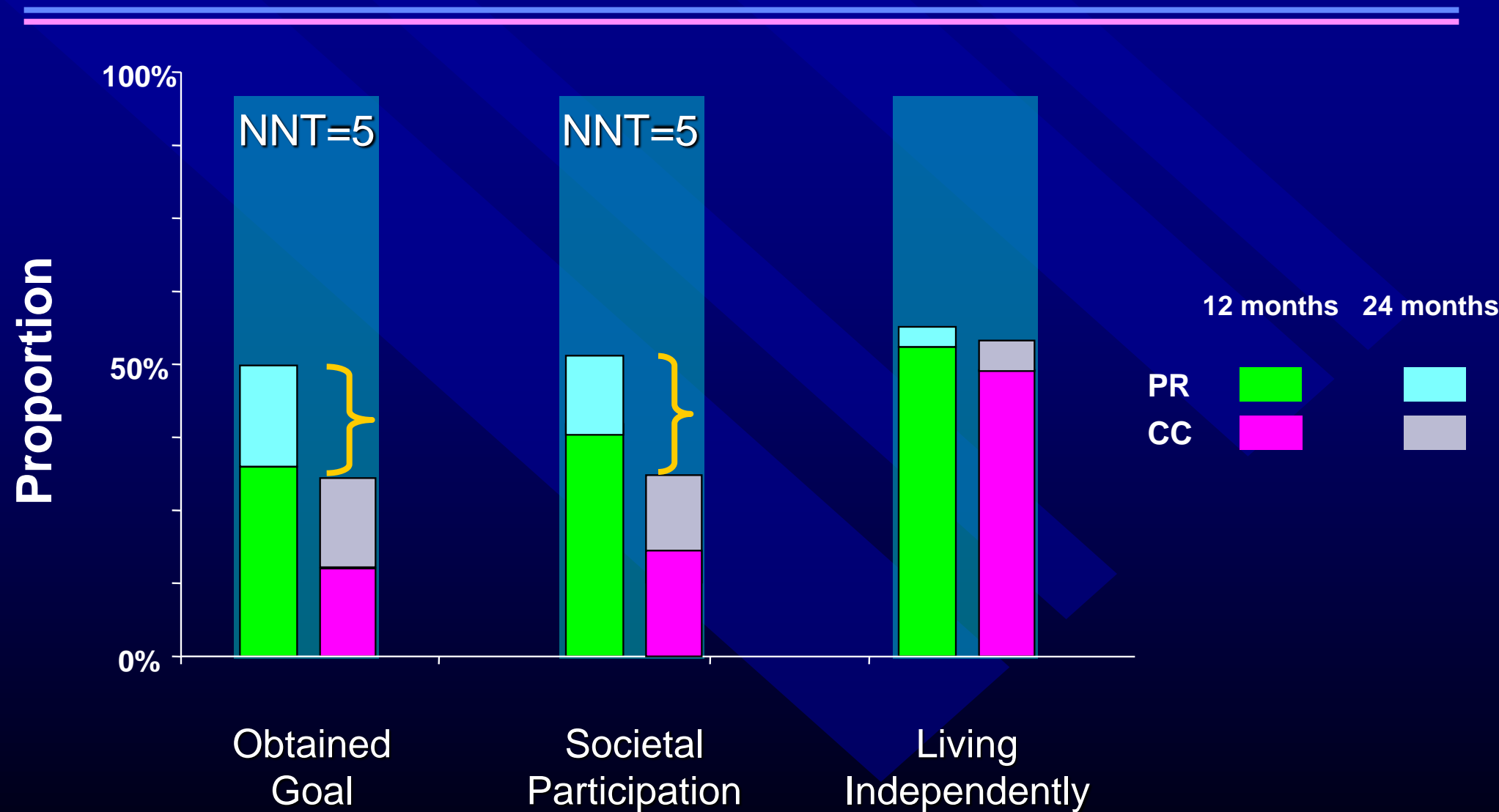
Dutch National RCT of the Boston Psychiatric Rehabilitation approach



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

Psychiatric Rehabilitation (PR) vs Control Condition (CC)

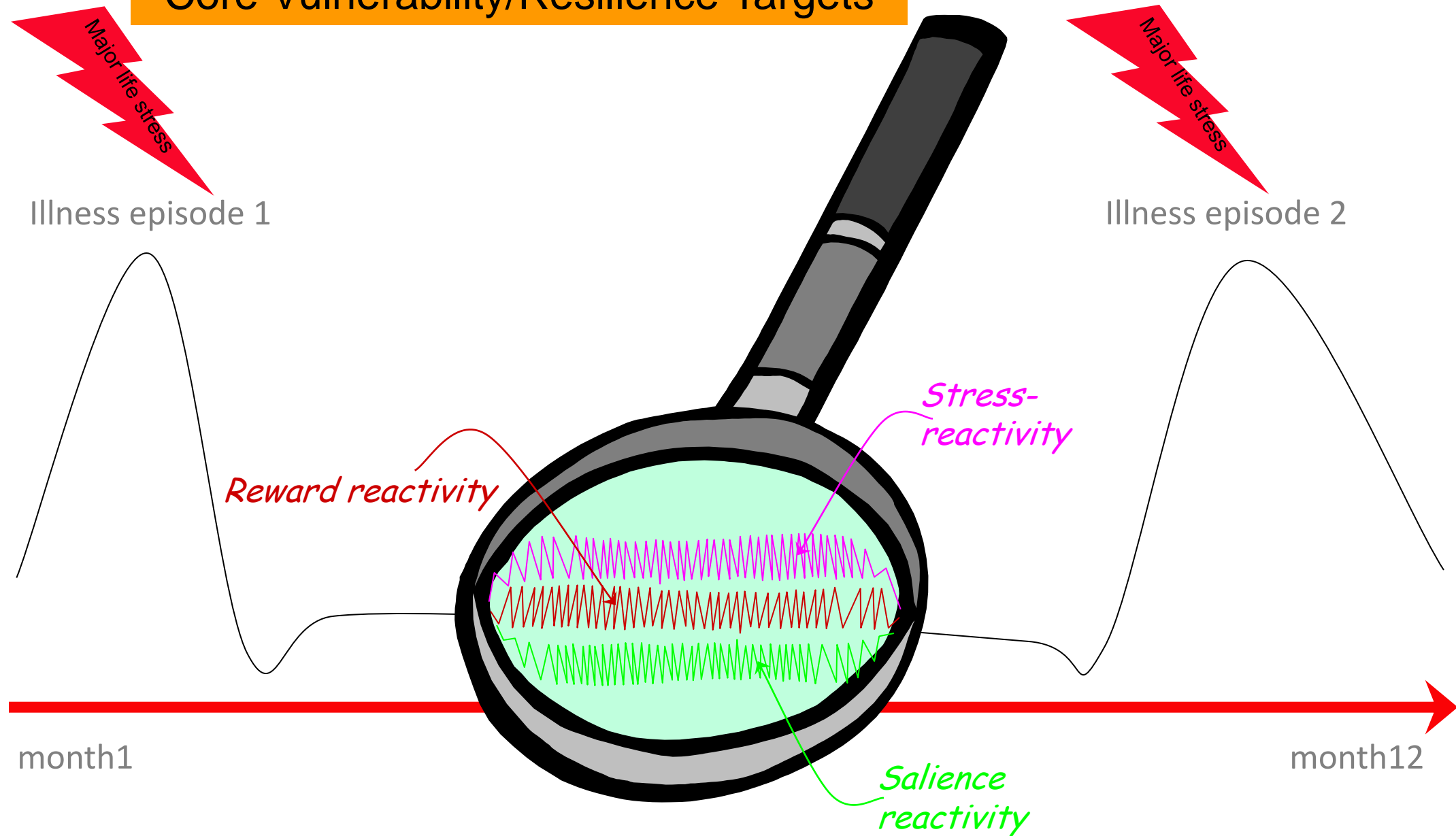




Mobile Self-management: Situating Therapeutics

Philippe Delespaul, Inez Myin-Germeys, Marieke Wichers

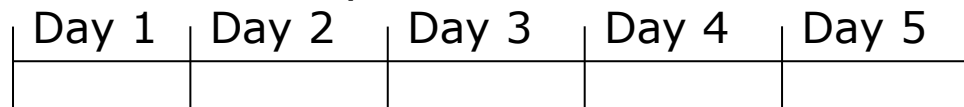
Core Vulnerability/Resilience Targets



PsyMate Person-Context Interactions



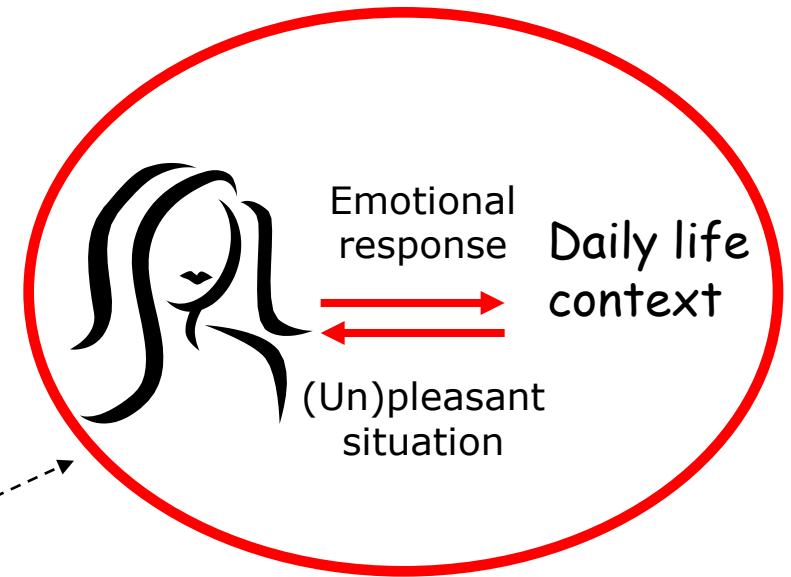
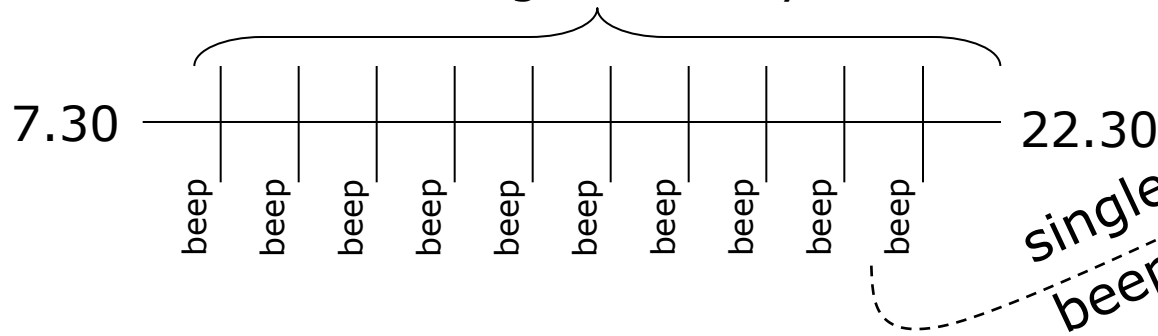
ESM procedure



Ik voel me
Enthousiast
Helemaal niet

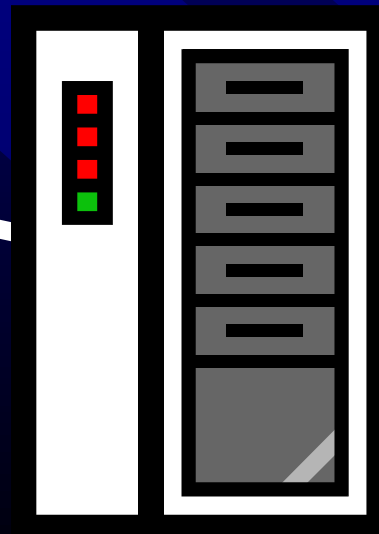
1	2	3	4	5	6	7
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A single ESM day



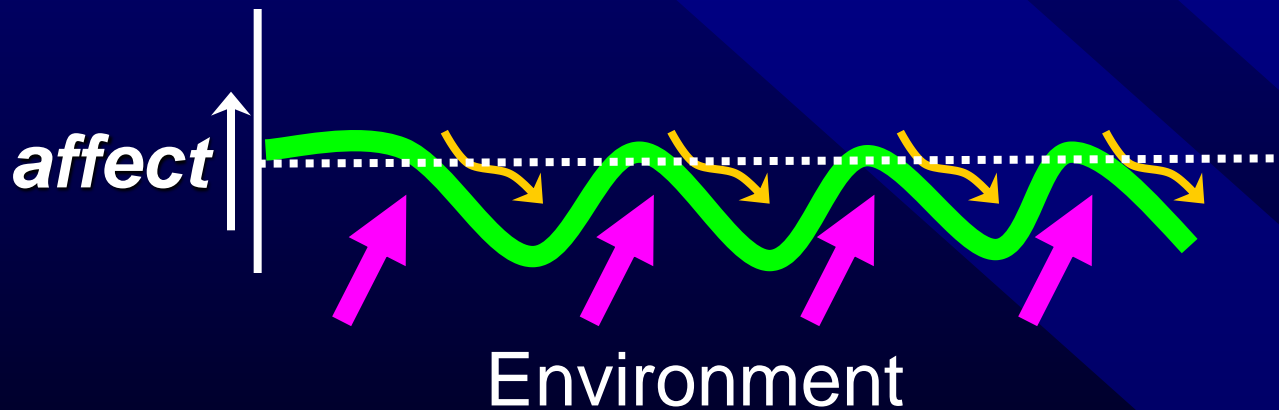
*Assessment of daily life
person-context interactions*

Web-based Feedback



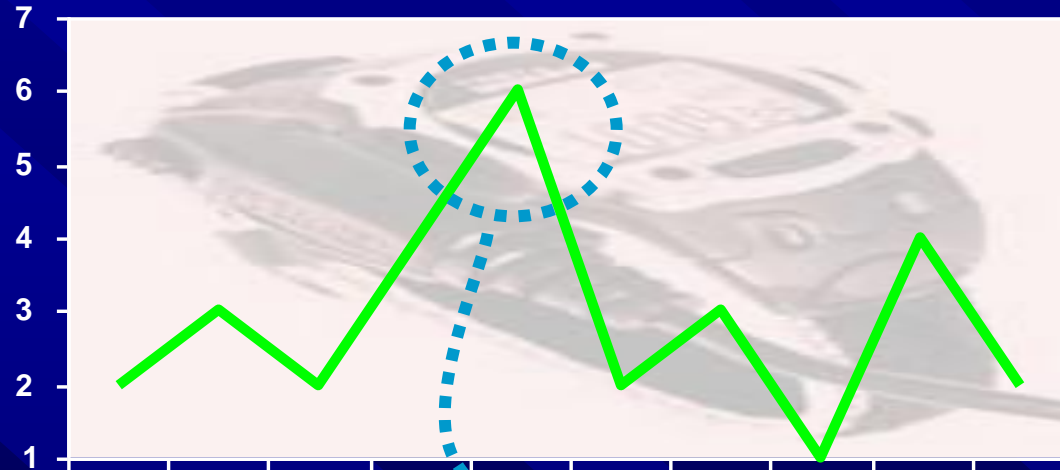
From Implicit to Explicit

Implicit \longrightarrow Explicit



Linking Affect and Psychosis

Mania

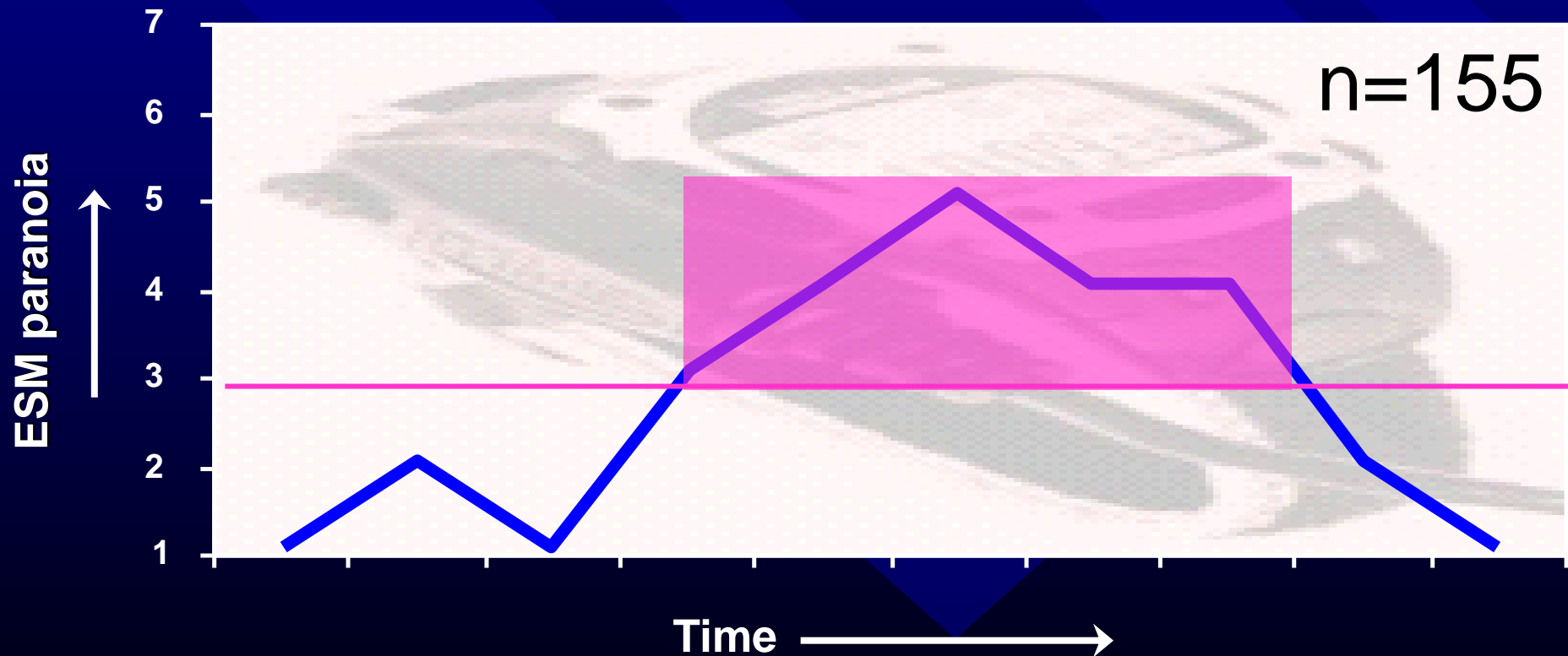


Depression

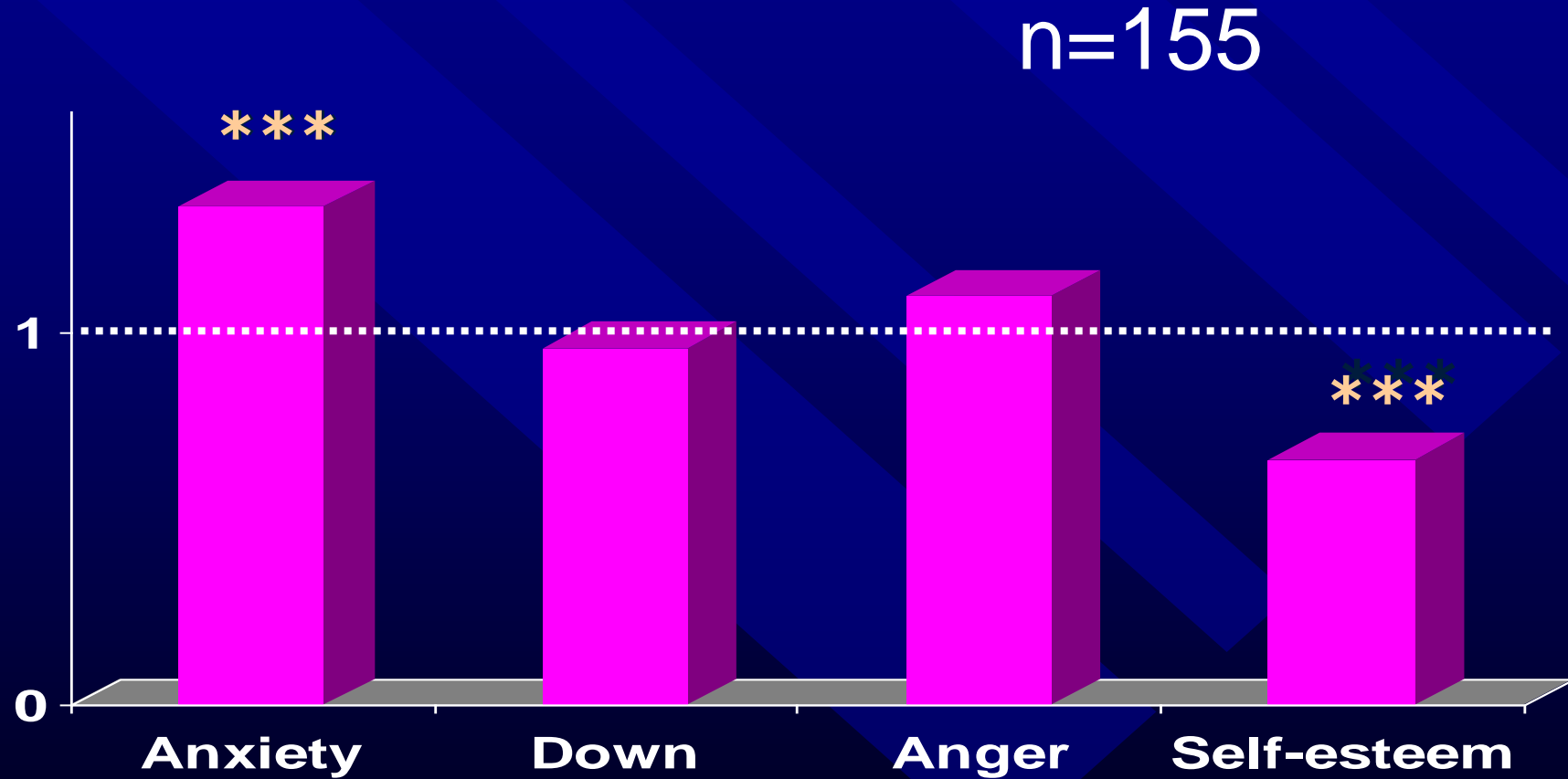


Studying Paranoia Episodes

Episode = uninterrupted series of occurrence of paranoia ≥ 3



Paranoia in daily life: onset of episode

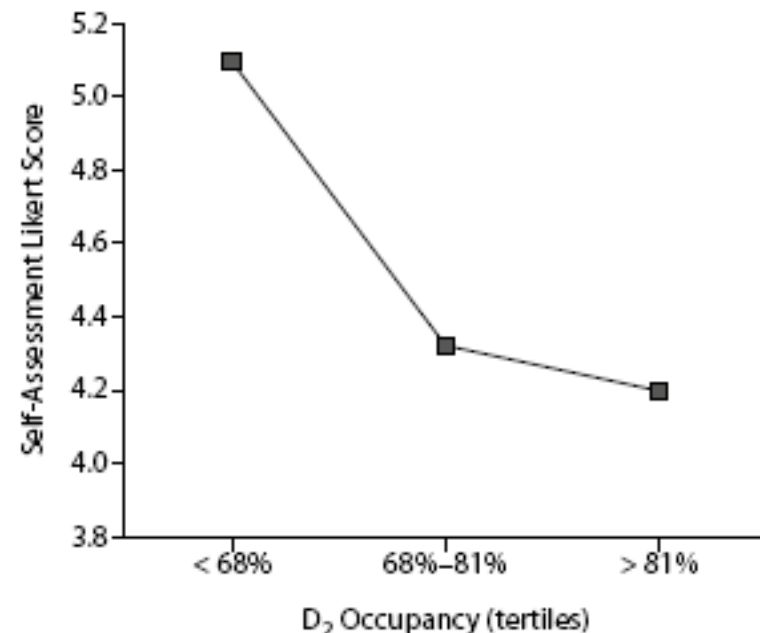


Medication Side Effects

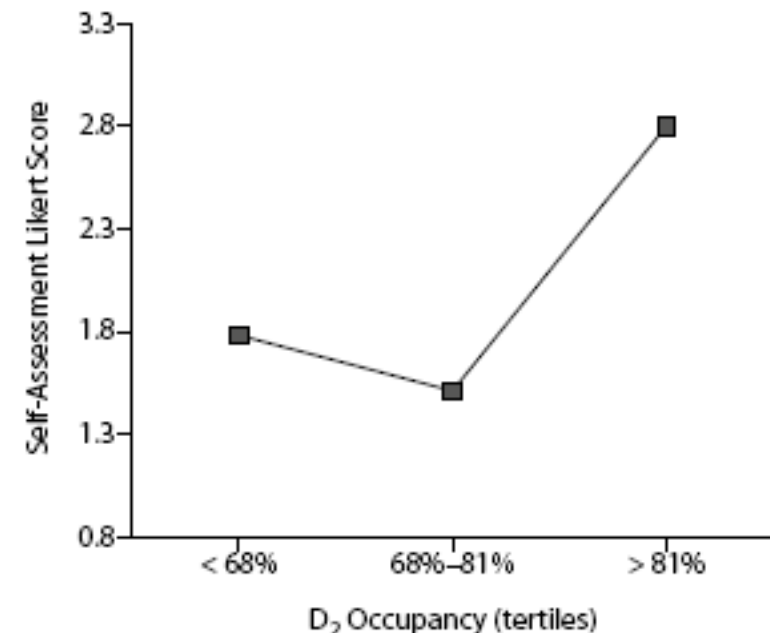
Emotional Experience and Estimates of D₂ Receptor Occupancy in Psychotic Patients Treated With Haloperidol, Risperidone, or Olanzapine: An Experience Sampling Study

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

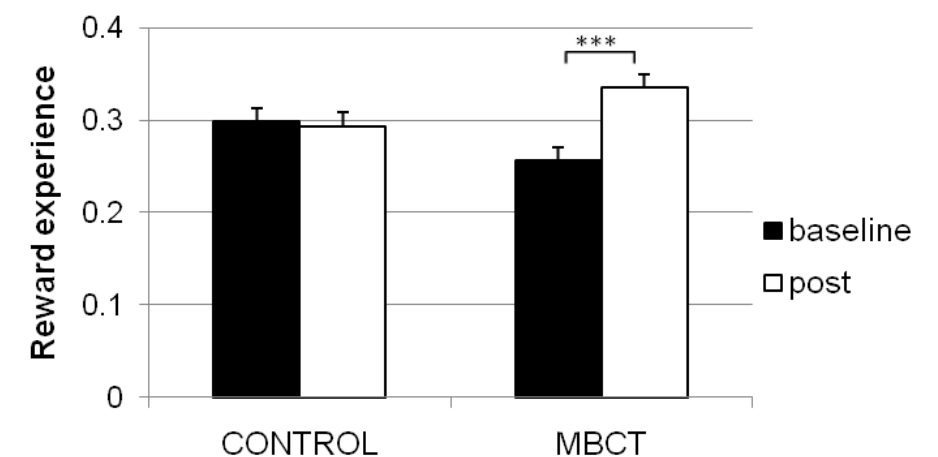
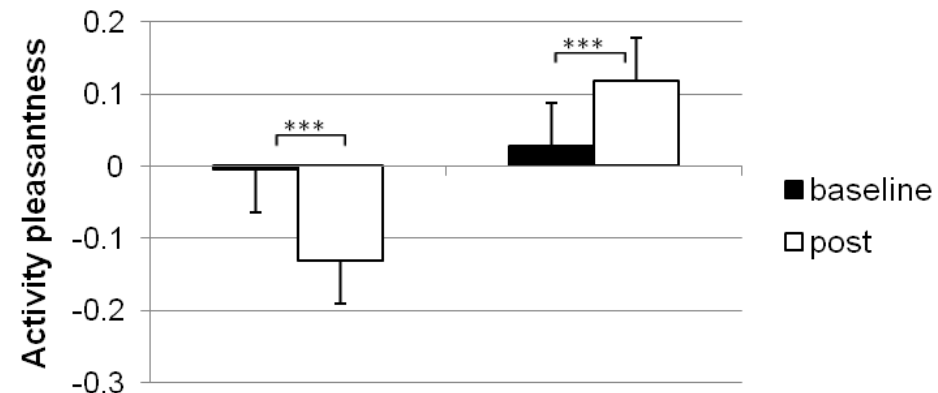
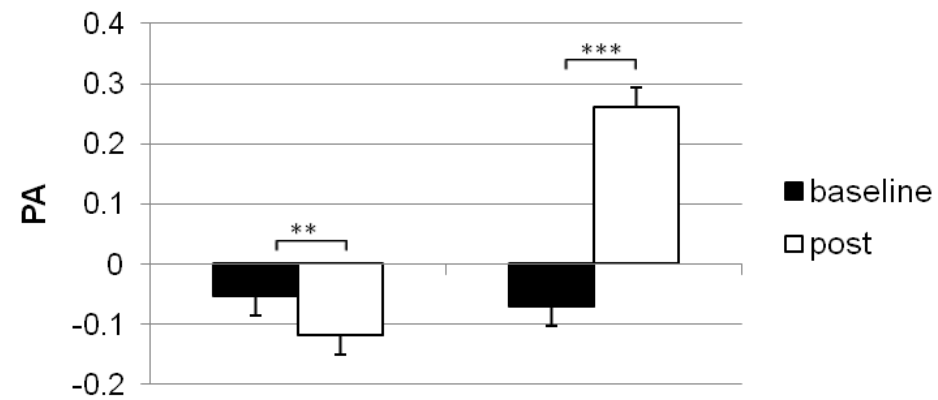
Positive Affect



Negative Affect



MBCT impacts on PA-related momentary outcomes: RCT



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

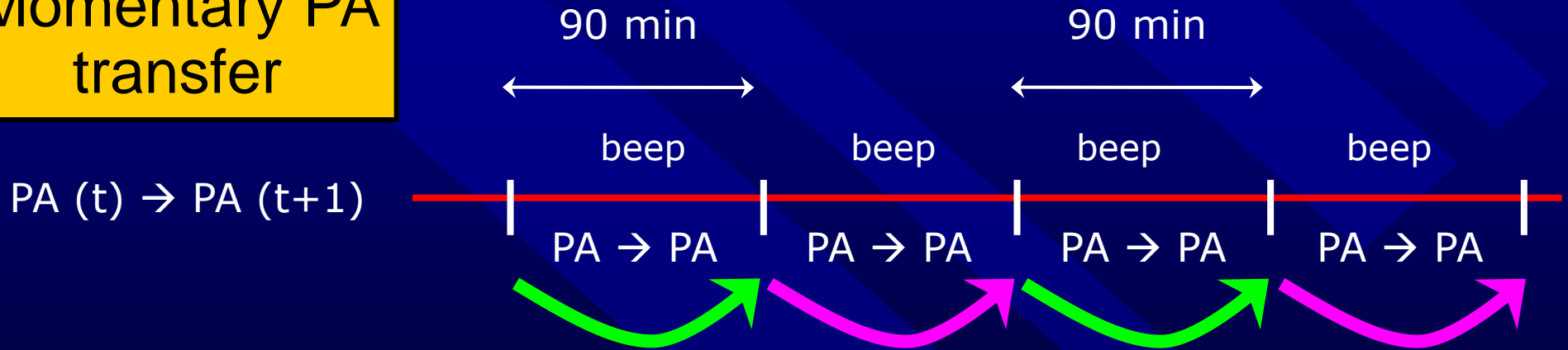
Marieke Wichers
Maastricht University Medical Centre

Journal of Consulting and Clinical Psychology
2011, Vol. 79, No. 5, 618–628

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0022-006X/11/\$12.00 DOI: 10.1037/a0024595

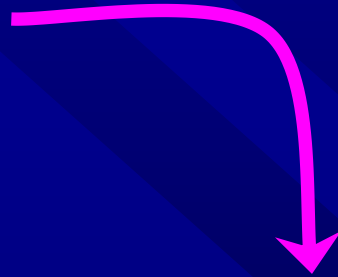
A Focus on Resilience

Momentary PA transfer

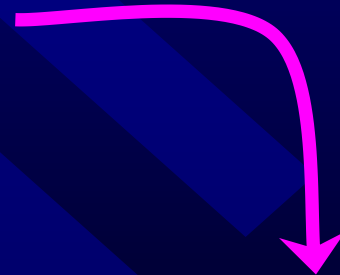


Reward Cycle: Negative symptoms

Experience of
positive affect



Incentive
Motivation



Reward-
directed
behaviour

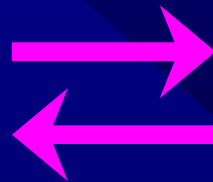
AO Dimensions: not one without the other

“Admission Prevention”

Crisis management,
medication-based
symptom reduction



Team organisation



Social Participation

Empowerment and
Social participation

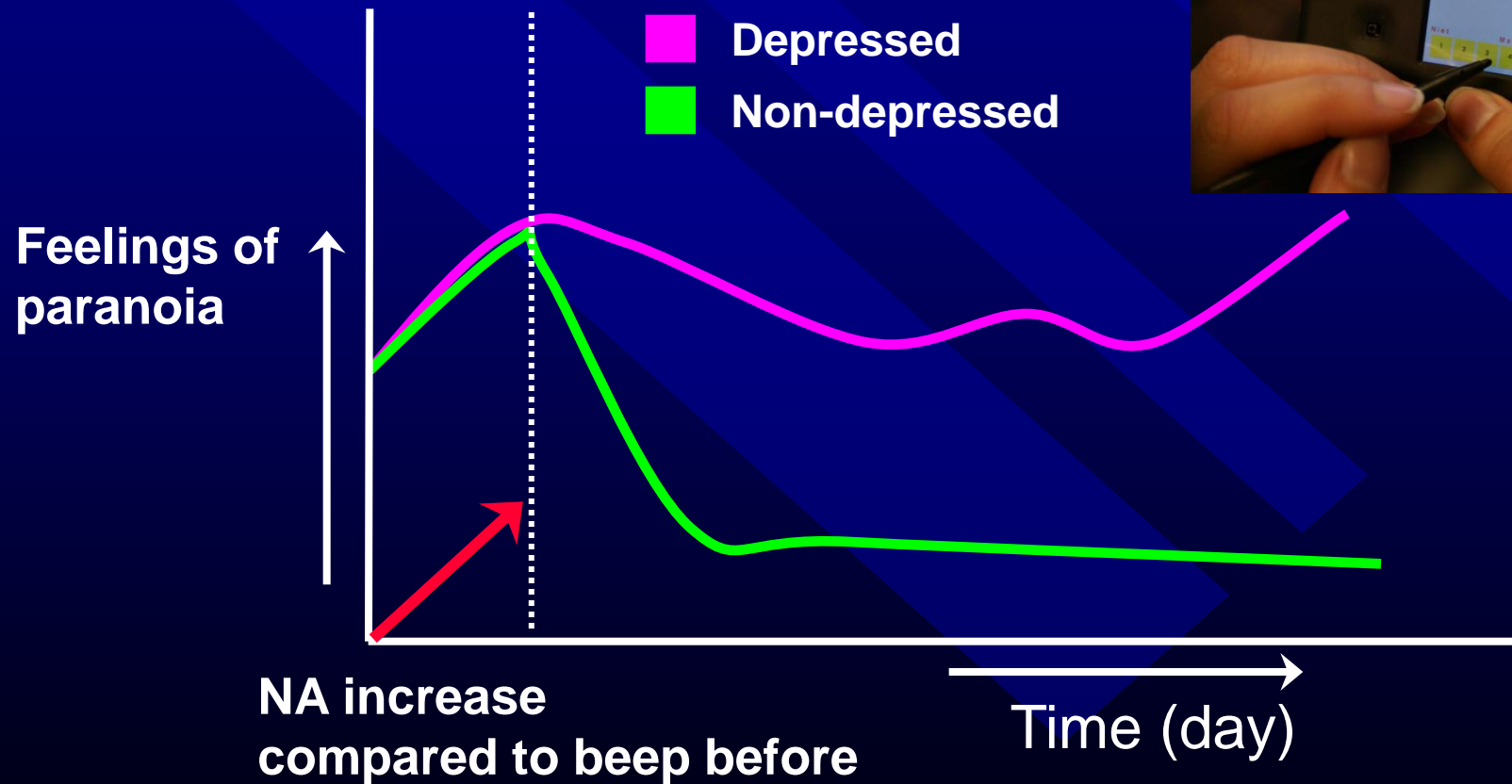


Treatment content



Fin

How Does Altered Mood Induce Psychosis?

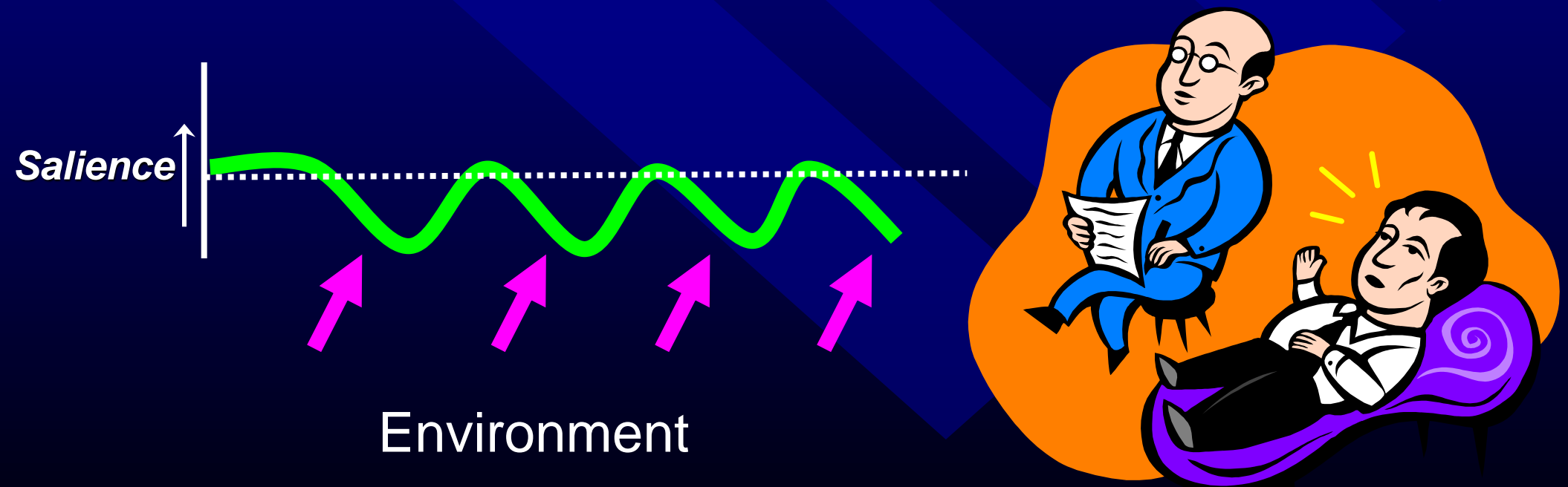


During a paranoid episode



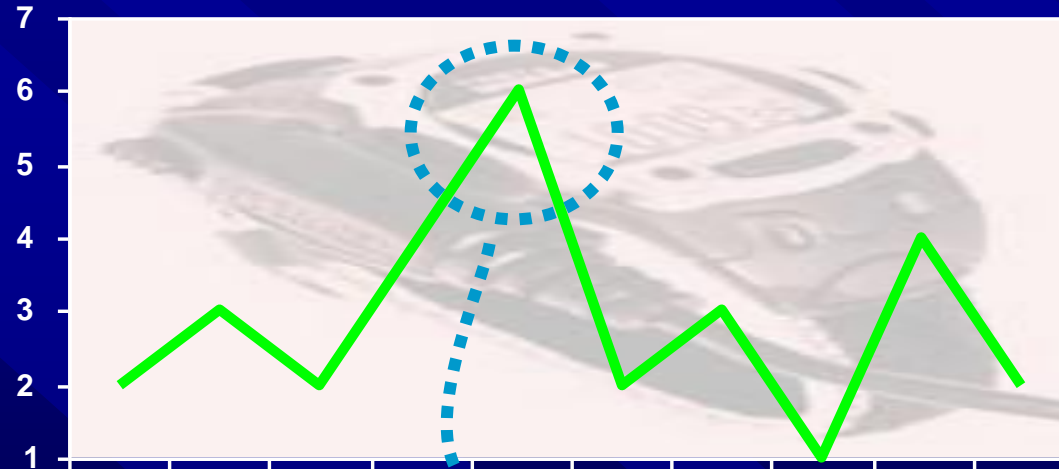
Web-based Feedback: From Implicit to Explicit

Implicit \longrightarrow Explicit

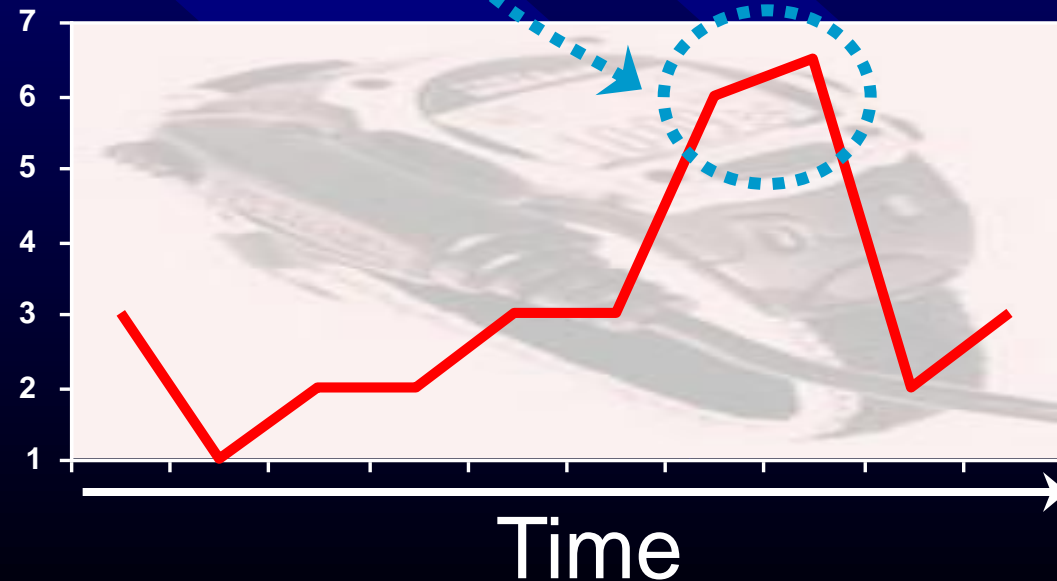


ESM: Measures of Affect

Intensity



Psychicality

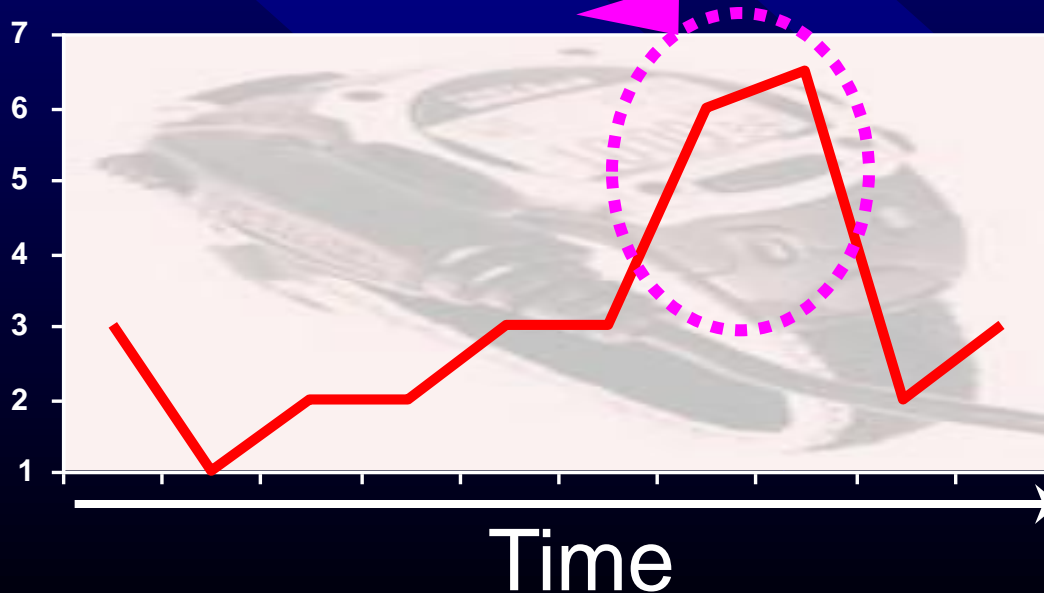


ESM Time Relationships

Anxiety



Paranoia

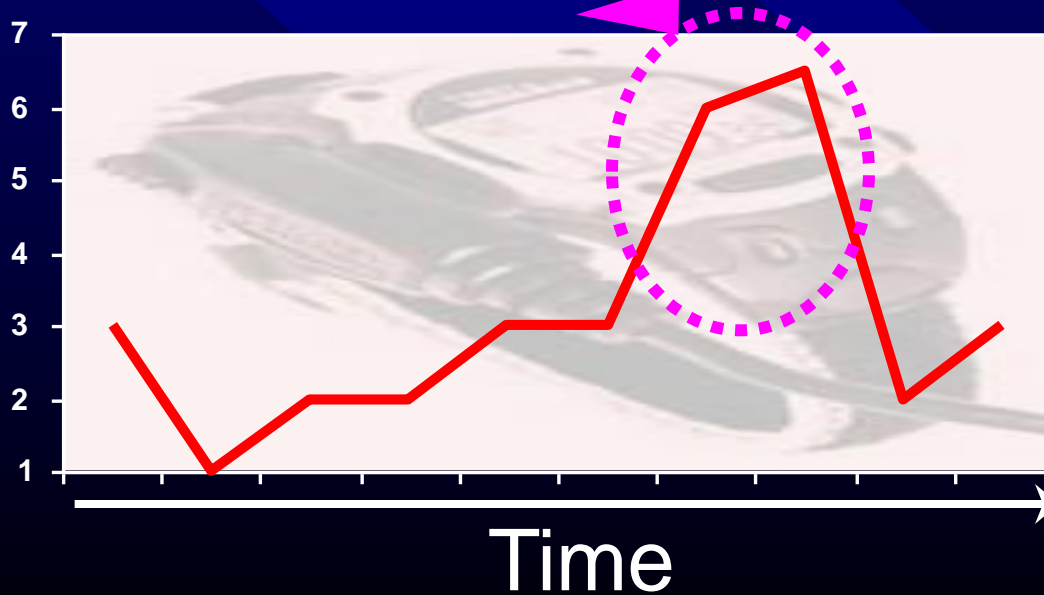


ESM Time Relationships

Paranoia



Anxiety



ACT and FACT in the Netherlands

ACT (35)	FACT (130)
ACT intensive care	ACT intensive + Individual extended
20% most severely affected	Entire SMI population in area
100 patients / team	220-250 patients / team
Caseload 1:10	Caseload 1:20
Psychiatrist 1/100	Psychiatrist 1/200
Psychologist: not required	Psychologist: 0.8/200
Job Coach /Expert by Exp: no	Expert by experience: 0.8/200
All patients daily discussed	20%-30% daily discussed
Contact frequency 3-4x / week	If required up to 4x / week possible
Job Coach: not required	Job Coach: 0.6/200

Assertive Outreach: The Challenge

- **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?

Social Cognition Predicts Community Functioning



Contents lists available at ScienceDirect

Neuroscience and Biobehavioral Reviews

journal homepage: www.elsevier.com/locate/neubiorev



Review

The relationship between neurocognition and social cognition with functional outcomes in schizophrenia: A meta-analysis

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

^a Department of Psychiatry and Neuropsychology, School of Mental Health and Neuroscience, Maastricht University, Maastricht, The Netherlands

^b Department of Methodology and Statistics, School for Public Health and Primary Care, Maastricht University, Maastricht, The Netherlands

^c Centre for Brain & Learning, Faculty of Psychology and Education, VU University Amsterdam, Amsterdam, The Netherlands

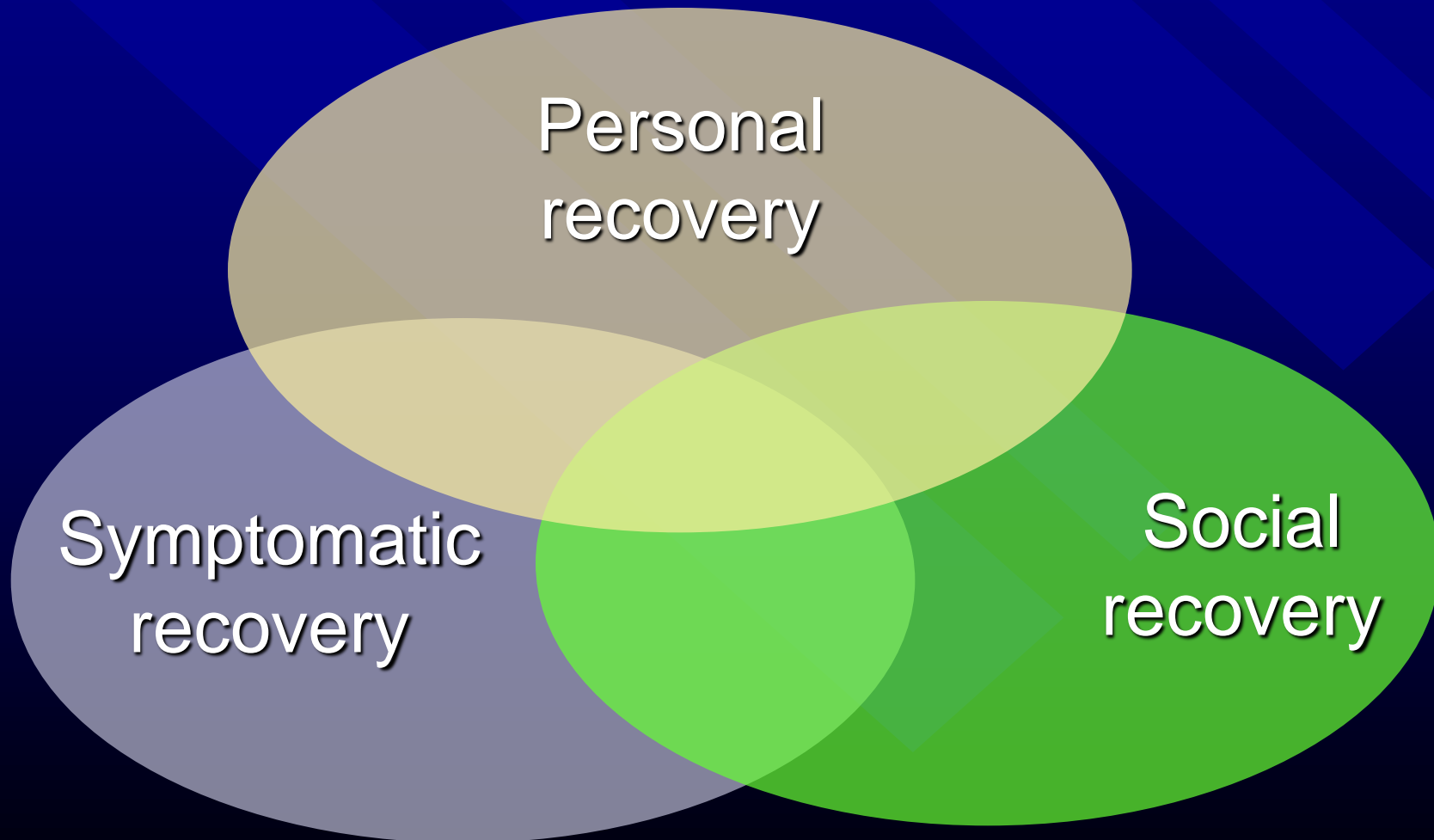
^d Department of Psychosis Studies, Institute of Psychiatry, London, United Kingdom

^e Department of Psychology, University of North Carolina Chapel Hill, United States

Social Cognition Predicts Community Functioning

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

Non-hierarchical goals

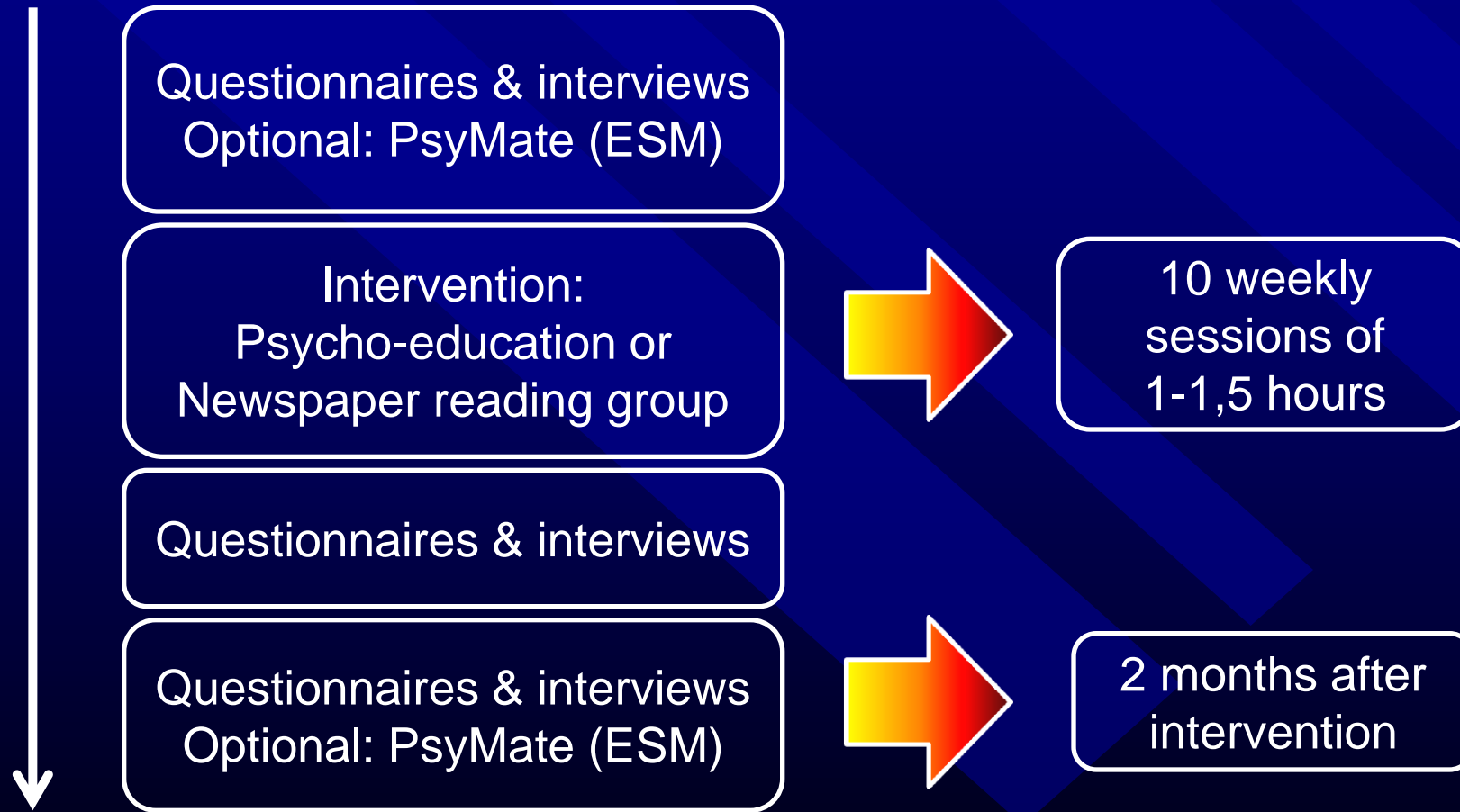


Characteristic	Assertive community treatment teams ¹⁶	Community mental health teams ¹⁷
Total team case load	80 to 100	300 to 350
Maximum individual case load	12	35
Availability	Extended hours (0800 to 2000 every day)	Office hours only (0900 to 1700 Mon-Fri)
Locations for appointments	Not office based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

ACT and CMHT

Killaspy et al, 2006

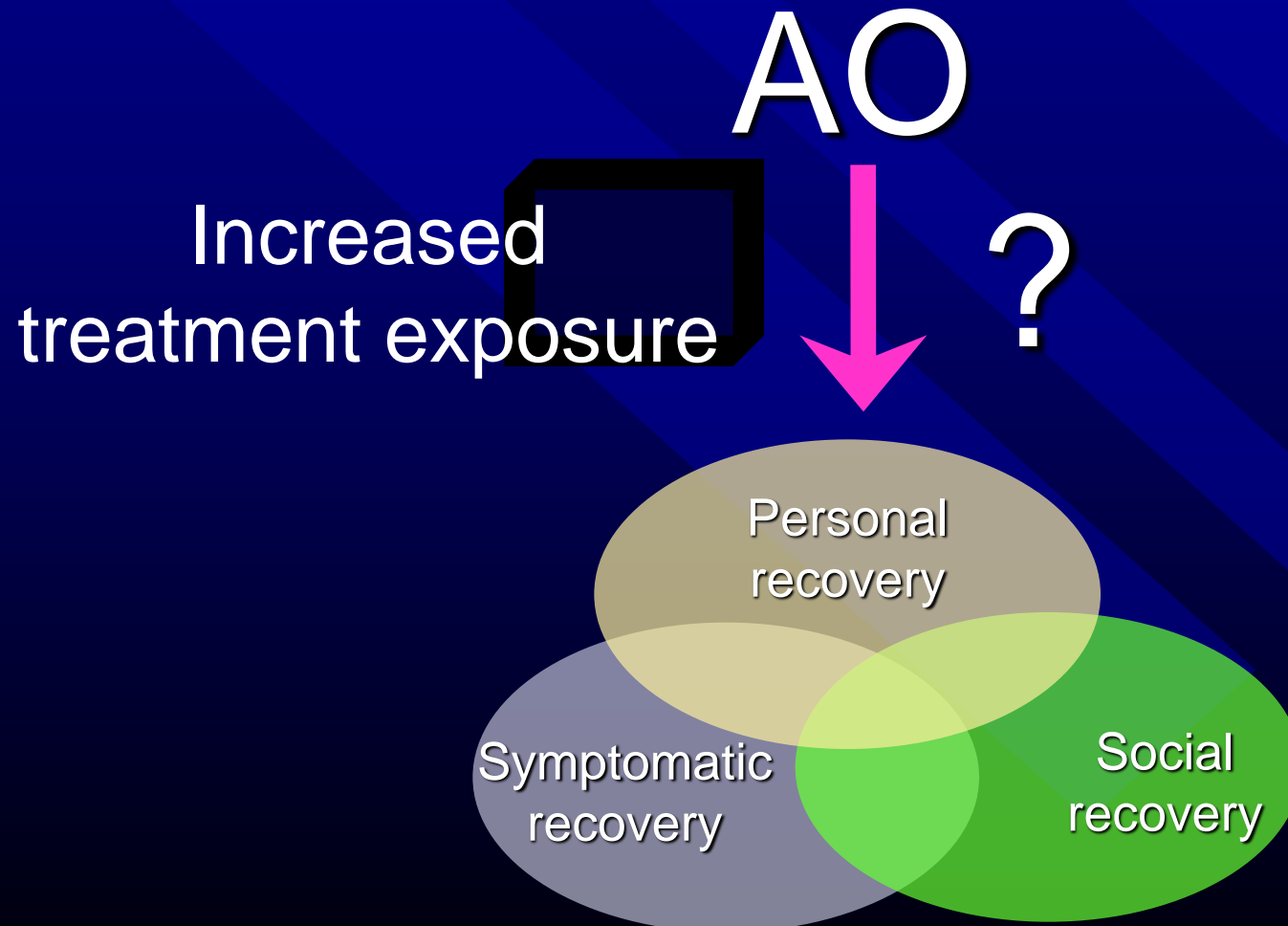
D-STIGMI: Study design



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



Are Treatments

Available?

Intensive CM for severe mental illness

“It is not clear.....what gain ICM provides on top of a less
more standard care
of n
↑ Satisfaction
↑ Continuity of care
know
d care

Cochrane review, Dieterich et al, 2010

Plasticity: neurocognition?

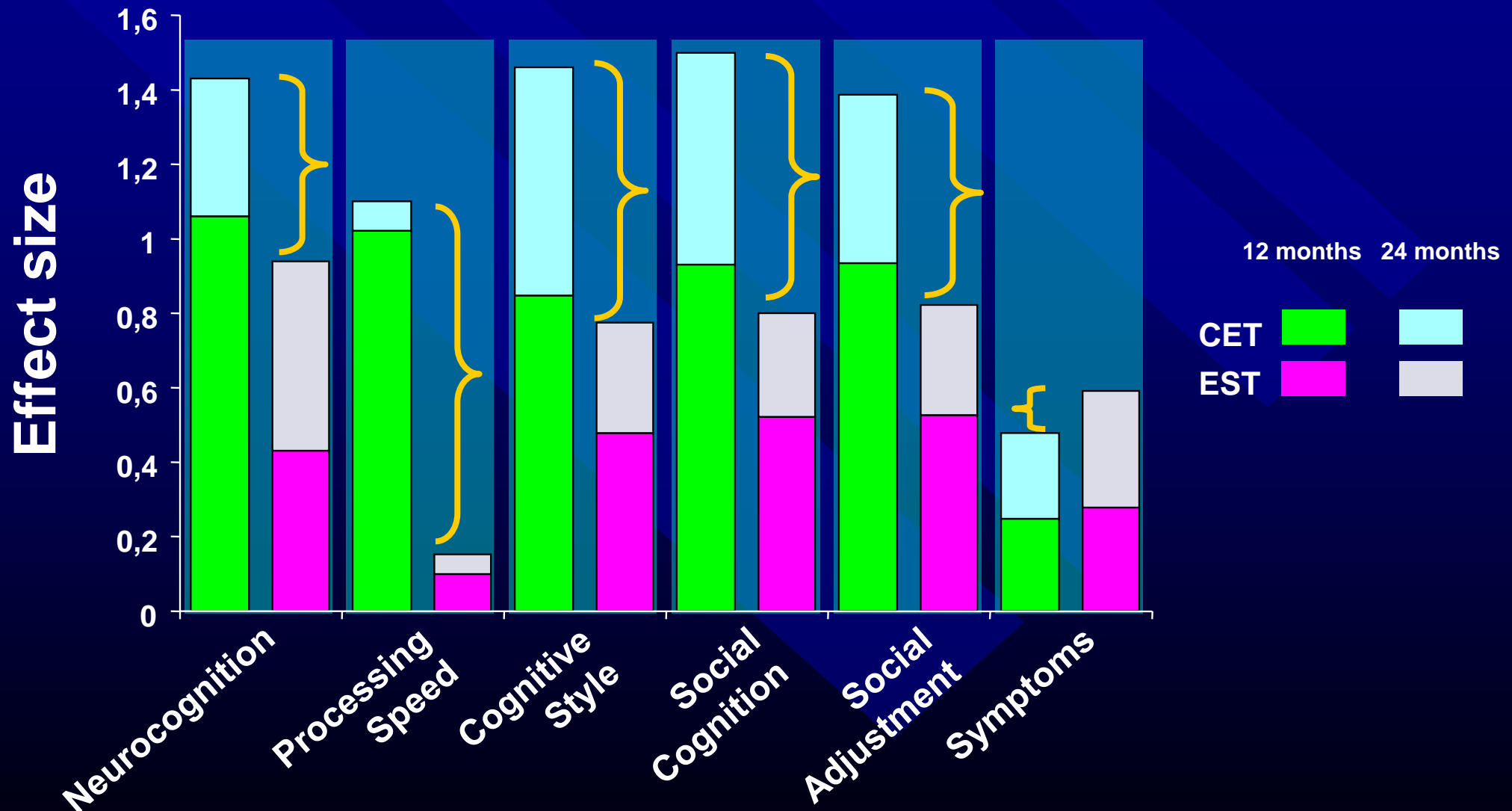
ORIGINAL ARTICLE

Cognitive Enhancement Therapy for Schizophrenia

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

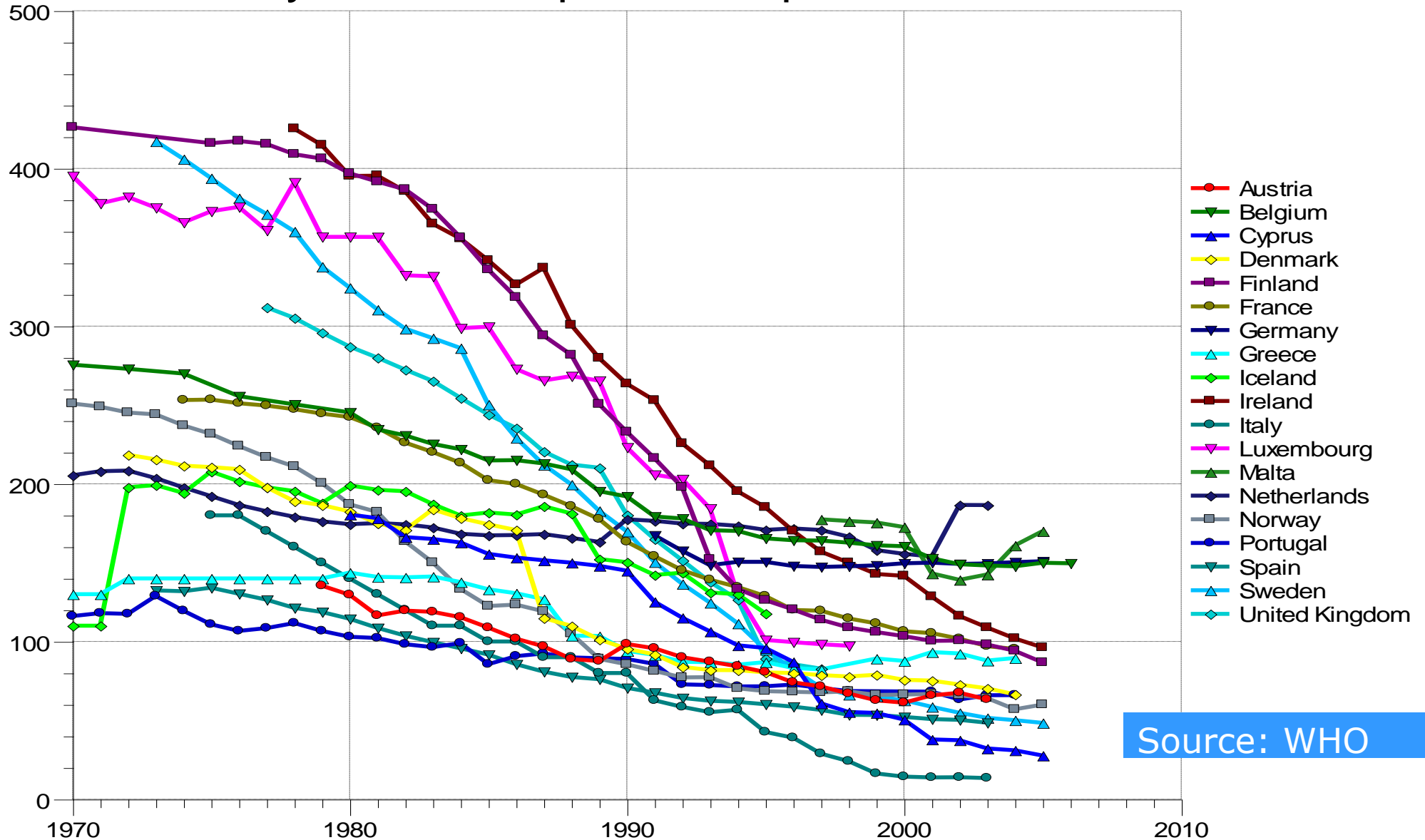
Gerard E. Hogarty, MSW; Samuel Flesher, PhD; Richard Ulrich, MS; Mary Carter, PhD; Deborah Greenwald, PhD; Michael Pogue-Geile, PhD; Matcheri Kechavan, MD; Susan Cooley, MSN; Ann Louise DiBarry, MSN; Ann Garrett, PhD; Haranath Parepally, MD; Rebecca Zoretich, MEd

Plasticity: Cognitive Remediation



Psychiatric beds - Western Europe

Psychiatric hospital beds per 100000



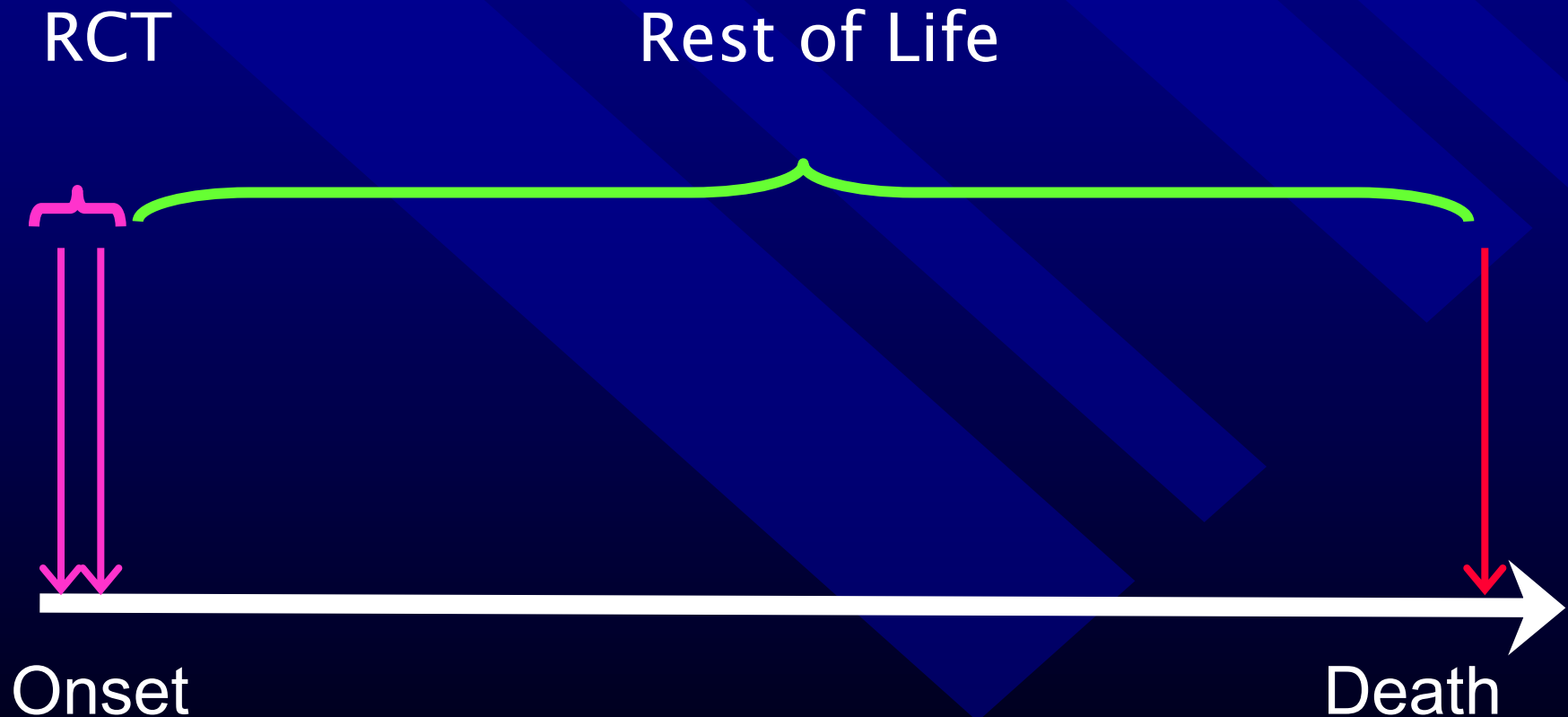
Source: WHO

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.....



CBT: Evolving Knowledge

Psychological Medicine (2010), **40**, 1943–1957. © Cambridge University Press 2010
doi:10.1017/S0033291710000772

REVIEW ARTICLE

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. Cuijpers^{1,2*}, T. Donker^{1,2}, A. van Straten^{1,2}, J. Li³ and G. Andersson^{4,5}

¹ Department of Clinical Psychology, VU University Amsterdam, The Netherlands

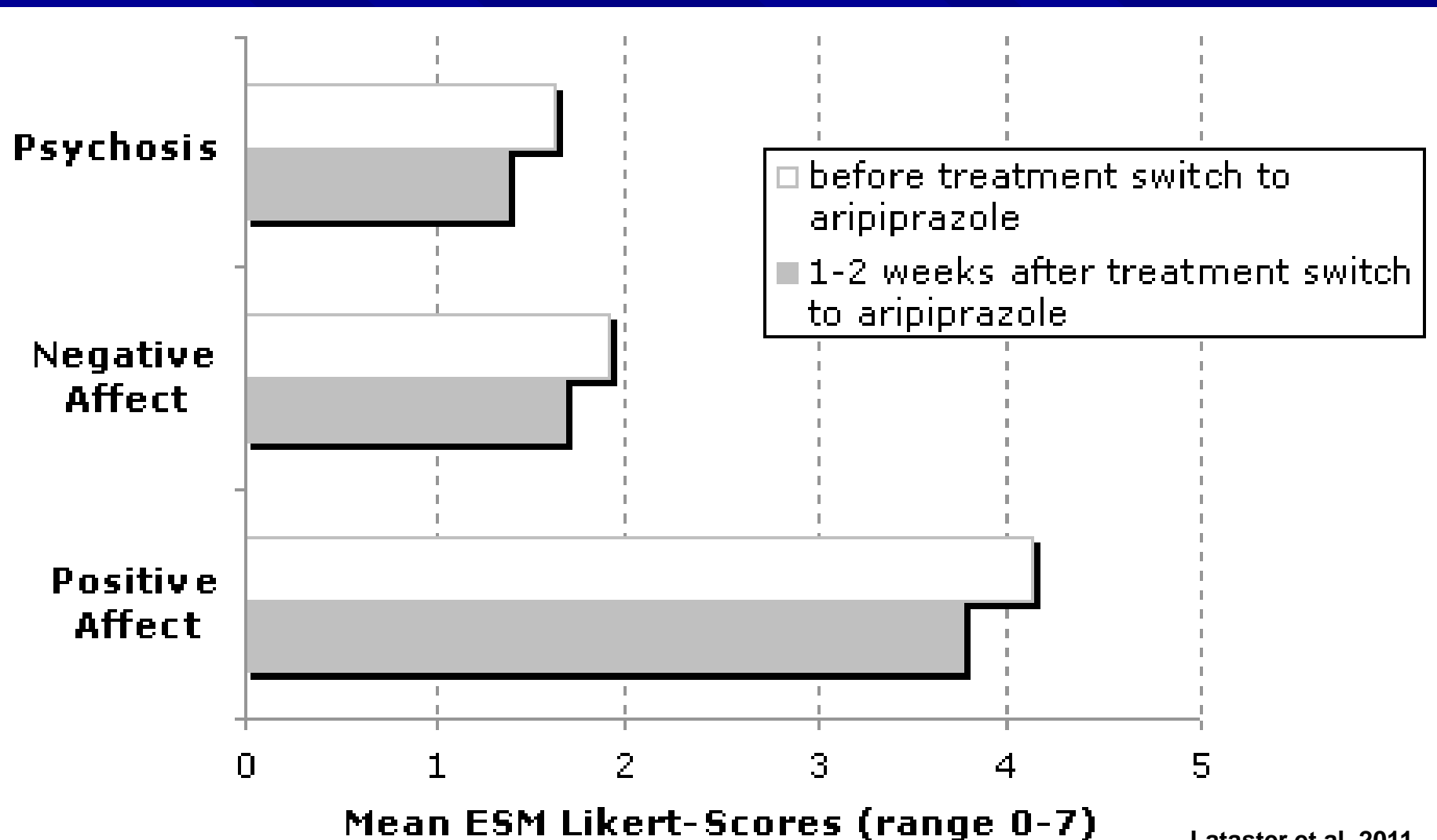
² EMGO Institute for Health and Care Research, VU University Amsterdam and VU University Medical Center, The Netherlands

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

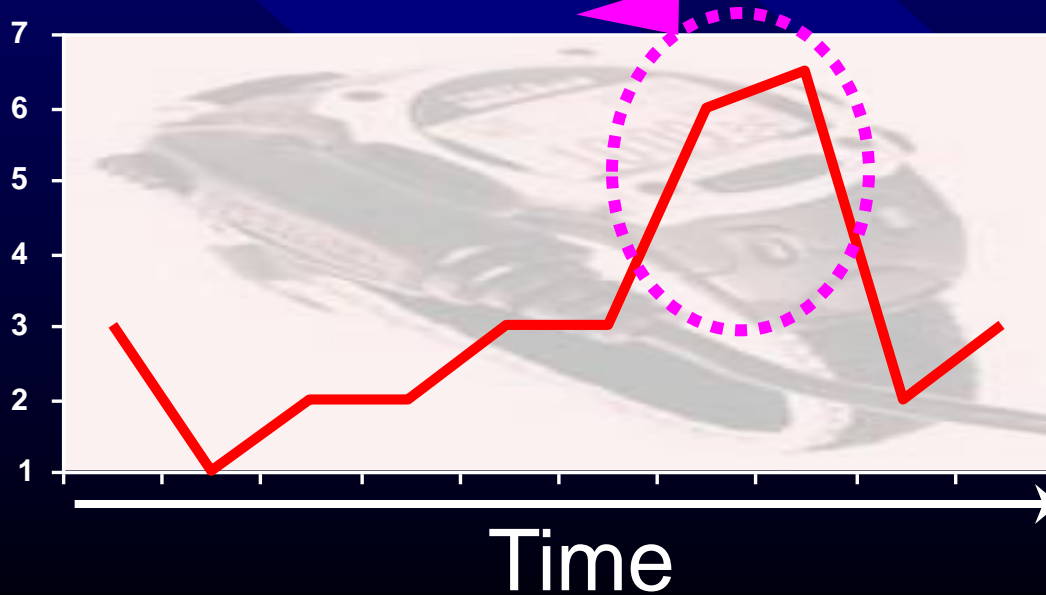


ESM Time Relationships

PA



Activity

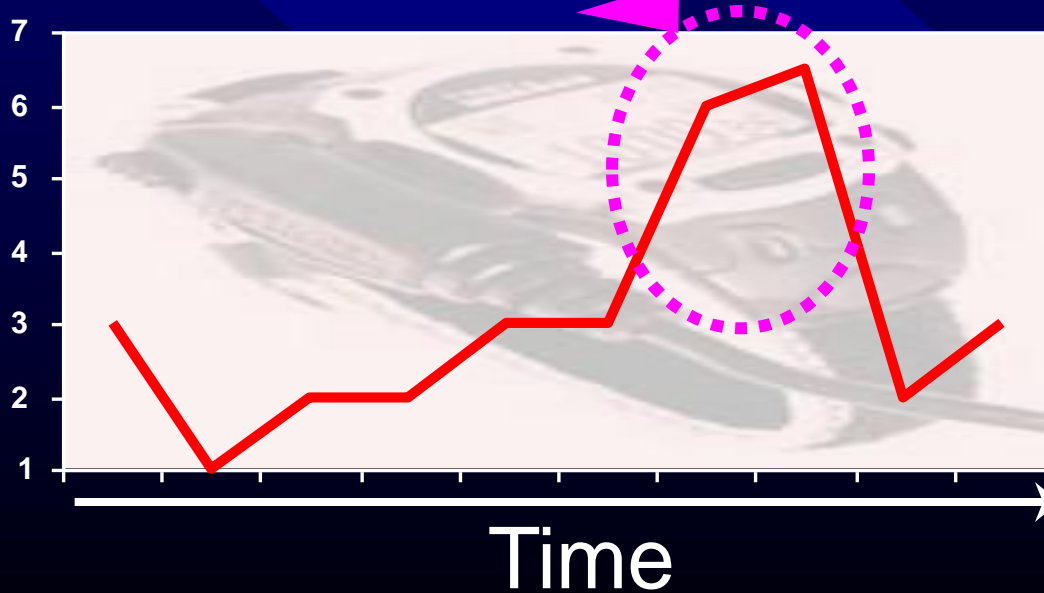


ESM Time Relationships

Compa-
ny X



NA

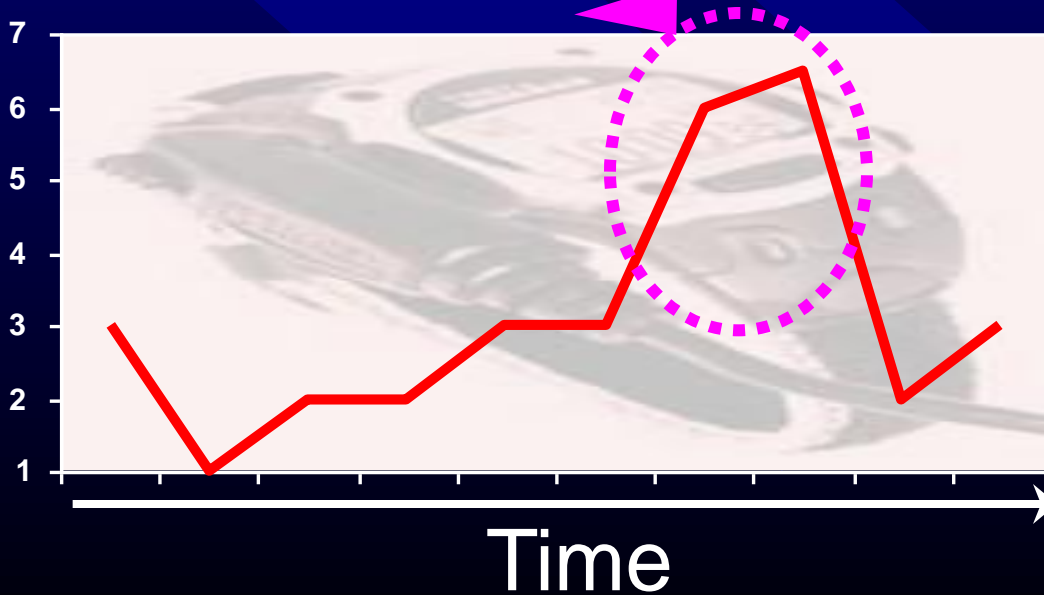


ESM Time Relationships

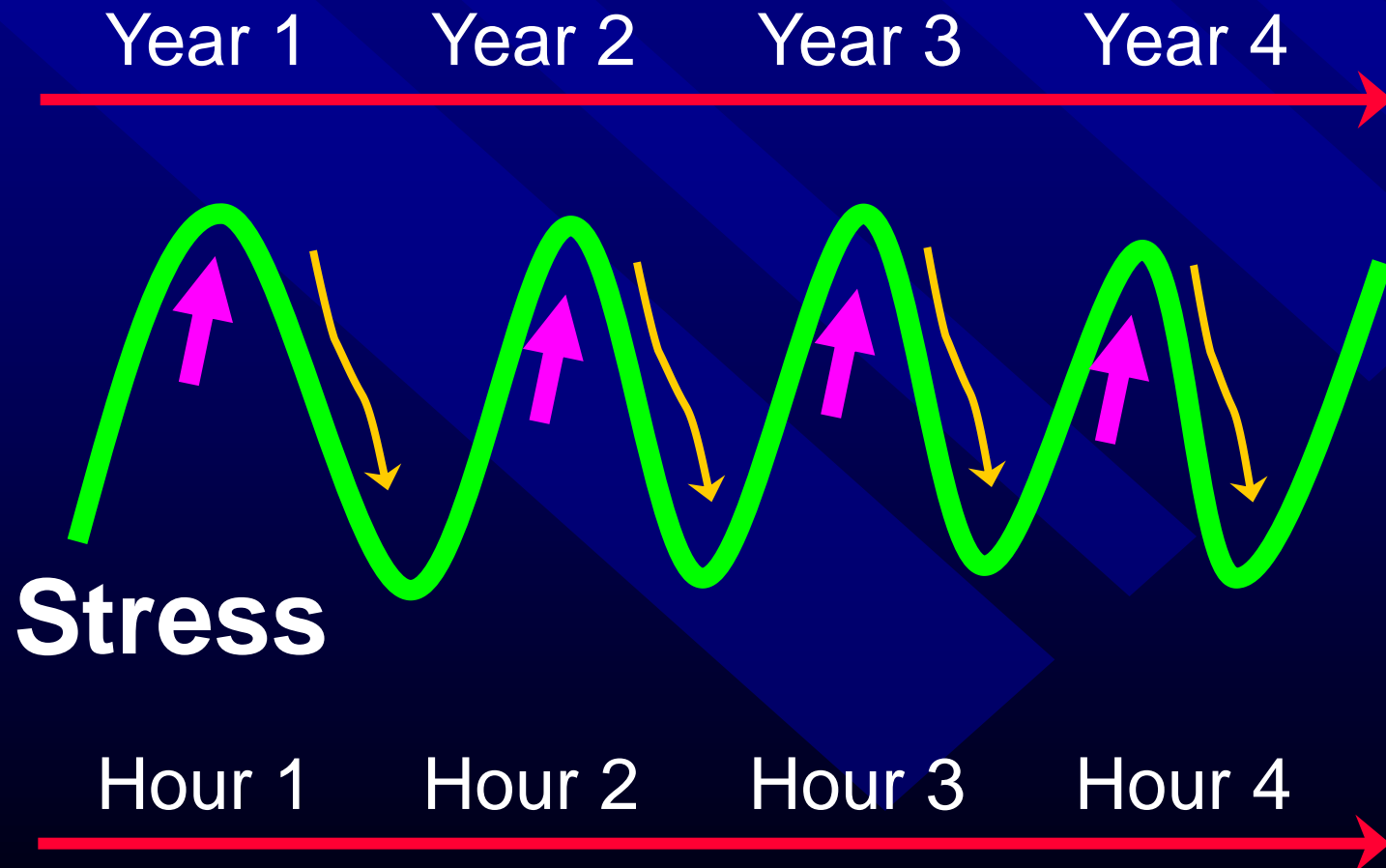
Self-esteem



Psychosis



Momentary Approaches GxE: Environmentally Reactive Phenotypes



“PsyMate”: Experience Sampling Method

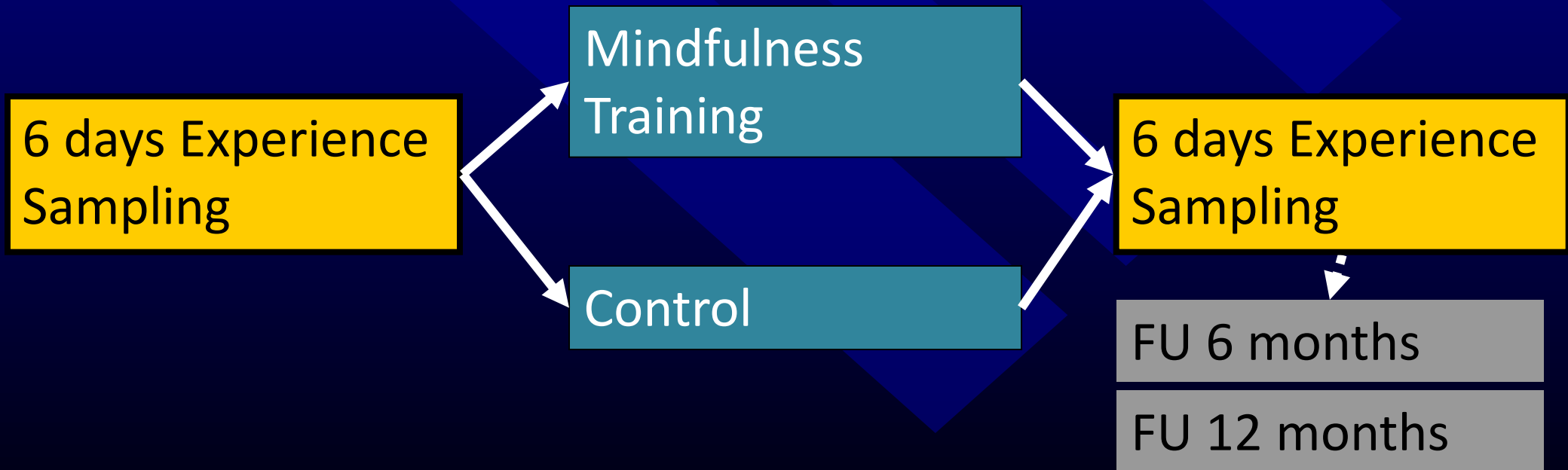


Situated Therapy

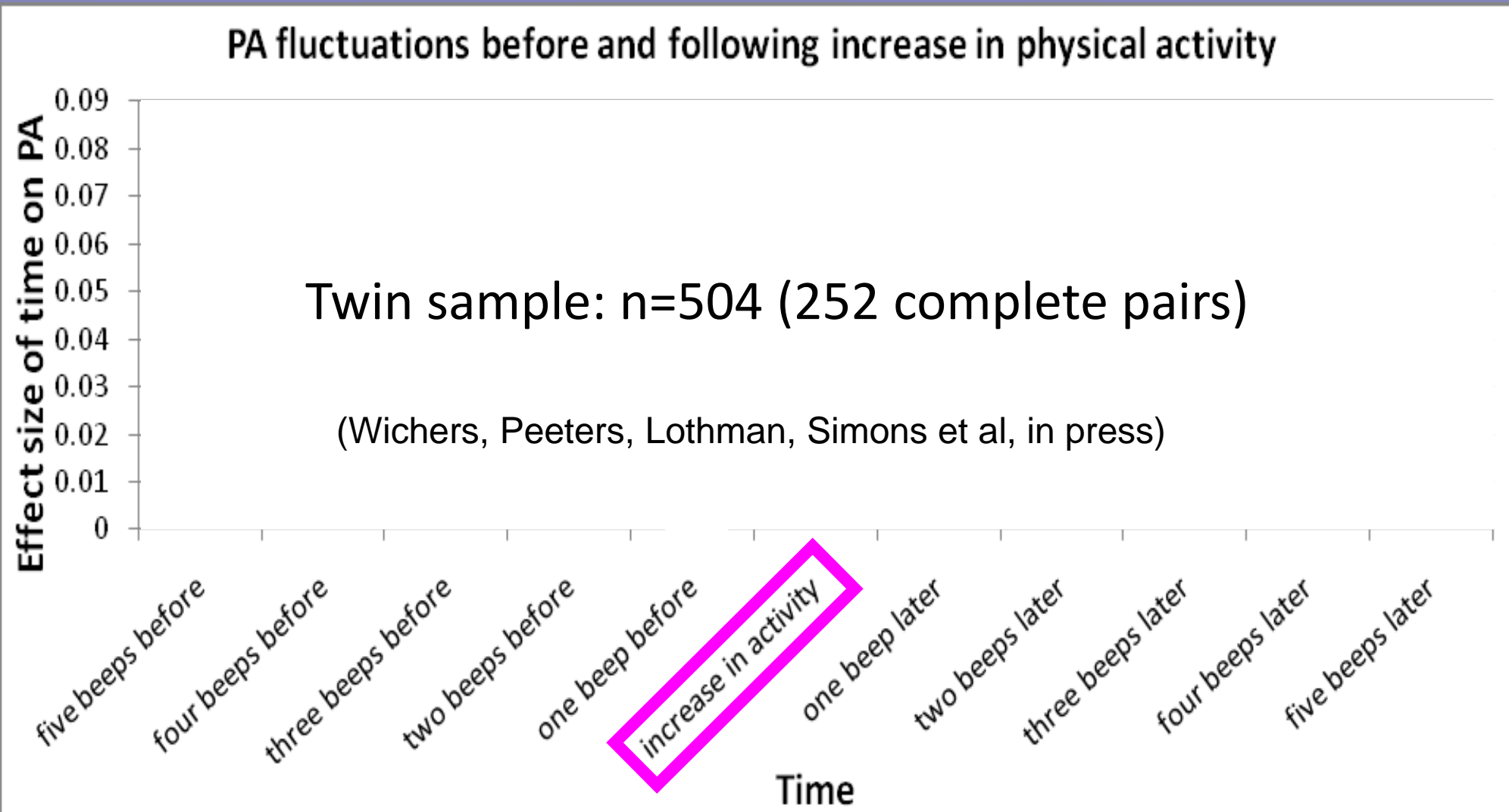
- ❖ Patient makes own diagnosis
- ❖ Patient assesses change
- ❖ Implicit (dysfunctional) patterns of experience made explicit
- ❖ Learning about experience in reaction to daily life circumstances

MindMaastricht RCT

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



“Inoculation” by Physical Exercise: Within-Study Replication Twin Design





Situated Therapeutics

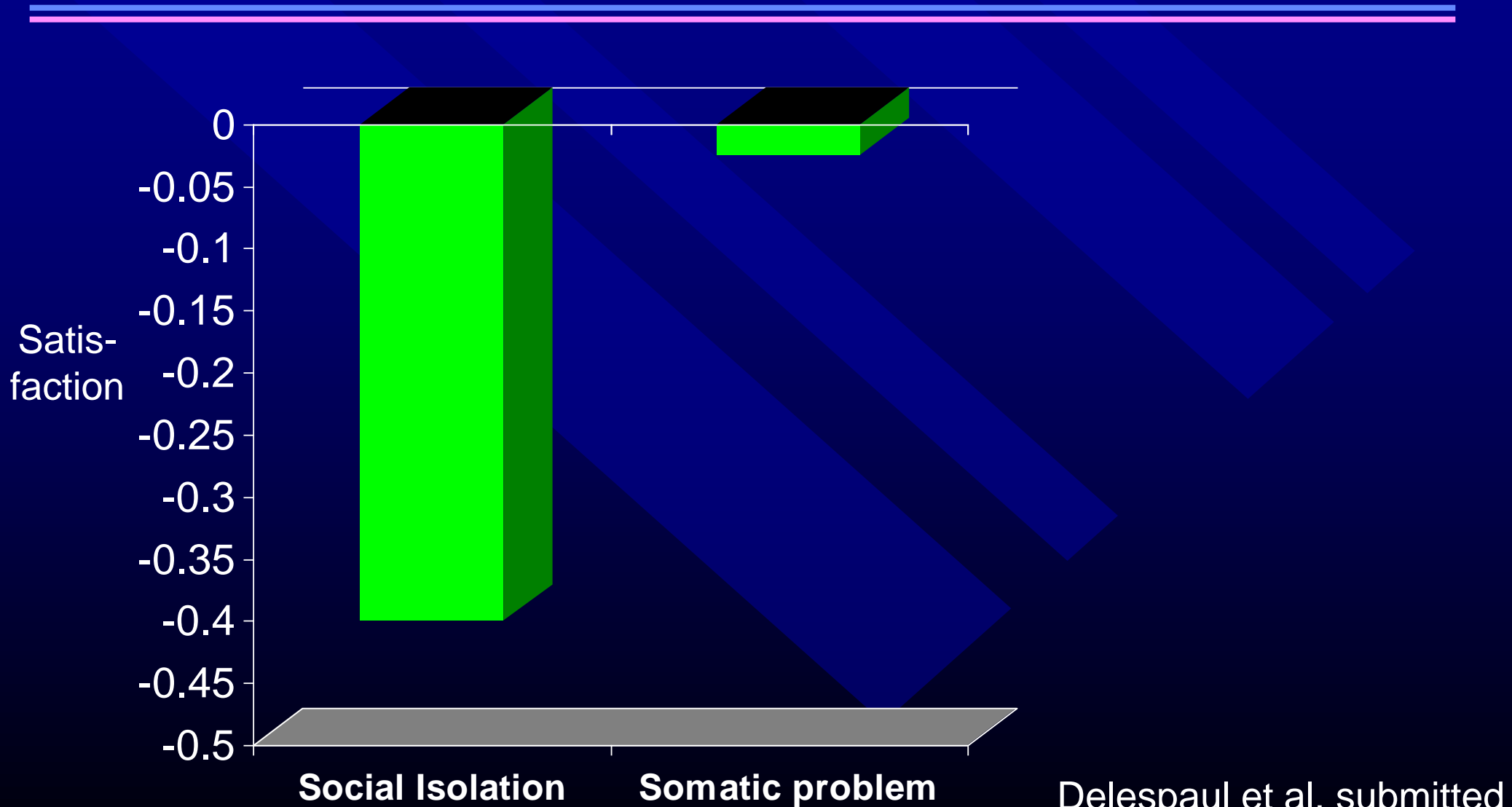
Self-Management

A 3D bar chart comparing the prevalence of Metabolic Syndrome (Met.Syindr.) and Diabetes Mellitus Type II (DM-II) between Men and Women. The Y-axis represents the prevalence percentage, ranging from 0 to 30. The X-axis shows two categories: Met.Syindr. and DM-II. The legend indicates that blue bars represent Men and red bars represent Women.

Condition	Men (%)	Women (%)
Met.Syindr.	19.5	28.0
DM-II	14.0	19.5

Bak et al, submitted

Patients do not attribute satisfaction with services to somatic outcomes



CBT: Evolving Knowledge

Psychological Medicine (2010), 40, 9–24. © Cambridge University Press 2009
doi:10.1017/S003329170900590X

REVIEW ARTICLE

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. McKenna^{3,4*}

¹ *Stobhill Hospital, Glasgow, UK*

² *School of Psychology, University of Hertfordshire, Hatfield, UK*

³ *Benito Menni CASM, Barcelona, Spain*

⁴ *CIBERSAM, Spain*

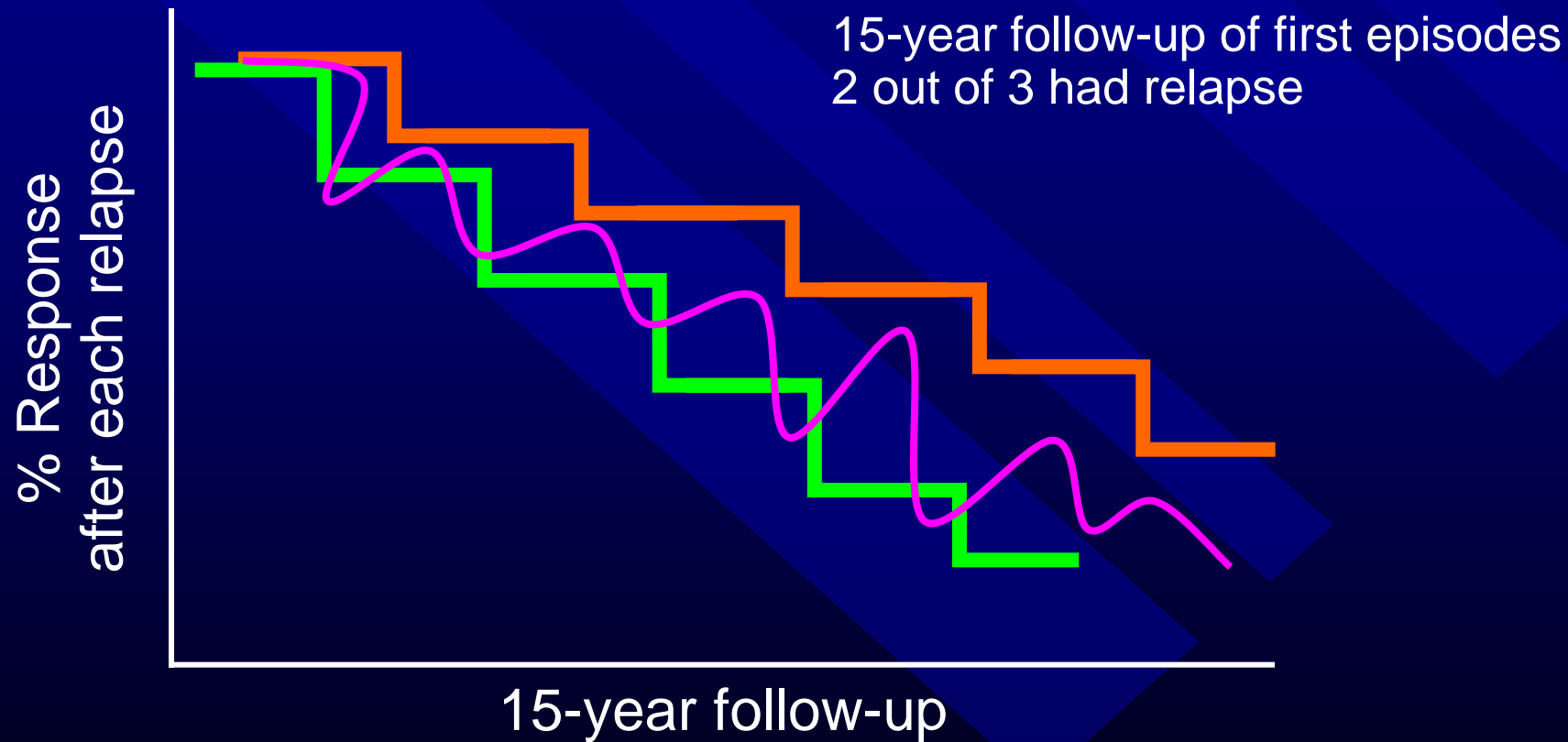
The Ultimate Global Sample

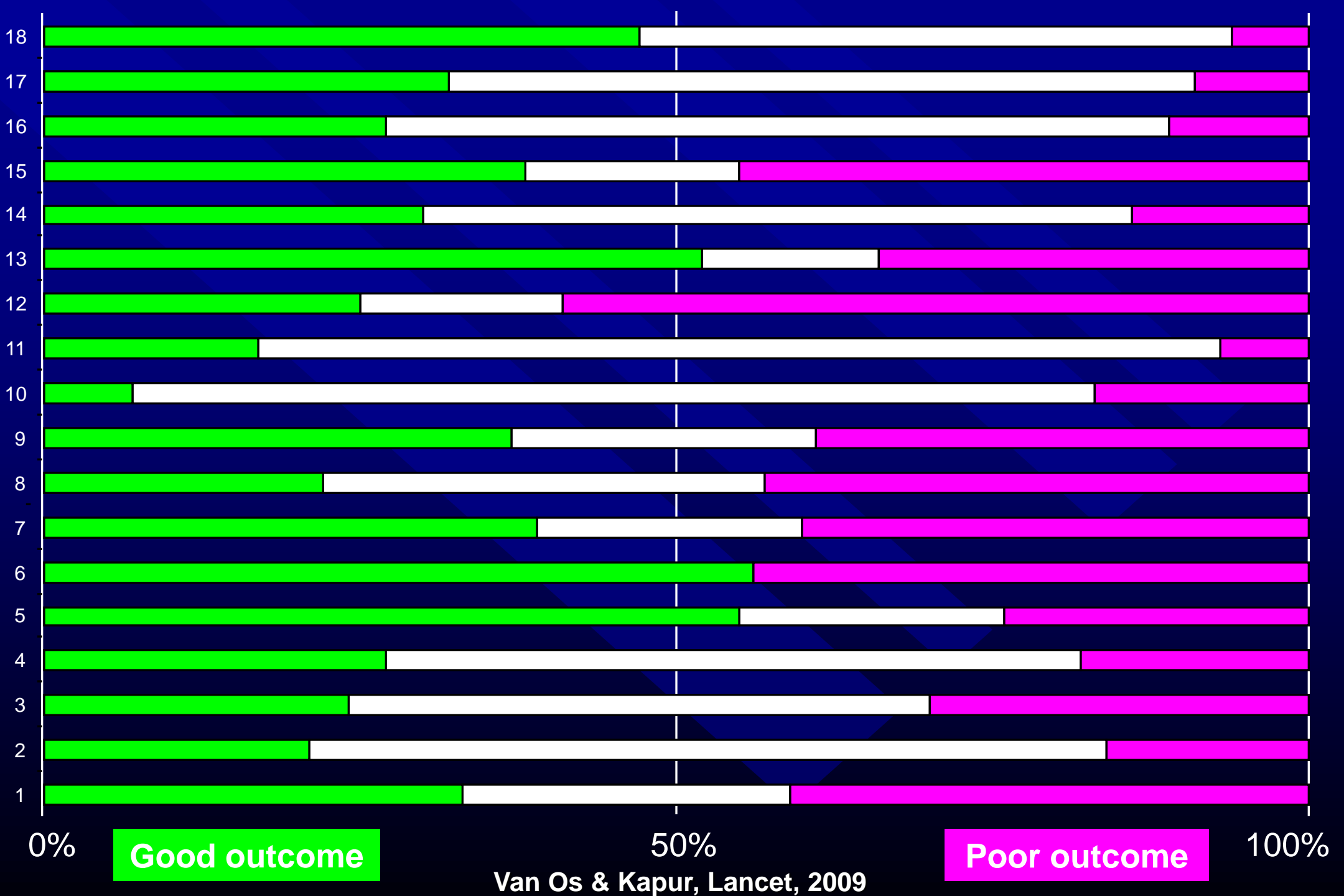
nature
genetics

Genome-wide association study identifies five new schizophrenia loci

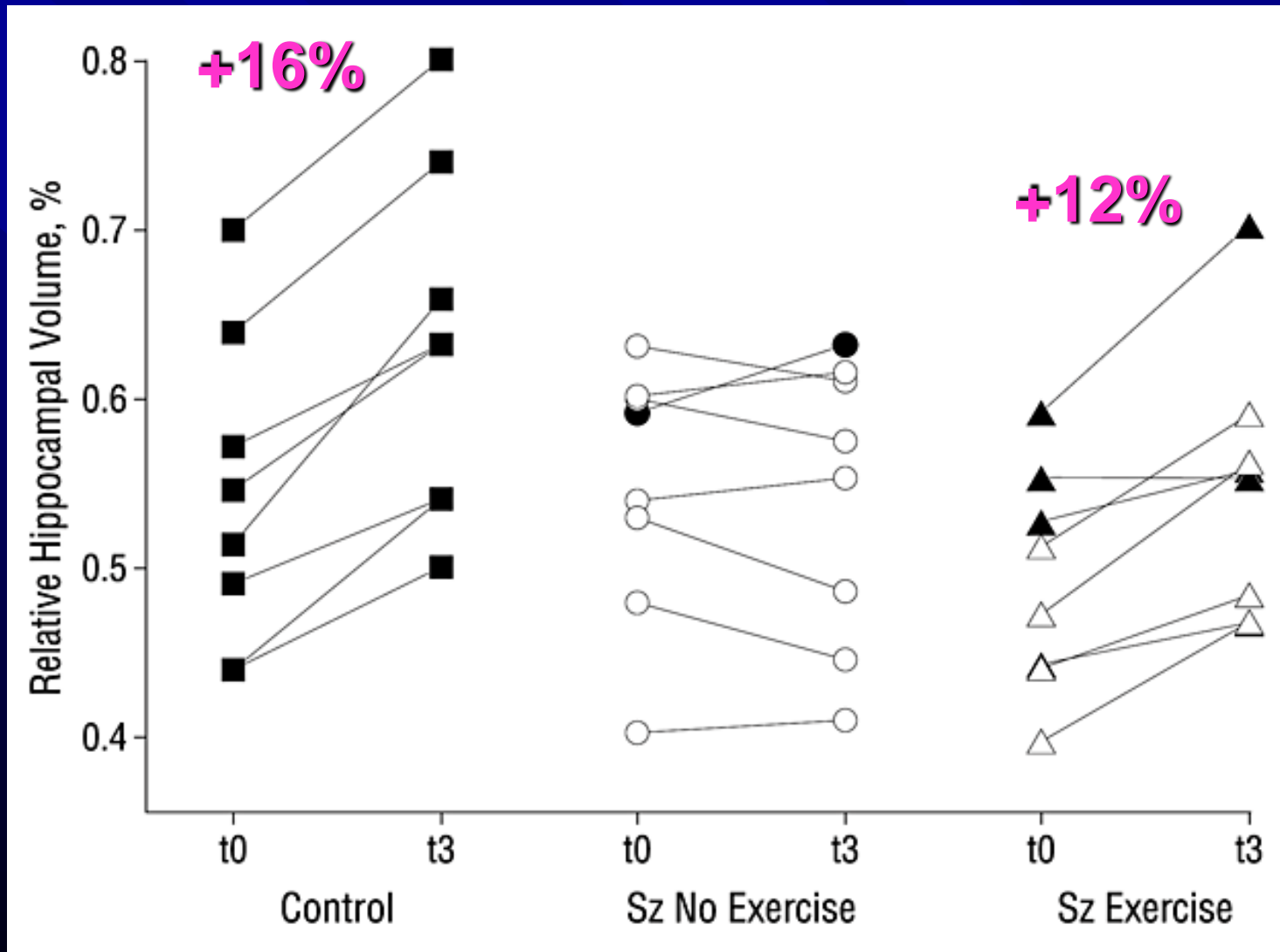
The Schizophrenia Psychiatric Genome-Wide Association Study (GWAS) Consortium¹

Recovery: Illness plasticity (illness changeability in response to treatment)





Plasticity: Hippocampal Volume and Aerobic Exercise



There is more to treatment than symptoms

