



**Three subgroups**

**Subclinical symptoms**

- Subthreshold intensity (relatively high frequent psychotic-like symptoms, e.g. Hearing one own thoughts loud inside the head)
- Subthreshold frequency (frank psychotic symptoms of low frequency, e.g. Hearing voices shorter than an hour once a month)

Genetic risk (parent with psychotic disorder)  
BLIPS (psychosis of maximum a week with recovery without treatment)

All have social decline of 30% over recent months or SOFAS < 55 in last year

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**UHR**

**Assessed with Comprehensive Assessment of At Risk Mental State (CAARMS)**  
Yung et al., 2005. *The Australian and New Zealand Journal of Psychiatry*, 39(11-12), 964-971.

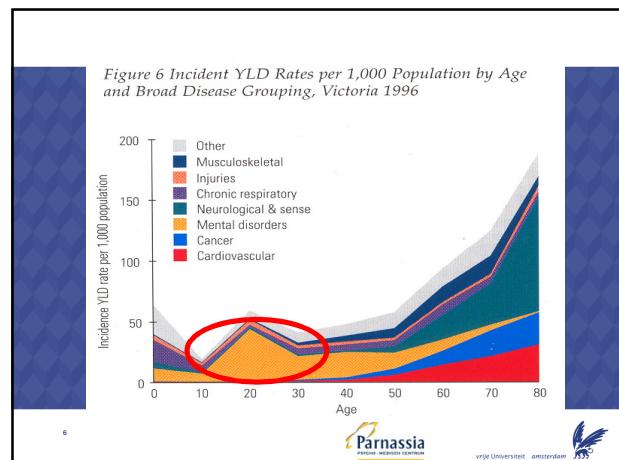
**Risk for transition**

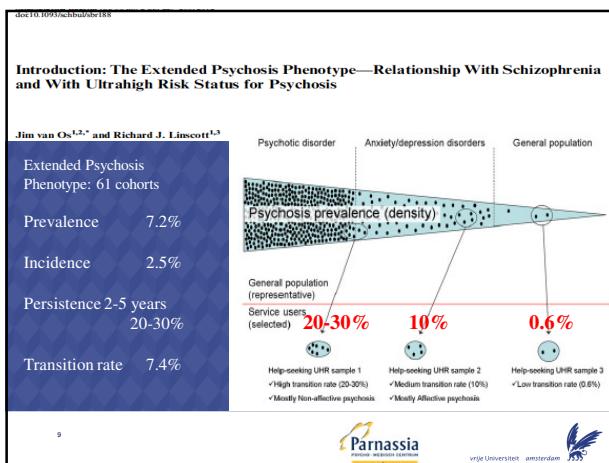
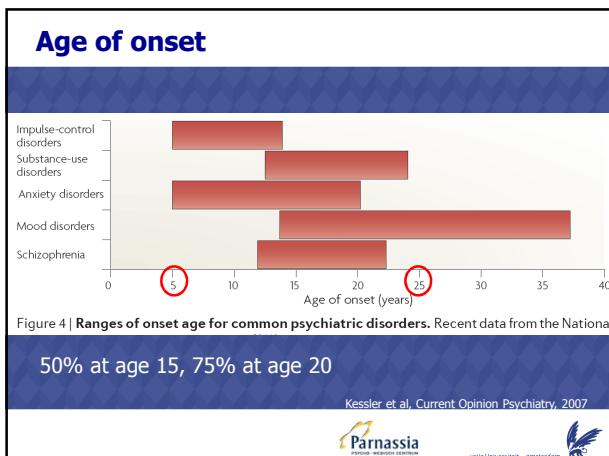
- 18% after 6 months of follow-up
- 22% after 1 year
- 29% after 2 years
- 36% after 3 years.

Fusar-Poli et al., 2012. *Archives of General Psychiatry*, 69(3), 220-9.

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**Transition rate, success rate, and Number Needed to Treat**

Van Os, J., & Delespaul, P. (2005). Toward a world consensus on prevention of schizophrenia. *Dialogues Clin Neurosci*, 7(1), 53-67.

Predictive value (%)	Treatment success rate (%)	Number needed to treat	Number needed to inconvenience
5	25	80	79
5	50	40	39
20	25	20	19
20	50	10	9
50	25	6	7
50	50	4	3

Table II. The number of people screening positive for subclinical psychotic experiences who needed to be treated to prevent one case of full-blown psychotic disorder, as a function of the predictive value of the test and the success rate of the prodromal treatment in preventing transition to full-blown psychotic disorder.

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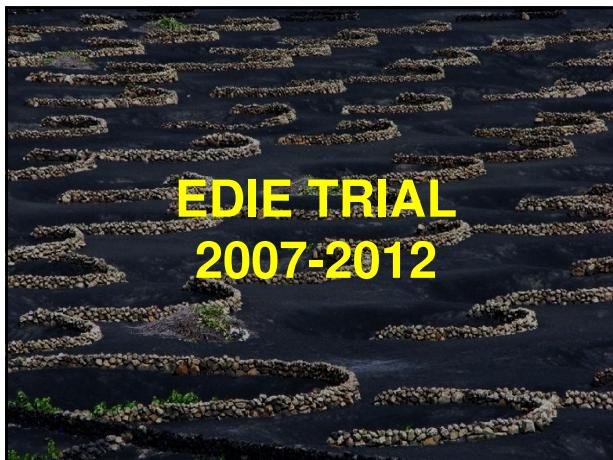
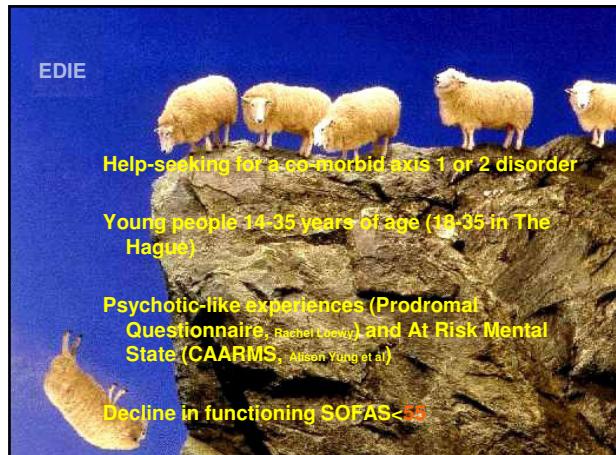
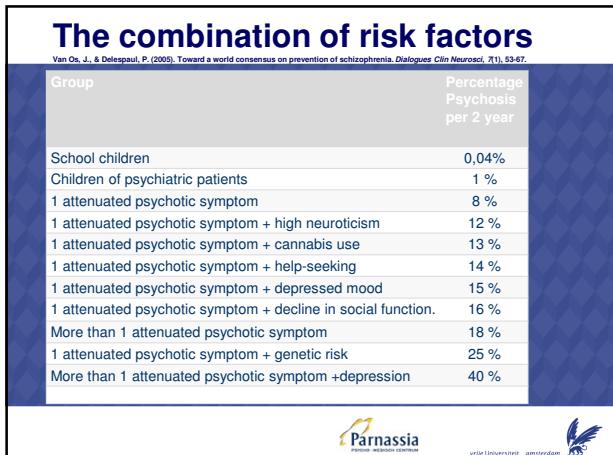


**'Closing in' strategy**

Van Os, J., & Delespaul, P. (2005). Toward a world consensus on prevention of schizophrenia. *Dialogues Clin Neurosci*, 7(1), 53-67.

Predictor A: subclinical psychotic experience	Predictor B: family history schizophrenia	Predictor C: A and B combined
1-year predictive value: 4%	1-year predictive value: 0.5%	2-year predictive value: 25%
Proportion of all schizophrenia predictable by this criterion: 90%	Proportion of all schizophrenia predictable by this criterion: 20%	Proportion of all schizophrenia predictable by this criterion: 18%

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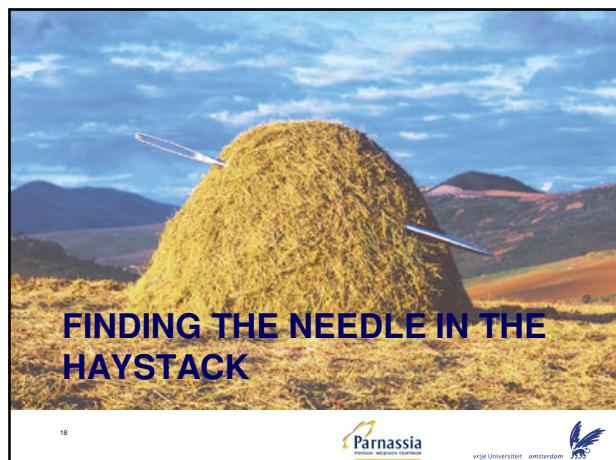


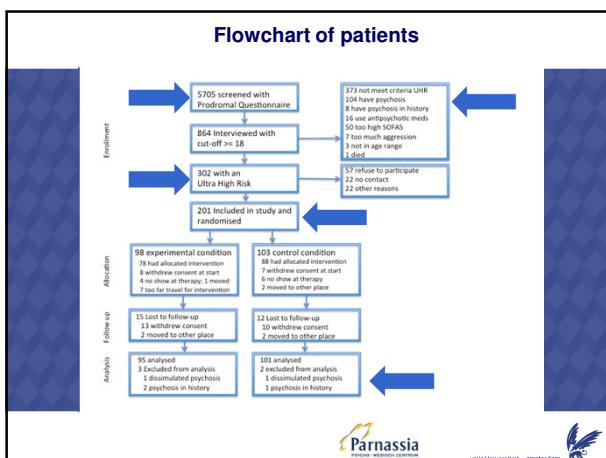
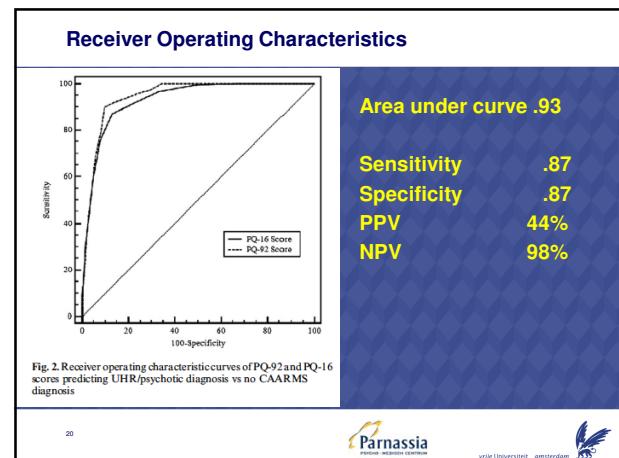
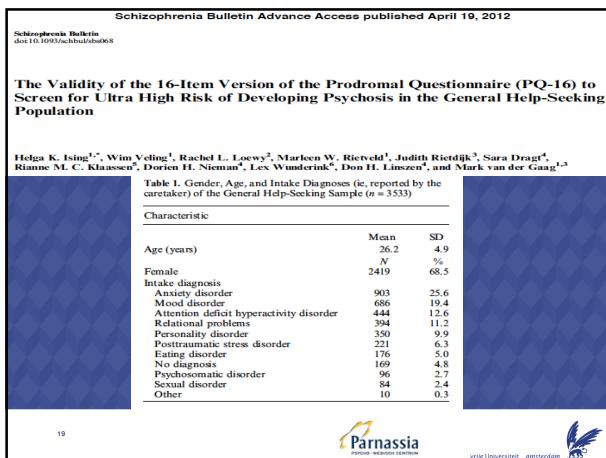
#### Acknowledgements Early Detection and Evaluation Intervention

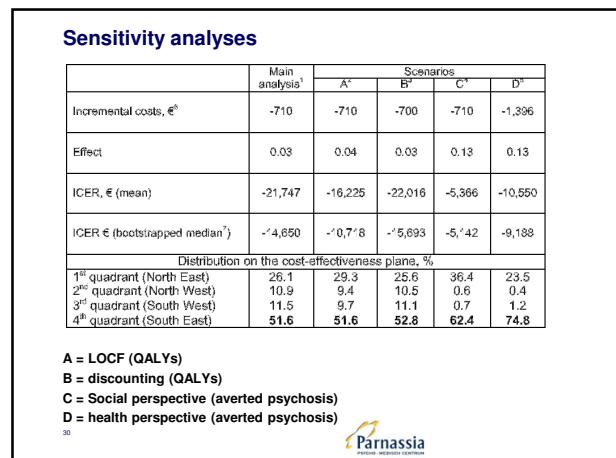
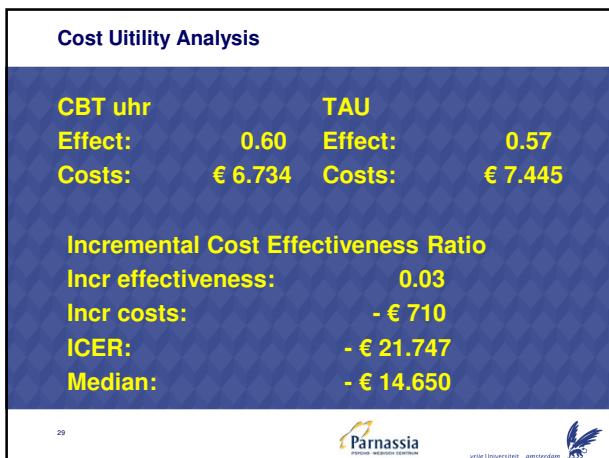
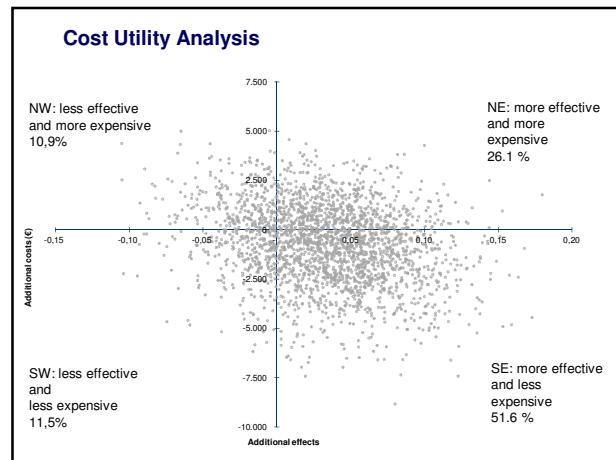
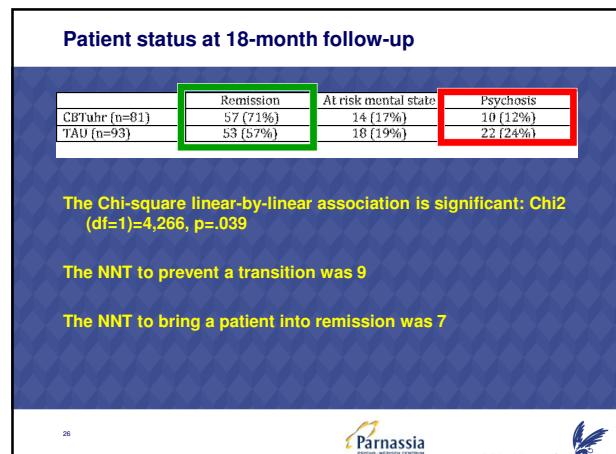
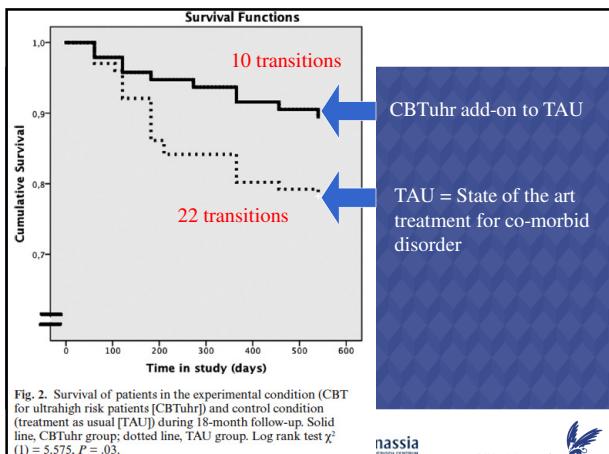
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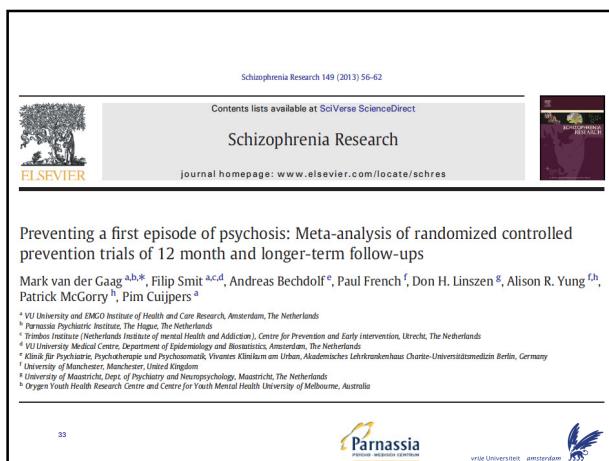
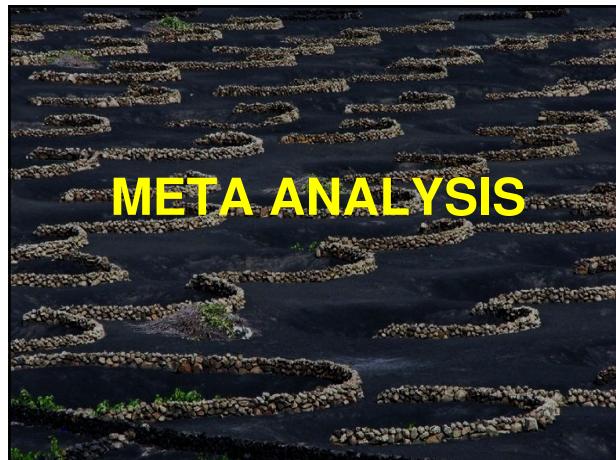




Results Cost Utility and Cost Effectiveness Analyses

## **CBT uhr is cost-effective:**

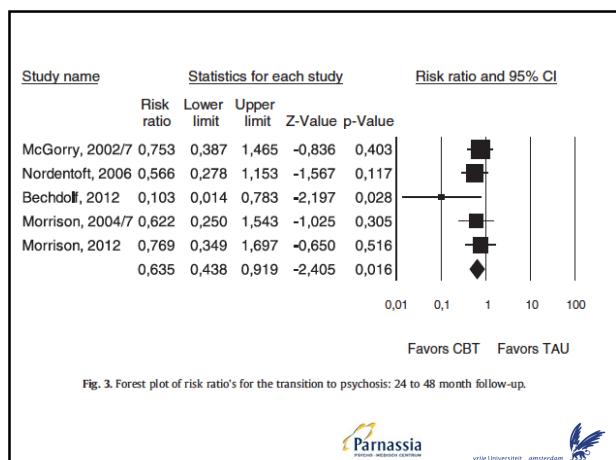
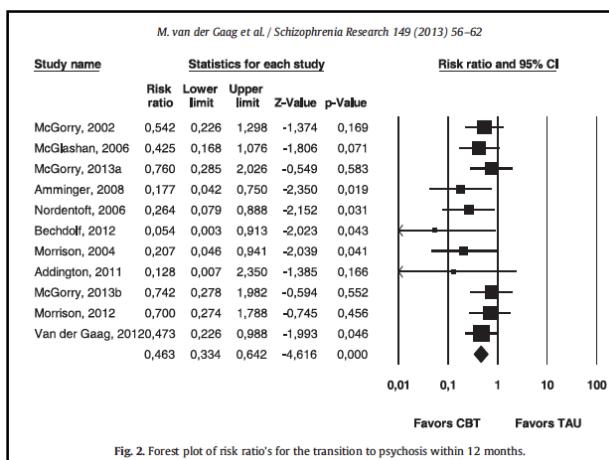
- Increased health QALYs for reduced costs
  - Reduced psychotic transitions for reduced societal costs
  - Reduced psychotic transitions for reduced health costs



**Table 1**  
Description of the interventions, patient characteristics, location, and transition criteria.

Description of the trials included, patient characteristics, interventions and outcome criteria											
Intervention	Author	Year	Duration interv.	Experimental condition intervention			Control condition			Country	Transit. criterion
				Dropout %	Age (mean $\pm$ SD)	Male Sex (%)	Intervention %	Dropout %	Age (mean $\pm$ SD)		
Anti-psychotic medication	McGarry et al.	2002	6 m.	1-2 mg/day	54%	20 (3.6) NBI	0%	20 (3.6) SBS	AU	CAARMS	
	McGashan et al.	2006	12 m.	Risperidone + CBT + NBI	55%	17 (4.0) 62%	Placebo	35%	18 (5.5) 68%	USA	SIPS
	McGarry et al.	2013	12 m.	1-5 mg/day Olanzapine	37%	18 (3.0) 53% Placebo	ST 32%	19 (3.7) 46%	AU	CAARMS	
Omega-3 fatty acid integrated psychological intervention	Amminger et al.	2010	2 m.	Risperidone + Omega-3	7%	17 (2.4) 34%	Placebo	5%	16 (1.7) 33%	AUS	CAARMS
	Nordentoft et al.	2006	24 m.	17 day omega-3	12%	21 (5.6) 74% CMHT	19%	25 (3.9) 59%	DK	KD-10	
	Bachofel et al.	2012	12 m.	ACT + STT + MFP	12%	25 (5.4) 62% ST	CBT + SST + CR + MFP	19%	27 (6.2) 65% ECR	EIPS	
Cognitive behavioral therapy	Morrison et al.	2004	6 m.	CBT	30%	21 (4.9) 60% Monitoring	20%	22 (5.2) 83%	UK	CAARMS	
	Addington et al.	2011	6 m.	CBT	41%	21 (4.5) 62% ST	38%	21 (4.5) 75% CR	CA	SIPS	
	McGarry et al.	2013	12 m.	Placebo + CBT	34%	18 (2.7) 39% Placebo + ST	23%	19 (3.7) 46%	AU	CAARMS	
Other	Morrison et al.	2012	6 m.	CBT	34%	21 (4.2) 62% Monitoring	35%	24 (5.1) 63% UK	CAARMS		
	van der Gaag et al.	2012	6 m.	CBT + TAU	15%	23 (3.6) 56% TAU	12%	23 (3.5) 49%	NL	CAARMS	

CBT = cognitive-behavioral therapy; NBI = Needs Based Intervention; ST = Supportive Therapy; ACT = Assertive Community Treatment; SST = Social skills training; MFP = Multi-family psycho-education; OMHT = Community Mental Health Team; CR = Cognitive remediation; TAU = standard treatment for non-psychotic disorder; AU = Australia; USA = United States of America; AUS = Australia; DK = Demander; Ger = Germany; UK = United Kingdom; Can = Canada; NL = Netherlands; CAAIMS = Comprehensive Assessment of At-Risk Mental States; SIRS = Structured Interview for Prodromal Symptoms; ICD-10 = International Classification of Diseases, version 10; ERS = ersch.edu; APACHE State =  $\Sigma$  anterior-posterior scale.



## Results

**Early detection and indicated prevention are about to become an evidence-based intervention**

**CBT that showed a transition reduction of 48% and a NNT of 13 in five RCTs with 672 subjects**

**CBT uhr is cost-effective: increased health for reduced costs**

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## From Routledge

**CBT for Those at Risk of a First Episode Psychosis**

Evidence-based psychotherapy for those with an 'At Risk Mental State'

By **Mark van der Gaag**, VU University and Parnassia Psychiatric Institute, The Netherlands, **Dorien Nieman**, Academic Medical Centre, The Netherlands and **David P. G. van den Berg**, Parnassia Psychiatric Institute, The Netherlands



"This book is an important contribution to the treatment of people with a high risk for developing psychosis. The authors succeed in integrating recent research findings on cognitive biases and the psychology of salience into a cognitive behavioural therapy framework. The authors are excellent researchers and therapists and this effective therapy is described stepwise, making this handbook transparent and easy to read." – Aaron T. Beck, M.D., Professor of Psychiatry, University of Pennsylvania, USA

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## Implementatietaject

GGz Friesland	3 x CAARMS training 2 dagen 5 videoconferences 3 toetsen
UMCG	
Accare	
GGz Drenthe	2x CGTuhr basis 8 dagen training 6 supervisiemiddagen
Mediant	
Dimence	
Noord-Holland Noord	2 x CGTuhr gevorderden 4 dagen training 4 supervisiemiddagen
Dijk en Duin	
Altrecht	
BAVO Europort	1 x Train de trainer 2 dagen
GGz Eindhoven	1 x Management 1 dag
Mondriaan	
AMC	
Rivierduinen	
Parnassia	Onderzoek Implementatie evaluatie

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**Thank you for your attention!**

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