Effective Training and Education for Early Psychosis Intervention Programs:

A Pilot Project to Develop and Test Evidence-Based Approaches to Training in Ontario

Chiachen Cheng
Canadian Mental Health Association Thunder Bay

March 28, 2012

Dr. Chiachen Cheng¹,² Carole Lem¹ Dr. Andrew Howlett³ Dr. Mark Hanson³,⁴

¹: Canadian Mental Health Association – Thunder Bay Branch
²: Centre for Addiction and Mental Health (CAMH)
³: University of Toronto, Department of Psychiatry
⁴: The Hospital for Sick Children (Sick Kids)
ACKNOWLEDGEMENTS

The evaluation team would like to especially thank Mr. Maurice Fortin, Executive Director of Canadian Mental Health Association-Thunder Bay Branch for his unwaivering support and contributions to this evaluation initiative. As well, Dr. Carolyn S. Dewa and Mr. Wayne deRuiter at the Centre for Research on Employment and Workplace Health in Centre for Addiction and Mental Health for their ongoing research mentorship, data analysis support and guidance. Without these individuals, the evaluation project would have only been a ‘good idea’.
Training about early intervention in psychosis has focused on family physicians to detect psychosis and intervene early. In rural Ontario, there is a shortage of primary care. We evaluated a training program for non-medical, rural youth mental health service providers.

**THE PURPOSE**

(1) To evaluate the effectiveness of specialized Early Psychosis Intervention (EPI) training in Northwestern Ontario via face-to-face and videoconference training; (2) To increase the capacity of NWO mental health service providers to identify and treat early psychosis; (3) To increase awareness of and access to EPI services for service providers, youth and families.

**THE PROGRAM**

Canadian Mental Health Association-Thunder Bay Branch (CMHA-TB) is part of a nation-wide charitable organization that promotes the mental health of all and supports the resilience and recovery of those experiencing mental illness. Thunder Bay is located in Northwestern Ontario (NWO). Early intervention in psychosis (EPI) was developed as an innovative and youth-focused approach to treating the early stages of psychosis. First Place Clinic and Regional Resource Centre (First Place) is an EPI program within CMHA-TB and is the only EPI service provider in NWO. The training program that was evaluated was a core mandate of First Place. While some EPI training has been completed, a full evaluation had yet to be implemented.

**THE PLAN**

The participants were mental health care providers of youth 18 years and younger, from Ministry of Child & Youth Services (MCYS) funded agencies across NWO. The intervention was a two-day training session; the training was delivered simultaneously via two modalities: on-site and videoconferencing. The evaluation consisted of administering previously validated knowledge questionnaires (Ascher-Svanum, 1999; Smith & Birchwood, 1987), satisfaction surveys, focus group interviews, region specific clinical outcomes data and knowledge
exchange activities. The questionnaires were administered pre and post-intervention, three, six and nine months follow-up. At six months follow-up, focus groups with participants were conducted across the study region. The purpose was to understand the participants’ experience of the intervention and of the evaluation process.

THE PRODUCT

19 participants across four community mental health agencies participated. Seven received the intervention on-site, and 12 via videoconferencing. Almost half of the participants had more than 10 years’ work experience. Among those participants with over 10 years of work experience, only half felt comfortable dealing with psychosis in youth. Pre-intervention, the level of EPI knowledge was high as participants had achieved an average score of 84 percent. Overall, the percent score did not significantly change over time. A repeated-measures ANOVA demonstrated a non-statistically significant increase in knowledge between pre-intervention and the three-month follow up; no significant change in scores was observed during the evaluation period. For any time period, there was no difference in score between those who had received the intervention on-site versus videoconferencing. The number of referrals meeting EPI service eligibility from participating agencies increased from zero for the year preceding intervention, to 50% of referrals in the 10 months post intervention. From the focus group interviews, emerging themes were: (1) growing concern for the youth population in the region, (2) innovative learning experience (the project intervention) helped to establish a partnership with specialized EPI services, (3) the intervention helped to strengthen professional relationships within agencies and between agencies, and (4) the evaluation piece was novel, enhanced the learning experience for participants and engaged them to continue with ongoing learning and evaluation.

Amount awarded: $ 34,126
Final report submitted: March 28, 2012
Region: Northern (Thunder Bay)
<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>4</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>10</td>
</tr>
<tr>
<td>RESULTS</td>
<td>15</td>
</tr>
<tr>
<td>CONCLUSION AND RECOMMENDATIONS</td>
<td>23</td>
</tr>
<tr>
<td>REFERENCES AND APPENDICES</td>
<td>26</td>
</tr>
</tbody>
</table>
BACKGROUND FOR PROGRAM

Psychosis in adolescents often presents as a clinical challenge because most clinicians are not equipped with the skills to effectively intervene, and often these adolescents are referred to a specialist or tertiary program. In Northern Ontario, most mental health clinicians work as generalists, often with a wide scope of practice. Many have voiced the need to understand and receive training in identifying early psychosis and implementing treatment. With increased capacity for early psychosis intervention (EPI), the goal is to intervene early, reduce the morbidity from long duration of untreated psychosis (DUP), and reduce the need to be treated outside of their community. Arguably, one of the tenets of EPI is early detection and identification to facilitate a decrease in DUP (McGorry, Killackey, & Yung, 2007). Education and training efforts to increase capacity for early psychosis detection and treatment among service providers who work with youth has been a priority for policy-makers. A number of countries (i.e., United Kingdom, New Zealand) have devoted significant resources to training and educating their general healthcare workforce in EPI (Ehmann, MacEwan, & Honer, 2004). Training and education of general practitioners, educators and other providers who work with youth remains an important facet for early intervention, because these providers are more likely to have first contact with youth experiencing early psychosis, rather than specialized EPI services. The goal of increased capacity and early intervention, right in their communities, is that more youth can remain in their communities.

PROGRAM DESCRIPTION

The setting of the program is Northwestern Ontario (NWO), MCYS Northern Region. The landmass is vast, approximating the size of France, or 45% of Ontario’s landmass. The 235,000 people living in the region represent 2% of Ontario’s population, with a population density of 0.4/km². Approximately 50% of the population live in the one mid-sized city, 35% live in the six smaller industrial towns and over 28 townships, and 15% live in the 64 remote First
Nations communities. Participants of the training program are usually mental health and healthcare providers for youth (ages 14 to 35 years) experiencing their first episode of psychosis, or early severe mental illness such as schizophrenia. For the purposes of this evaluation project, the participants are those who only service child and adolescents, up to 18 years of age.

The training program for mental health workers was developed by a consortium in the UK (Shiers & Smith, 2007). This program has been distributed widely and the authors have granted Canadian Mental Health Association-Thunder Bay Branch permission for training purposes since 2006. The original training program was approximately 17 hours long, with the aim to provide education about psychosis to a wide audience. The authors were also clear that the program can be adapted and only components used, depending on the audience. The UK consortium has used the program mainly to train new early psychosis intervention mental health service providers, though the content can be used to educate non-mental health workers such as teachers and other youth workers. We have adapted the training program to consist of a two-day workshop for child and adolescent mental health care providers across the region. The flyer advertising the workshop is included, in Appendix A. The training was delivered simultaneously via two modalities: on-site and by videoconferencing, similar to a virtual classroom. Participants living furthest away from the City of Thunder Bay are offered training via videoconferencing, and sites within two hours’ driving distance to the training venue are offered in-person training.

First Place Clinic and Regional Resource Centre (First Place) started in 2006, as the only program in Northwestern Ontario providing early psychosis intervention services. Within the core, First Place staff is 8.5 full-time equivalent (FTE) front-line staff, each with the mandate to provide education, training and evaluation within their clinical work. In addition, there is a 1.0 FTE research and communications assistant and a 1.0 FTE education and training coordinator who are dedicated to the education and training components of First
Canadian Mental Health Association-Thunder Bay Branch (CMHA-TB) is part of a nation-wide charitable organization that promotes the mental health of all and supports the resilience and recovery of those experiencing mental illness. First Place and all its component programs is a part of CMHA-TB that provides early psychosis intervention. The training program that was evaluated has been part of the core mandate of First Place since its inception six years ago. While the training program has hosted two to three workshops with service providers across the region per year, a full evaluation, separate from satisfaction surveys, has yet to be implemented.

**LOGIC MODEL**

![Program Logic Model](image)

The purpose of this evaluation project was to evaluate the EPI training program in Northwestern Ontario. We wanted to evaluate if the training program at First Place was
meeting the program’s goals and objectives. (Please refer to the program logic model, Figure 1) The goals of the training program were: to provide education and training across the region of Northwestern Ontario (NWO); to implement and evaluate training curricula in EPI; to recruit frontline workers in MCYS funded agencies for the training’s pilot project; to increase the capacity of NWO mental health service providers to identify and treat early psychosis and to increase access to proper pathways of care for youth experiencing early onset of psychosis. The objectives included: to empower communities in NWO to deliver EPI; to increase awareness of and access to EPI services for service providers, individuals and families; to increase capacity of mental health professionals to intervene as early and effectively as possible with at risk youth; and to increase accuracy of referrals made by mental health workers to EPI services.

The outcome evaluation questions were: 1. Is the EPI training program effective for knowledge acquisition?; 2. What are the facilitators and barriers to receiving off-site training?; 3. Does the mode of delivery for EPI training affect knowledge retention?; 4. Has the pathway of care for youth with psychosis improved as a result of the training?; 5. How has the training affected children and youth in NWO?

We were further interested in the following process evaluation questions: 1. Was the training workshop delivered as intended? 2. Have all desired target groups been reached? 3. How did the off-site training experience differ from on-site? 4. Was engagement of community partners successful? 5. Was the partnership well-received? (see Figure 2.)

**Literature Review**

Psychoeducation in mental health practice is a commonly used intervention to educate people about the nature of their illness, how treatment can help and how to improve their mental health (McGorry, 1995; Jackson & Iqbalt, 2000). EPI services around the world have widely adopted different psychoeducation strategies: psychoeducation for clients as part of the
psychotherapeutic recovery process; psychoeducation for families of affected youth as part of comprehensive care of the youth; education of service providers such as general practitioners as part of early identification and continuing medical-education of a specialty-field; and public education campaigns as part of mass early identification and detection strategies to decrease the duration of untreated psychosis (DUP). According to international best practice guidelines, psychoeducation is part of the EPI standard of care (International Early Psychosis Association Writing Group, 2005).

**Education of service providers:** Australia and the UK have been pioneers in increasing mental health literacy in schools. Most of the evaluation of EPI training among healthcare workers has been completed in the UK, focusing on clinical outcomes and primary care providers as the main recipient of training. The LEOCAT (Power et al., 2007), and REDIRECT (Lester, Birchwood, Freemantle, Michail, & Tait, 2009) cluster randomized controlled trials focused on training's effect on reducing duration of untreated psychosis (DUP). They found that training general practitioners (GP) did not reduce DUP. The systematic review in 2003 by Gilbody and colleagues found that CME alone did not improve management of mental illness (Gilbody, Whitty, Grimshaw, & Thomas, 2003). The study by Nelson and colleagues (Nelson et al., 2008) in Australia was one of the few that measured knowledge or skill acquisition. None of the evaluations to date have focused on educational outcomes of the training program or effectiveness of the mode of training. In NWO, there is a shortage of primary care providers. If only primary care providers were trained in EPI, this would continue to limit access to services for youth. The evidence for reducing DUP by training healthcare providers is not particularly strong. However, there is evidence that access to early psychosis intervention programs can improve outcomes for youth experiencing psychosis (Marshall & Rathbone, 2011; Malla, Norman, & Joober, 2005). The goal of the training program at First Place is to train generalist youth mental health professionals to have improved capacity to identify, refer or treat youth in
the early stages of psychosis.

**Rural mental health:** The people living in rural and remote communities have unique mental health needs, that have been largely overlooked by health research (Kirby & Keon, 2006), including early psychosis intervention research (Welch & Welch, 2007). Rural and remote communities represent 30% of the Canadian population (Statistics Canada, 2007), a smaller but significant portion of the population. Most of the evidence in EPI has been based on research in large urban centres. Welch and Welch conducted a systematic review in 2007 for research evidence about early psychosis intervention in rural areas (Welch & Welch, 2007). They found evidence about rural EPI programs only in Canada and Australia. Other literature, since their review, has suggested similar key messages: there are distinct challenges for rural programs in delivering specialized services; there is an increased role for primary healthcare providers in providing EPI services; often, EPI specialists are embedded in generalist services which are spread across a vast region; there is an essential need for adequate education, training and ongoing supervision for these isolated EPI front-line workers; a strong EPI network is very important to support these workers; increased monies are required for similar services to urban centres and the youth who are experiencing psychosis have longer duration of untreated psychosis and decreased access to services (Welch & Welch, 2007; Stain, Sartore, Andrews, & Kelly, 2008; Kelly, O'Meara Howard, & Smith, 2007; Wilson, 2007). The challenge for rural and remote Northern areas, is providing EPI services that would meet “the fidelity” evidence of urban EPI services, while at the same time providing accessible, quality EPI services to a rural and remote population.

**Distance Education:** In NWO, the region is vast, with very small population density. The distance between communities requires a different mode of training rather than the in-person lunch-time seminar or in-person training that was previously evaluated in the literature. Telepsychiatry has become a new method for delivering psychiatric care, particularly in rural
and remote regions. Hilty and colleagues (Hilty, Marks, & Urness, 2004) defined telemedicine as the use of electronic communication and information technologies to provide or support clinical care at a distance. Indeed, telepsychiatry has demonstrated success and cost-effectiveness in the provision of discrete psychiatric care such as consultations in depression, dementia, child psychiatry, OCD, panic disorder, schizophrenia (Hailey, Roine, & Ohinmaa, 2008); with the Ontario Telemedicine Network (OTN) becoming fully operational over the past five years, the network and videoconference technology presents an opportunity to investigate a broader educational application, especially in remote and rural Northern Ontario.

**Setting**

NWO has a population of 250,000 people, which includes the City and District of Thunder Bay and the Districts of Kenora and Rainy River. The region is composed of urban-remote and rural communities. The First Nations communities represent the largest growing segment of the population. In 2010, we understood that there were eight MCYS funded agencies within the region. While MCYS funded agencies were the priority, other mental health services in the region also service adolescents. There are at least four other mental health agencies receiving funding from multiple ministries such as MCYS, Ministry of Health and Long Term Care and Ministry of Community and Social Services. Our aim was to train as many mental health service providers who service youth 18 years or younger across the region. Our goal was to reach sites across the region spread roughly across four main parts of NWO: District of Thunder Bay, City of Thunder Bay, District of Kenora, and District of Rainy River.

**Participants**

*Recruitment:* Emails were sent, by the Executive Director of CMHA-TB, to the Executive Directors of eight MCYS funded agencies and other known services, that provide services to
youth, about the training program and with a request to save the date. They were asked to forward the invitation poster and information email to their appropriate service manager/supervisor. Via their supervisor, front-line professionals were notified and invited to participate. The same supervisor, or the participants themselves, contacted the study assistant to enroll in the intervention. We sought participation equally from all eight MCYS funded agencies, with the goal of having approximately 48 participants in the intervention (training program). Please refer to Appendix A for recruitment poster and introductory letter that were used.

**Inclusion/exclusion criteria:** Inclusion criteria included any healthcare or mental health service provider (i.e., social worker, child and youth worker, nurse) who had regular contact with adolescents aged 18 years or younger in their daily work. Exclusion criteria included those individuals who have received previous education or training specific to early psychosis intervention, or who could not agree to the nine-month follow-up evaluation post-training.

**Consent:** After connecting with the project assistant, potential participants forwarded the consent form and the project assistant discussed with them any questions or concerns. The project assistant (CL) ensured that the Consent to Participate form (Appendix B) was completed and signed prior to the participant enrolling in the evaluation project.

**Ethics Approval:** Ethics approval was granted from the following institutions’ review boards: the Hospital for Sick Children, University of Toronto, Centre for Addiction and Mental Health. Neither the intervention, nor the evaluation component commenced prior to approval.

**INTERVENTION**

The intervention was a two-day group training session to youth healthcare providers across the region; the training was delivered simultaneously via two modalities: on-site and videoconferencing, similar to a virtual classroom. The training curricula used an interactive seminar approach with multi-media and case scenarios. Participants living furthest away from
the City of Thunder Bay were offered training via video, and sites within two hours’ driving
distance were offered in-person training. This non-random allocation between delivery
methods was to approximate real-world scenarios based on geography for service providers.
See Appendix D for a list of topics covered in the training program.

**Measures Used & Data Collection**

**Knowledge and knowledge acquisition:** To answer the evaluation question: ‘is the EPI
training program effective for knowledge acquisition’ and ‘does the mode of delivery for EPI
training affect knowledge retention’, we measured participants’ knowledge acquisition using
previously validated measurement tools. The Knowledge About Schizophrenia Questionnaire
(KASQ) (Ascher-Svanum, 1999) was administered pre-intervention, then at three and nine
months post-intervention. As a comparison, a second knowledge tool, the Birchwood
Acquisition Questionnaire (Smith & Birchwood, 1987)(BAQ) was administered immediately
post intervention, and at nine months follow up. These tools were administered by the project
assistant (CL) electronically via Adobe Acrobat (Adobe Systems Incorporated, 2011), sent to
participants’ email with answers emailed back to the project assistant. Fax and paper options
were also available to participants on request. Please refer to Appendices E & F for a copy of
these two measurement tools.

**Process evaluation:** We used two methods to collect data to answer the evaluation questions
‘was the training delivered as intended’, ‘how did the off-site training experience differ from on-
site’, ‘was engagement of community partners successful or well received’ and ‘what are the
facilitators and barriers to receiving off-site training’: surveys and focus group interviews.
Immediately post-intervention, the participants were asked to fill out a survey (Appendix G)
electronically, the results of which were returned to the project assistant. A similar survey
(Appendix H) was re-administered following the six months post focus-group meeting. Also, the
evaluation team completed the intervention checklist found in Appendix I. At six-months post-intervention, members of the evaluation team (AH, CL) conducted five focus group meetings across the region, often meeting participants in their local communities. We explained to each group that the purpose of the focus group meeting was to understand their experience of the

Figure 2: Evaluation Matrices

EDG 1327: PROCESS EVALUATION MATRIX

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Indicators</th>
<th>Measurement Tool(s)</th>
<th>Data Source</th>
<th>Method to Collect Data &amp; Frequency</th>
<th>Person Responsible for Data Collection</th>
<th>Dates of Data Collection (Month/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the training workshop delivered as intended?</td>
<td>2 day training workshop in-person and via video</td>
<td>Workshop process checklist and participant rating scales</td>
<td>Participants</td>
<td>Pre &amp; Post Workshop Checklists and surveys</td>
<td>Research Assistant</td>
<td>Two-day training workshop: March 24/25 2011</td>
</tr>
<tr>
<td>Have all desired target groups been reached?</td>
<td>8 MCYS agencies in rural/remote NWO</td>
<td>MCYS Funded Agencies in NWO</td>
<td>MCYS agency listing</td>
<td>Pre-recruitment</td>
<td>Research Assistant</td>
<td>Stage 1 (pre-training)</td>
</tr>
<tr>
<td>How did the off-site training experience differ from on-site?</td>
<td>2 day training workshop in-person and via video</td>
<td>Satisfaction &amp; process surveys</td>
<td>Participants</td>
<td>Post workshop Email surveys</td>
<td>Research Assistant</td>
<td>Two-day training workshop: March 24/25 2011</td>
</tr>
<tr>
<td>Focus groups</td>
<td>Focus Group qualitative responses re: experiences of off-site vs on-site</td>
<td>Focus Group</td>
<td>In-person focus groups at 6 months</td>
<td>Learner/ Resident</td>
<td>Focus Groups (6 mos)</td>
<td></td>
</tr>
<tr>
<td>Focus groups</td>
<td>Focus Group responses</td>
<td>Focus Group</td>
<td>In-person focus groups at 6 months</td>
<td>Learner/ Resident</td>
<td>Focus Groups (6 mos)</td>
<td></td>
</tr>
<tr>
<td>Participant satisfaction surveys</td>
<td>Participant qualitative survey responses</td>
<td>Focus Group</td>
<td>In-person focus groups at 6 months</td>
<td>Learner/ Resident</td>
<td>Focus Groups (6 mos)</td>
<td></td>
</tr>
<tr>
<td>Survey</td>
<td>Survey</td>
<td>Participants</td>
<td>Email survey</td>
<td>Research Assistant</td>
<td>3, 6, 9 month follow up</td>
<td></td>
</tr>
</tbody>
</table>

EDG 1327: OUTCOME EVALUATION MATRIX

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Short-Term Outcomes</th>
<th>Indicator(s)</th>
<th>Measurement Tool(s)</th>
<th>Data Source</th>
<th>Method to Collect Data &amp; Frequency</th>
<th>Person Responsible for Data Collection</th>
<th>Dates of Data Collection (Month/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the EPI training curricula effective for knowledge acquisition?</td>
<td>Increased knowledge acquisition</td>
<td>Pre &amp; Post training questionnaire scores</td>
<td>KASG &amp; Birchwood Q</td>
<td>Participants</td>
<td>3.6, 9 month follow up</td>
<td>Research Assistant</td>
<td>3, 6, 9 month follow up</td>
</tr>
<tr>
<td>Will trainers retain knowledge?</td>
<td>Increased retention in participants</td>
<td>Referral data base system (First Place)</td>
<td>First Place</td>
<td>Participants</td>
<td>Ongoing monitoring of referrer numbers after baseline</td>
<td>Research Assistant</td>
<td>Continuous</td>
</tr>
<tr>
<td>Are trainers satisfied with the training, regardless of delivery mode?</td>
<td>Improved understanding of impact of delivery method on training</td>
<td>Participant feedback, comments &amp; criticism</td>
<td>Focus Group</td>
<td>Participants</td>
<td>In-person focus groups at 6 months</td>
<td>Learner/ Resident</td>
<td>Focus Groups (6 mos)</td>
</tr>
<tr>
<td>Does the mode of delivery for EPI training affect knowledge retention?</td>
<td>Increased knowledge acquisition and retention in participants (on or off site)</td>
<td>Pre and post training questionnaire scores</td>
<td>KASG &amp; Birchwood Q</td>
<td>Participants</td>
<td>Pre &amp; Post Workshop, 3.6 month follow up</td>
<td>Research Assistant</td>
<td>Pre training, 3, 6, 9 month follow up</td>
</tr>
<tr>
<td>Has the pathway of care for youth with psychosocial improved as a result of the training?</td>
<td>Increased referral rate and accuracy</td>
<td>Referral data base system</td>
<td>First Place</td>
<td>Participants</td>
<td>Ongoing monitoring of referrer numbers after baseline</td>
<td>Research Assistant</td>
<td>Continuous</td>
</tr>
<tr>
<td>How has the training affected children and youth in NWO?</td>
<td>Decreased duration of untreated psychiatric disorder (DUP)</td>
<td>GAF, CAFAS, (SCFPI)</td>
<td>CAFAS, First Place</td>
<td>Research Assistant</td>
<td>Program Director &amp; Research Assistant</td>
<td>Continuous</td>
<td></td>
</tr>
</tbody>
</table>

EDG 1327: FINAL REPORT
intervention, if the training improved their capacity to assess and manage individuals with early psychosis. An interview guide was developed focusing on warm up questions, key content exploration questions and examples of clarifying questions (please refer to Appendix J for the full focus group interview guide).

**Increased access to services:** to answer the questions ‘has the pathway of care for youth with psychosis improved as a result of the training received’ and ‘how has the training affected children and youth in NWO’, we examined referral data to First Place (EPI services in NWO) from participating agencies by comparing the year before and ten months post-training, and Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges & Wong, 1996) data for NWO. CAFAS was selected by MCYS in 2000 as a measure of service outcome for children and adolescents receiving mental health services in Ontario (CAFAS, 2002).

Illustrated in Figure 2 (page 13) are the process and outcome evaluation matrices developed for this evaluation project. As well, Figure 3 describes the four stages of the project. Appendix K illustrates a detailed breakdown of the timeline for the entire project.

**Analysis**

The knowledge questionnaires, KASQ and BAQ were analysed using repeated measures ANOVA. Quantitative data were analysed using statistical software. Survey quantitative data was analysed using simple calculated group means. For the focus group
data, each interview with participants was recorded and transcribed verbatim. The transcripts were double independently coded for emerging themes using principles from Charmaz’ constructivist grounded theory (Charmaz, 1990) by two members of the evaluation team. Themes were discussed after each interview and interview questions adjusted according to emerging themes. Transcripts were coded and organized using NVIVO (QSR International, 2011) software.

**LIMITATIONS**

The most significant limitation to this evaluation is the indirect measure of youth outcomes by looking at only regional CAFAS data. Due to ethical considerations and lack of consent, we were not able to collect information about the youth involved with the participants of the training program. The NWO region has low population density, and therefore the sample size is small, with non-random allocation between groups.

**PARTICIPANTS**

19 participants across four community mental health agencies participated in the intervention. Types of workers included case managers, counsellors, social workers, therapists, psychometrist, student, and managers. Seven received the intervention on-site, and 12 received the intervention via videoconferencing technology. Almost half of the participants had more than 10 years’ work experience. However, work experience
did not always correlate with the participants’ confidence in dealing with youth experiencing psychosis. Among those participants with over 10 years’ work experience, only half felt comfortable dealing with psychosis in youth; whereas among the group with the least experience (less than three years’ experience), over half felt comfortable dealing with psychosis in youth.

**Is the EPI training curricula effective for knowledge acquisition? Does the mode of delivery for EPI training affect knowledge retention?**

**Knowledge Acquisition:** Pre-intervention, the level of EPI knowledge was quite high among all the participants. The average score on the KASQ was 84 percent. Overall, the percent score of the KASQ did not significantly change over time. Between pre-intervention and three months, there was a non-significant increase in scores (p<0.066); similarly between pre-intervention and nine months, there was a non-statistically significant increase (p<0.068) in scores. Interestingly, there was a statistically significant decrease in scores (p<0.03) between the three months and nine month follow up periods. In comparing the off-site and on-site participants’ knowledge acquisition scores, there was no difference between the two groups’ scores. These results are in keeping with similar studies in the literature. Figure 4 shows the trend from pre-intervention, to three months, to nine months’ knowledge changes. The off-site group had slightly higher scores going into the workshop; the on-site group showed greatest increase in scores at three months post-intervention, but the on-site group lost the most knowledge by nine months. Both groups showed similar trends of improvement, then loss of knowledge between pre-intervention and nine months post-intervention. It is also important to note that the changes in the knowledge scores represented only four percentage points, from 84% to 88%. These small changes in scores also indicate that this group of participants had relatively high level of knowledge about EPI, regardless of their years’ of work experience and despite their reported level of comfort dealing with psychosis.
What are the facilitators and barriers to receiving off-site training? Was the training workshop delivered as intended? How did the off-site training experience differ from on-site? Was engagement of community partners successful? Was the partnership well-received?

**Satisfaction:** Overall, immediately post-intervention the participants had expressed high degree of satisfaction (Figure 5) despite their dissatisfaction with the videoconferencing mode of training. In general, the participants highly valued the training and were extremely satisfied with the knowledge gained, the facilitator style, and interactive nature of the training received. One off-site participant stated "I now know the signs and symptoms of psychosis that are different than other disorders such as anxiety, depression, etc.". The most critical feedback provided by participants was about the organization of training, the technology glitches that
occurred and use of videoconferencing. One on-site participant wrote:

“the connection by video to the other [sites] cut out a number of times. Some of the [sites] were only able to connect part of the time”.

**Experience of training workshop (intervention):** The participants had much to say about their experience registering for the training workshop, the consent form they were required to sign, and the workshop itself. The consent form explained that the workshop was valued at $500 per participant; however, the fee was waived as long as each participant agreed to continue in the evaluation during the follow-up period. Participants were not required to pay in advance. However, the consent process distracted from the excitement of receiving much needed training and education. Participants were most concerned about whether they were responsible personally for the $500, and whether they were able to stay in the project over nine months post-workshop. Another participant commented that the numbers participating would have been higher, if it were not for the possibility of paying $500:

“[$500] was definitely a deterrent. Like there was probably the majority of mental health workers did not take it and should have.”

Despite the initial reservation and distraction, many expressed interest and excitement to learn a new topic. Although many were familiar with the term “psychosis”, they were less familiar with psychosis in youth and early psychosis intervention.

“I was just really interested in taking the workshop …it’s a pretty important one, especially if you’re working with youth.”

The participants had much to comment on about the workshop itself. Many were dissatisfied with the facilities they used, most commonly the videoconferencing technology, and the availability of the handouts not being available or being mailed to the wrong site.

“Where we were, umm, the facility wasn’t ready. When we went there it was locked. Umm, we had to go back to our own agency. We had to locate these people in town who finally come and opened after it started. There was no, there was no snacks, no drinks, no … umm, we were pretty much locked in a room and there you go.”

They found the videoconferencing frustrating due to the connection problems for some sites, the small size of monitor to view the training, and difficulty to hear or see ‘role plays’ that were
being used to illustrate case examples. Overall, they were very pleased with the facilitator of the workshop because the facilitator’s style was engaging and enhanced their learning. Despite the range in responses about the content of the workshop, most participants found it helpful in their work with youth. Participants sometimes differed on what they perceived as important content areas where some wanted more and others wanted less of the same topic:

“I found it really helpful, the medication and side effects because one thing I find with parents that we work with is sometimes the slightest side effect and they want to pull a kid right off of meds.”

As compared to:

“I thought it was really good. Except for that [medication] part, yeah. And even, it’s not that it’s a bad thing, it’s just I don’t think I needed that part.”

Many stated that despite the challenges, or areas for improvement, they would recommend to their colleagues to attend in the future. The participants themselves were eager for the next workshop that built on knowledge gained from this introductory training to EPI.

**Experience of evaluation:** Many of the participants were surprised and overall very pleased with the evaluation component of their experience. Initially participants did not know what to expect with the evaluation, and were concerned that it may take up too much time. However, they recognized at the focus group interviews that the hands-on experiences of the evaluation helped them appreciate the purpose and value of the evaluation:

“usually we just follow-up with ourselves [own team] but now we also feel accountable to you.”

Many participants emphasized how the repeated knowledge questionnaires acted like a “booster-effect” whereby the information from the training workshop was reinforced over a nine-month period. The evaluation helped participants engage more with the workshop content.

“I can’t help but think that this is definitely going to stay in my brain because I have had to really think about it a few times and self-reflect.”

**Qualitative Interviews - Emerging Themes:** There were four major themes that emerged from the focus group data: the participants had growing concern for the youth population in
NWO; the training workshop was experienced as an innovative learning experience which helped participants establish a partnership with First Place; the workshop helped to strengthen professional relationships within agencies and between agencies; the evaluation part of the experience was novel and unexpectedly enhanced the participants’ learning experience.

1. Concerns for youth: Participants spoke about increased concern about the limited peer group opportunities and lack of peer support for the youth that they saw in their mental health services. They explained that peer groups in adolescence had significant influence on their behaviours and identity formation. They worried that the youth were experiencing an ‘identity crisis’ because they are losing their historical identity from changes in their environment due to economic hardships or lack of healthy mentorships. The participants described that if youth did not find a group that shared their interests and strengths, they are often isolated placing them at risk.

“There are so many that have other interests outside of hockey. So for them to be able to participate in other activities, they are limited in what they’re able to access.”

They described dichotomous relationships in peer groups such as substance abusers vs non-abusers, or hockey players versus non-players. The participants have observed an increase in early childhood anxiety and increase in youth engaging in risky behaviours such as early onset sexual activities and substance abuse.

2. Partnership with First Place: The workshop and evaluation definitely enhanced the participants’ partnership with First Place. Prior to the workshop, most of the participants were generally unfamiliar with First Place operations. They found this entire experience an opportunity to ‘meet the people’ who work there, and there was a significant increase in comfort in talking with, contacting, discussing cases and making referrals. They stated that it was helpful that the facilitator of the workshop was also the lead on this evaluation project, and the Child and Adolescent Psychiatrist at First Place.
“After this training I feel really connected…and a lot more comfortable to call [Child & Adolescent Psychiatrist]”

The participants experienced the staff at First Place as very knowledgeable, friendly, passionate about their work, and interested in the participants’ learning. In fact, many of the participants wanted to maintain a connection with First Place and made suggestions such as creating a ‘network’ of providers who have undergone training about EPI, further EPI training or to receive periodic newsletters or updates from First Place about EPI.

3. Professional relationships: Many participants spoke about how the training and evaluation project helped to strengthen their professional relationships not only with First Place or with people within their agency, but with each other. They felt a connection with other sites, and wanted to hear their stories and whether they had similar or different work experiences.

“Now you debrief with other people if you’ve got challenges. They can also challenge you...part of our role for eachother is to move past our comfort zone and for all of us to grow.”

They wanted to share resources; despite the region being vast, they felt a bond together because they believed that many of the issues they face in working with youth was universal and transcended the region. They stated that this nine-month journey was a unique experience to learn together through the training workshop and evaluation process. This was an indirect team-building exercise where it was easier for participants to share knowledge with each other and discuss cases with one another.

4. Novel evaluation experience: Many of the participants found the different stages and methods of this evaluation project a novel experience. Many also shared their experiences with co-workers who did not attend the workshop. The participants’ predominantly felt that the evaluation component impacted their learning; they expressed appreciation that not only were they invested in their own learning, but we also were invested in their learning:

“What I found was nice, was [that] we were invested in our learning. But with the evaluations and the follow-up...lets you know that you guys were invested with our learning as well.”
This created pride and ownership of the material taught, and helped them to integrate into their daily work. Some participants initially felt that they weren’t qualified to evaluate the process, yet once they understood the purpose of the focus groups, that we were being evaluated, instead of the participants, they were quite eager to contribute. In fact, the evaluation process even inspired some participants to consider integrating evaluation into their own programs.

**Has the pathway of care for youth with psychosis improved as a result of the training? How has the training affected children and youth in NWO?**

**Referrals from participating agencies:** Figure 6 illustrates the referral data to First Place for the budget year 2010/2011 (just prior to the intervention) and nine months into the 2011/2012 year, approximating the evaluation period. This graph represents only the referral patterns of the participating agencies in the intervention, and not all MCYS funded agencies in NWO. In the year prior to the intervention, there were two referrals from participating agencies, and both were closed at referral, indicating that neither referral met the eligibility criteria for the early psychosis intervention program. During the first nine months of the following year, there were eight referrals, and four entered the EPI program, indicating that those four referrals were youth with likely their first episode or early psychosis.

**CAFAS Data:** CAFAS data from the final quarter of 2011 was still being finalized to be released to MCYS agencies. At the time of this report, we were still trying to locate a copy of the CAFAS report for the Northern Region for 2011, post-training workshop. We plan to continue to locate the CAFAS data as part of our data analysis and knowledge exchange strategy, even as this project closes.
DISCUSSION AND INTERPRETATION OF FINDINGS

Although the knowledge acquisition from the training did not significantly increase over time, knowledge scores pre-intervention indicated a high level of EPI knowledge among participants even before the training. At 84% pre-training scores, it is difficult for participants to show significantly more knowledge acquisition. We provided feedback to their managers, our project stakeholders, that their youth mental health workforce had a high degree of expertise and knowledge prior to the workshop. Therefore, we deducted that knowledge acquisition and retention was only a secondary benefit to the training and evaluation process.

Training using videoconferencing, or telepsychiatry technology is a viable option for increasing capacity to provide EPI services across a vast region. These findings are consistent with the literature (*ref), and are of particular interest to CMHA-TB. Capacity is improved by solidifying local providers’ EPI knowledge, by encouraging non-medical mental health professionals to invest in their own learning, and strengthening partnerships between generalists and specialist EPI services. It is possible that the increase in accuracy of referrals, from no referrals accepted into EPI services in the year prior to training, to 50% of the referrals post-training, indicated that there was increased access to appropriate services for youth experiencing psychosis.

The training and evaluation process built on the consultation relationship between generalist mental health providers and specialist EPI services. The evaluation process was an important asset of the training program. The evaluation process enhanced not only participants’ learning, but also their engagement and further strengthened their relationship with First Place. There was a strong desire from participants to maintain their connection with First Place and enhance the partnerships developed from the training and evaluation process. This finding was especially important to CMHA-TB because of our agency’s investment in building partnerships with other healthcare service providers, and our core value of
collaborative, multi-disciplinary approach to providing care.

**Sustainability:** The training program is part of First Place’s core mandate and will continue. Providing effective training is vital to our partnerships with other service providers and stakeholders. However, for the training program to be successful, and to truly engage participants in their own learning, evaluation needs to continue. Some participants spoke about their excitement for evaluation, and how to incorporate it into their own programs. We need to continue evaluating our training program, but also to incorporate it in other program areas within our own agency. Evaluation is an important component of the programs’ sustainability.

**Recommendations and Next Steps**

**Key Messages**

1. The relationship between managers among stakeholders is crucial for the launch and success of an unfamiliar program. Providing training opportunities about specialist EPI services helps to strengthen the partnerships with stakeholders.

2. Videoconferencing is a viable option for providing training, provided the facilitator is able to use the technology easily and capable of using a variety of techniques to engage participants during the training workshop.

3. The Ontario Standards for Early Intervention in Psychosis (Ministry of Health and Long Term Care, 2011) clearly indicate the importance of engaging youth in services by facilitating access; training non-medical youth mental health service providers who have more contact with youth than specialized EPI services is an important step in facilitating youth to improved pathways to care.

4. Engaging stakeholders in evaluation is essential for success; engagement needs to be active and dynamic, more than simply educating stakeholders; when engagement to the evaluation process can occur, it contributes to the program’s sustainability.

5. Program sustainability depends on ongoing quality evaluation processes.
Relationship with the Centre (OCE)

As an evaluation project team, we have benefitted and valued the support we have received from the Centre throughout this evaluation project. For example, everything from the resources available on the website, the templates for each step of the evaluation process, and the regular personal attention from our Research Associate (Dr. Émard) have been absolutely helpful in educating us about evaluation. The lessons we have learned, and the opportunities provided to us by this evaluation grant have been invaluable. Our capacity to do evaluation has increased tremendously, as illustrated by the improvements in our project logic models and evaluation matrices. Our only suggestion is changing the content of webinars. Perhaps it may be useful to have two separate streams of webinars: webinars that teach broad concepts and webinars that teach specifics, even dividing those specifics over several separate sessions. Overall, our project team, including CMHA-TB, is extremely grateful for the learning opportunities afforded to us by granting us an “evaluation doing grant”. We want to especially thank Dr. Émard for all her assistance and support throughout this evaluation project. We hope that our connection with the Centre can continue, even after the project closes.
i. Reference List

ii. Glossary of Acronyms

iii: Appendices:
   A. Psychosis 101 Recruitment Poster
   B. Invitation to Participate
   C. Consent to Participate Form
   D. Workshop Training Programme
   E. Knowledge About Schizophrenia Questionnaire (KASQ)
   F. Birchwood Acquisition Questionnaire (BAQ)
   G. Post-Workshop Satisfaction Survey
   H. Post Focus Group Satisfaction Survey
   I. Process Checklist
   J. Interviewer’s Focus Group Guide
   K. Project Timeline & Overview
Reference List


Ministry of Health and Long Term Care (2011). *Early Psychosis Intervention Program Standards*.


QSR International (2011). NVIVO 9 (Version 9) [Computer software].

Shiers, D. & Smith, J. Early Intervention in Psychosis Training and Resource CD-Rom. 2007. National Health Services (NHS); National Institute for Mental Health in England (NIME); Care Services Improvement Partnership; Rethink: Severe Mental Illness; National Institute for Mental Health in England; IRIS Early Intervention in Psychosis.


## Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Dr. Andrew Howlett</td>
</tr>
<tr>
<td>BAQ</td>
<td>Birchwood Acquisition Questionnaire</td>
</tr>
<tr>
<td>CAFAS</td>
<td>Child and Adolescent Functional Assessment Scale</td>
</tr>
<tr>
<td>CC</td>
<td>Dr. Chiachen Cheng</td>
</tr>
<tr>
<td>CL</td>
<td>Carole Lem</td>
</tr>
<tr>
<td>CME</td>
<td>continuing medical education</td>
</tr>
<tr>
<td>CMHA-TB</td>
<td>Canadian Mental Health Association-Thunder Bay Branch</td>
</tr>
<tr>
<td>DUP</td>
<td>duration of untreated psychosis</td>
</tr>
<tr>
<td>EPI</td>
<td>Early Psychosis Intervention</td>
</tr>
<tr>
<td>First Place</td>
<td>First Place Clinic and Regional Resource Centre</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioners</td>
</tr>
<tr>
<td>KASQ</td>
<td>Knowledge About Schizophrenia Questionnaire</td>
</tr>
<tr>
<td>KE</td>
<td>Knowledge Exchange</td>
</tr>
<tr>
<td>KT</td>
<td>Knowledge Translation</td>
</tr>
<tr>
<td>LEOCAT</td>
<td>Lambeth Early Onset Crisis Assessment Team Study</td>
</tr>
<tr>
<td>MCYS</td>
<td>Ministry of Child &amp; Youth Services</td>
</tr>
<tr>
<td>NWO</td>
<td>Northwestern Ontario</td>
</tr>
<tr>
<td>OCD</td>
<td>obsessive compulsive disorder</td>
</tr>
<tr>
<td>OCE</td>
<td>Ontario Centre of Excellence for Child and Youth Mental Health</td>
</tr>
<tr>
<td>OTN</td>
<td>Ontario Telemedicine Network</td>
</tr>
<tr>
<td>REDIRECT</td>
<td>Birmingham Early Detection in unREated psychosis Trial</td>
</tr>
</tbody>
</table>
As a part of a regionwide capacity-building research initiative, C.M.H.A Thunder Bay invites you to participate in an innovative training opportunity.

The multi-phase training will include:

- A FREE two-day introductory workshop focusing on detecting and screening early psychosis symptoms in youth
- Access to on-going case based consultations and additional early psychosis education
- Post-workshop contact at 3, 6, 9 months for feedback and evaluation

Workshop Objectives Include:

1. Increased detection of early psychosis symptoms in youth so that earlier intervention can take place
2. Increased reach of limited EPI specialist services in NWO while building local capacity
3. Evaluation of the established training content via face to face and videoconferencing opportunities

FOR INFORMATION & DATES PLEASE CONTACT:

First Place
Clinic & Regional Resource Centre
Regional Early Intervention Psychosis Services

Tel: (807) 345-0060  Fax: (807) 345-0030
firstplace@cmha-tb.on.ca, ATTN: Research

Dr. Chi Cheng, MD, MPH, FRCP(C) is a child and adolescent psychiatrist. She has been the Medical Director of First Place Clinic and Regional Resource Centre in Thunder Bay, Ontario since its inception in 2006. Her clinical interests are in early psychosis intervention (EPI), in particular, models of care delivery to rural and remote populations. To this end she has worked in rural Ontario and Newfoundland. Her research interests are in EPI health services policy, and evidence-based practice as it interfaces with pediatric mental health policy. She has academic appointments at the Health Systems Research and Consulting Unit at the Centre for Addictions and Mental Health and McMaster University. Her past training has included psychiatry residency at McMaster University, a clinical fellowship with the Cleghorn Program (at McMaster University) and Masters of Public Health degree at Harvard University.
INVITATION TO PARTICIPATE

Dear Executive Director,

The Canadian Mental Health Association-Thunder Bay Branch is excited to offer your organization’s direct service staff an opportunity to participate in a training event, at no cost, as part of an innovative research initiative.

Training Initiative: **Psychosis 101: Early Psychosis Intervention (EPI) Training**

Overview:
- Applicable to healthcare or mental health service providers in Northwestern Ontario who have not received previous EPI training.
- Training will be facilitated by Dr. Chiachen Cheng of CMHA’s Regional Early Psychosis Intervention (EPI) Services.
- Training consists of a 2 day training course based on established EPI training modules.
- Training will take place at CMHA Thunder Bay Branch for participants living in or near Thunder Bay. Videoconferencing technology will be used to maximize outreach and minimize travel for training. Classroom will reflect the varied communities of LHIN 14.
- Post-workshop contact will occur at 3, 6 and 9 months for feedback and evaluation.

This training opportunity aims to increase knowledge about EPI in Northern and rural communities. Through the training, participants will improve their capacity to identify psychosis and will have the understanding of EPI needed to implement early intervention. Those participating via tele-training will also have the opportunity to evaluate how useful the medium is for training. Most importantly, increased capacity to identify psychosis means individuals experiencing early psychosis are more likely to be spotted, which means improved long-term outcomes. This project is sponsored by Canadian Mental Health Association-Thunder Bay Early Psychosis Intervention program, which is funded by the Ontario Ministry of Health and Long-Term Care. A grant was also awarded by the Foundation of the Canadian Psychiatric Association - Scotiabank Grant for Research in Children’s Mental Health.

Participants will complete the 2 day training workshop, with a subsequent evaluation of knowledge, skills, and attitudes acquisition and retention. Participants will have the opportunity to evaluate their training through feedback sessions during and after the workshop. Training is free so long as the participant follows through with post-workshop followup at 3, 6, and 9 months. Attached you will find a consent form which further details the conditions of the training.

Please see the attached invitation and circulate to members of your staff who you consider the best fit for this training opportunity. Up to three health professionals from your agency who meet the criteria outlined above may participate in training. Participation is entirely voluntary, and all information is confidential.

Accepting this EPI training opportunity could change the lives of individuals who are experiencing psychosis and remain untreated. We hope you do.

Sincerely,

**Mirella Fata**
EPI Program Director, CMHA – Thunder Bay

**Maurice Fortin**
Executive Director, CMHA – Thunder Bay
CONSENT TO PARTICIPATE

Voluntary agreement to participate in the 2-day training initiative entitled: “Psychosis 101: Early Psychosis Intervention (EPI) Training”.

I understand that training will be free of charge on the following conditions:

1. I am present, in person or via teleconference, for the full 2-day training workshop.
2. I agree to post-workshop contact at 3, 6, 9 months for evaluation, which will be maximum 1 hour, for each contact.
3. I am willing to commit to the research project and complete all stages of the research initiative, including attendance of the workshop and completion of all required questionnaires and survey material.
4. I understand that the workshop is free only as part of the research initiative, and failure to complete the post-workshop requirements nullifies the free-training agreement. Failure to complete any part of the research requirements is understood by me and my agency to be an indication of withdrawal, as well as an agreement to pay the $500 sessional training fee to the facilitator(s).

I understand that I may withdraw from the study without consequence at any time, under the following conditions:

1. Withdrawal occurs before the workshop start date.
2. I am unable to attend the workshop, and therefore cannot complete the post-workshop requirements.
3. Extenuating circumstances hinder my ability to participate. Circumstances may be brought to the attention of the Lead Investigator, Dr. Cheng, at (807)345-0060 or by email to: firstplace@cmha-tb.on.ca, subject line “ATTN: Dr Cheng”

I understand that the “Psychosis 101” training is free only with participation in post-workshop follow-ups by the facilitator and research team; I understand that attending the workshop without participating in the post-workshop research activities will result in the mandatory payment of a $500 sessional training fee to the facilitator(s). I understand that I may withdraw from the study at any time, under the above conditions.

Name: ______________ Signature: ______________ Date: ______________
(Please Print)

There will be minimal potential risks to this study. Any risk to the participant for not passing the evaluation will be mitigated by confidentiality and grouping the results in aggregate form. Information gathered in the course of this study will be strictly confidential. All information will be pooled with information from other participants. There will be no identification of individual participants or ability to trace results to individuals in the study. Only the abovementioned researchers and their research team will have access to the information obtained in this study. Any report or publication will show results in aggregate, rather than individually or by institution.

My signature below confirms that I understand all information contained in this form, and that I agree to participate in the “Psychosis 101” training initiative to its full extent.

______________________________  ____________________________  ____________________________
Participant Name (Please Print)  Signature                      Date

Program Site: ____________________  Person Obtaining Consent: ______________________

If you have questions regarding the study please feel free to contact Dr. Cheng, Study Principal Investigator at phone number (807) 345-0060. In addition, if you have any questions regarding your rights as a research participant, you may contact the CMHA – Thunder Bay Branch Chair of the Research Ethics Committee, Sharon Pitawanakwat, or the Executive Director, Maurice Fortin, at phone number (807)345-5564.
PSYCHOSIS 101: TRAINING CONTENT

Day 1 Content:

Introduction to Workshop
What is Psychosis?
Stress Vulnerability and Psychosis
An Introduction to Early Psychosis Intervention
Assessment in First Episode Psychosis

Day 2 Content:
Treatment in Early Onset Psychosis
Psychological Interventions in Early Onset Psychosis
Medication in Early Onset Psychosis
Depot Medications
Substance Misuse and Mental Health
Case Discussions

Source:
Care Services Improvement Partnership (CSIP); Rethink Severe Mental Illness; NHS; National Health Institute for Mental Health in England; IRIS Early Intervention in Psychosis. EIS Project Introduction. Early Intervention in Psychosis: Training and Resource CD-Rom. 2006.
Knowledge About Schizophrenia Questionnaire (KASQ)

1. How many people have schizophrenia?
   a. One person in every 1,000.
   b. One person in every 100.
   c. Two persons in every 10.
   d. Twenty persons in every 100.

2. How do we know if someone has schizophrenia?
   a. By asking the person about unusual thoughts, delusions, hallucinations, or if he/she feels like things are no longer real.
   b. By taking X-rays of the head (like CT scan).
   c. By determining whether the person is working or not.
   d. By using special blood tests.
   e. All of the above.

3. Which areas of a patient’s life does schizophrenia affect?
   a. Thinking.
   b. Feeling.
   c. Behaving.
   d. None of the above.
   e. All of the above.

4. A delusion is:
   a. Seeing things that are not really there.
   b. Not a symptom of schizophrenia.
   c. A feeling of sadness.
   d. A belief that seems very real even though it is totally false and not shared by other people.

5. A visual hallucination is:
   a. Not a symptom of schizophrenia.
   b. Seeing things that are not really there.
   c. A type of delusion.
   d. A symptom that psychiatry cannot treat.

6. Which of the following is a possible cause of schizophrenia?
   a. Being mistreated by a parent in childhood.
   b. Receiving poor education.
   c. A disorder of brain chemistry combined with life stressors.
   d. None of the above.

7. A person with schizophrenia:
   a. Can be rapidly cured by hypnosis.
   b. Will always experience a worsening of the illness over a lifetime.
   c. Is very likely to be helped by the right medicines.
   d. Will get better eventually without help.

8. Schizophrenia is:
a. Like having multiple personalities.
b. A mental illness that causes people to become confused and have difficulty deciding what is real.
c. Likely to be caused by using LSD or marijuana.
d. A contagious disease.
e. All of the above.

9. Which of the following makes schizophrenia worse?
   a. Stress with family members.
   b. Having nothing to do with one’s free time.
   c. Taking street drugs.
   d. Drinking alcohol.
   e. All of the above.

10. Common side effects of antipsychotic drugs are:
    a. Drowsiness.
    b. Sensitivity to sunburn.
    c. Restless legs or shakiness.
    d. All of the above.
    e. None of the above.

11. Ways of coping with and reducing side effects include:
    a. Waiting awhile.
    b. Reducing the dosage on doctor’s advice.
    c. Changing to a medication without the annoying side effects on the doctor’s advice.
    d. All of the above.
    e. None of the above.

12. A person suffering from schizophrenia nearly always has:
    a. Difficulty deciding what is real and what is not real.
    b. An abnormal heart beat.
    c. A fear of heights.
    d. A tendency to behave violently.
    e. Two or more personalities.

13. A person suffering from schizophrenia:
    a. See things that others do not see.
    b. Hear voices when there is nobody around.
    c. Believe that thoughts are being put into his/her mind by other people.
    d. Believe that her/she is someone very important (like Jesus, Virgin Mary).
    e. All of the above.
14. A person with schizophrenia who is under pressure should:
   a. Take an extra dose of medication (without consulting the doctor).
   b. Spend several days in bed and rest.
   c. Discuss his/her difficulties with a doctor or therapist.
   d. Ignore it because time will heal all problems.

15. Which is the most important treatment of schizophrenia?
   a. Electro-shock treatment (ECT)
   b. Medication.
   c. Occupational therapy.
   d. Recreational therapy.

16. Antipsychotic medications do not cure schizophrenia, but they do:
   a. Damage the brain.
   b. Result in addiction to the drug.
   c. Take all your problems away.
   d. Help control the symptom of the illness.

17. What are the chances of complete recovery from schizophrenia?
   a. 100 percent.
   b. 0 percent.
   c. 33 percent.
   d. 50 percent.

18. Which symptoms of schizophrenia tend not to be improved by antipsychotics?
   b. Hallucinations.
   c. Delusions.
   d. Problems in thinking.

19. Antipsychotics are known to be:
   a. easy to overdose on, possibly resulting in death.
   b. Addictive over time.
   c. Unsafe medications.
   d. Effective in controlling symptoms of schizophrenia.

20. If an adult psychiatric patient is committed by court (temporary or regular commitment),
    he or she:
   a. Can give a 24-hour notice and then leave the hospital.
   c. Can refuse treatment but first needs to petition the court about it.
   d. Is more likely to receive electro-shock treatment (ECT).

21. An adult who is admitted voluntarily to the psychiatric hospital:
   a. Has very few legal rights.
   b. Has no right to refuse psychiatric treatment.
   c. Cannot be placed in seclusion or restraint.
   d. Can leave the hospital 24 hours after his/her request reaches the hospital's superintendent.
22. Electro-shock therapy (ECT) is rarely used in the treatment of schizophrenia, but when it is used, it is:
   a. Very painful.
   b. Painless and safe.
   c. Very time-consuming and much slower to help than medicines.
   d. Quite unsafe.

23. Tardive Dyskenesia is:
   a. A type of skin problem.
   b. A type of medicine for schizophrenia.
   c. A very rare but serious side effect of antipsychotic medicines.
   d. A problem of all people with schizophrenia.

24. If a person who has been diagnosed with schizophrenia continues to take medicines as prescribed by the doctor, he or she:
   a. Is likely to have more severe symptoms during a relapse (recurrence of the illness).
   b. Does not change all the chances of being rehospitalized for schizophrenia.
   c. Is more likely to be rehospitalized because of medicine’s side effects.
   d. Double one’s chances of staying out of the hospital (of not having a relapse).

25. Persons with schizophrenia are more likely to have:
   a. A close relative with schizophrenia.
   b. A punitive and domineering mother.
   c. Allergic reactions to starches and sweets.
   d. Fear of heights.
1. Who can become psychotic?
   a. Anyone
   b. Men only
   c. People with personality disorders
   d. Criminals
   e. Don’t know

2. The typical age for a first episode of psychosis is:
   a. Anytime
   b. Middle age
   c. In early twenties
   d. Childhood
   e. Don’t know

3. The odds of developing psychosis are:
   a. 1 in 1000
   b. 1 in 500
   c. 1 in 100
   d. 1 in 200
   e. Don’t know

4. If one of your parents has psychosis, the chances of you also having psychosis are:
   a. The same as anyone else
   b. Higher than anyone else
   c. Lower than anyone else
   d. A 99% possibility that you will also have psychosis
   e. Don’t know

5. An episode of psychosis may be triggered by:
   a. A knock on the head
   b. Difficulties at birth
   c. Physical illness
   d. Stress
   e. Don’t know

6. Which of the following is most common in psychosis?
   a. To have just one attack and recover completely
   b. To have several attacks but with periods in between where things seem better
   c. To be permanently ill with no periods of recovery whatsoever
   d. To have one attack, but without full recovery to the pre-first epidemic state
   e. Don’t know
7. Which of the following are common symptoms of psychosis? (check all that apply)
   a. Hearing voices
   b. Lack of energy
   c. Incontinence
   d. Delusions
   e. Headaches
   f. Irritability
   g. Loss of appetite
   h. Lack of affection
   i. Sleep problems
   j. Over activity
   k. Withdrawal
   l. Don’t know

8. Which of the following are negative symptoms? (check all that apply)
   a. Hearing voices
   b. Withdrawal
   c. Lack of affection
   d. Lack of energy
   e. Thought disorder
   f. Delusions
   g. Irritability
   h. Don’t know

9. A positive symptom of psychosis is:
   a. A symptom that is definitely due to schizophrenia and not due to anything else
   b. A symptom that is used to diagnose schizophrenia
   c. When something is added to a person’s behaviour
   d. When there is a loss from the person’s normal behaviour
   e. Don’t know

10. When psychotic symptoms reappear and get much worse this is called:
    a. Relapse
    b. Omission
    c. Remission
    d. Prolapse
    e. Don’t know

11. When a person with psychosis is admitted to hospital under “section” this means:
    a. Voluntary admission
    b. Compulsory admission
    c. Admission with patient’s consent
    d. Admission by the police
    e. Don’t know
12. The average length of stay in hospital for a first attack of psychosis is:
   a. 3-6 weeks
   b. 6 months
   c. 12 weeks
   d. 1 year
   e. Don't know

13. Medication can help reduce (remove symptoms) in what percentage of patients?
   a. 25% (one quarter)
   b. 75% (three quarters)
   c. 50% (half)
   d. 100% (all)
   e. Don't know

14. The main medication given to remove psychotic symptoms are:
   a. Antihistamines
   b. Narcotics
   c. Neuroleptics
   d. Tranquilizers
   e. Don't know

15. If a psychotic patient is taking medication, the risk of experiencing a second episode of psychosis within one year is reduced from 75% to:
   a. 70%
   b. 50%
   c. 10%
   d. 30%
   e. Don't know

16. Rehabilitation is the word for:
   a. Giving medication
   b. Helping the patient to settle back to a normal life out of hospital
   c. Helping the patient to find accommodation
   d. Hospital treatment
   e. Don't know

17. Medication is more effective with:
   a. Positive symptoms
   b. Negative symptoms
   c. All symptoms equally
   d. Mainly the negative symptoms
   e. Don't know
18. Which of the following are often associated with the onset of psychosis? (check all that apply)
   a. Too much stress
   b. Poor diet
   c. Inability to get angry and express feelings directly
   d. Runs in the family
   e. Biological problems, body chemicals
   f. Personality “type”—just that kind of person
   g. A split in personality
   h. Family problems while s/he was a child
   i. An upsetting experience, ie. Loss of an important person by death, divorce, etc.
   j. Don’t know.

19. To help a person recover from schizophrenia the family should try to: (check all that apply)
   a. Leave the person alone
   b. Try to get him to do things for himself
   c. Do as much for the person as possible
   d. Encourage him to go out and mix with people
   e. Let the person do what he wants to do
   f. Not burden the patient with household tasks
   g. Ensure that he takes his medication
   h. Don’t know

20. To help themselves, the family should: (check all that apply)
   a. Leave the person totally alone
   b. Talk about their difficulties with friends
   c. Try and forget about the difficulties and problems they have to face
   d. Get out of doing things and seeing friends
   e. Help the patient as much as possible, but make sure they keep their own interests
      and hobbies
   f. Put all their efforts and time into helping the patient to recover
   g. Ignore the patient and try to get on with their own lives
   h. Don’t know

21. Which of the following are unhelpful to a person with psychosis? (check all that apply)
   a. Too much pressure on the person
   b. Nagging by the family
   c. Sitting around all day
   d. Discontinuing medications
   e. Giving the person responsibility
   f. Treating the person like an adult
   g. Don’t know

22. If you notice side effects of the medication that the patient is taking, you should:
   a. Wait to see if the side effects go away
   b. Ask the doctor’s advice
c. Recommend coming off the medication altogether
d. Recommend a lower dose of the medication than prescribed by the doctor
e. Don’t know

23. The best family environment for a person suffering from schizophrenia is where:
   a. The person can do what s/he likes
   b. The person spends most of his/her time with another family member
   c. The person is forced to go out and get a job
   d. The person is encouraged to take up things s/he used to do
   e. The family takes care of all the persons needs, and protects the person from any stress
   f. Don’t know

24. If one of your clients were to present with any signs or symptoms of psychosis: (check all that apply)
   a. You feel confident that you would recognise that there was a problem
   b. You would talk to the client first
   c. You would talk to the parents first
   d. You would consult colleagues/specialists
   e. You do not feel confident you would recognise the signs or symptoms of psychosis
   f. Don’t know

25. What would you do to refer someone with what you suspect to be a first episode of psychosis?
   a. Refer him to your local mental health service provider/psychiatrist
   b. Bring your client to your local Emergency Room.
   c. Speak to his/her General Practitioner
   d. Ask the parents to take him/her to their GP for referral
   e. Don’t know

POST-WORKSHOP SATISFACTION SURVEY

Date: ____________________________ Delivery Mode/Attendance: ON-SITE ☑ VIDEOCONFERENCE ☐

1. Overall, how would you rate this workshop?

   1  2  3  4  5  N/A
   Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐

2. Please evaluate the following aspects of today’s workshop using this rating scale as a guide:

   1  2  3  4  5  N/A
   Strongly Disagree Disagree Neutral Agree Strongly Agree Not Applicable

   a) There was adequate advance notice provided for enough members of our staff to attend this workshop
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   b) This workshop met the stated learning objectives
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   c) There was adequate time to cover the objectives
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   d) The workshop met my expectations
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   e) The workshop was relevant to my work
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   f) I was able to interact with other participants
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   g) The technology enhanced the workshop
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   h) The environment (ie. Seating/lighting for the workshop was adequate
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   i) The information was presented clearly
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   j) I was able to participate actively in the workshop
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   k) There was enough time for active discussion
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   l) The audio/visuals were used effectively in presenting information
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   m) The facilitator created an interactive environment between the speaker and the participants
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   n) The teaching method enabled me to make the link between the new knowledge provided and the management of my clients
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   o) I will use the workshop resources to refer clients to the most appropriate service
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐

   p) I would recommend this workshop to members of my agency and/or profession
   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ n/a ☐
3. a) Will you be integrating the knowledge and skills of early identification of psychosis into your practice for all your clients and families?

   Yes ☐ No ☐ Maybe ☐

b) if no or maybe, why not?

4. a) Do you need additional information/resources about this topic to help your clients?

   Yes ☐ No ☐ Maybe ☐

b) if yes or maybe, what would you like to receive?

5. Describe at least two particularly strong features of this workshop:

6. Describe at least two areas of weakness you would like to see changed:

7. Describe at least two ways you feel more confident in your ability to manage issues related to early episode psychosis as a result of this workshop.

8. Was there evidence of a pharmaceutical industry bias?

9. How did you hear about the workshop?

10. How would you improve (any aspect of) this workshop?

11. General comments and suggestions:

CLICK HERE TO SUBMIT THIS QUESTIONNAIRE
6 MONTH FOLLOW UP:
POST FOCUS-GROUP SATISFACTION SURVEY

Date: 

Delivery Mode/Attendance (for workshop): ON-SITE ○ VIDEOCONFERENCE ○

1. Overall, how would you rate your experience thus far in the evaluation?

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Please evaluate the following aspects of your focus group interview using this rating scale as a guide:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a) There was adequate advance notice provided for participants to attend the focus group

b) This focus group met the stated objectives

c) The facilitator created an interactive environment between the speaker and the participants

d) There was adequate time to cover the objectives

e) The focus group met my expectations

f) The focus group was relevant to the training

g) I was able to interact with other participants

h) There was enough time for active discussion

i) The questions were presented clearly

j) The environment (ie. Seating/lighting) for the focus group was adequate

k) The length of the focus group was appropriate.

3. a) Did you leave the focus group feeling satisfied with your level of contribution?

   Yes ○ No ○ Maybe ○

b) if no or maybe, why not?

4. a) Do you have any thoughts or comments which you didn’t share but wish you had?

   Yes ○ No ○ Maybe ○

b) if yes or maybe, please share them now.
5. a. In the last six months: How comfortable have you been dealing with psychosis in youth?
   Very Uncomfortable  |  Uncomfortable  |  Neutral  |  Comfortable  |  Very Comfortable
   1  |  2  |  3  |  4  |  5

b. Please describe ways you feel more confident in your ability to manage issues related to early episode psychosis as a result of this workshop.

6. In the last six months: How would you rate your ability to use the knowledge acquired from the training in your client work?
   Poor  |  Fair  |  Good  |  Very Good  |  Excellent
   1  |  2  |  3  |  4  |  5

7. a. In the last six months: How many client referrals have you made or phone consultations have you required for Early Psychosis Intervention services?
   0  |  1  |  2  |  3  |  4  |  5  |  6  |  7  |  8  |  9  |  10  |  >10

b. How has this changed since the training workshop? increased  |  decreased  |  unchanged

8. In the last six months: Have you required or requested any educational information or materials regarding Early Psychosis Intervention services?
   Yes  |  No

9. Reflecting on the past six months post-workshop, what would you recommend be changed or continued as part of this training initiative?
   Changed:  |  Continued:

10. Any other comments?

Submit by Email
ONE MONTH (OR MORE) BEFORE WORKSHOP:
- Education & Training Coordinator (ETC): Contact made with off-site host coordinators;
- ETC: Off-site videoconferencing rooms booked.
- ETC: OTN sites booked and confirmed with OTN reps.
- Research Assistant (RA): Local videoconferencing equipment and room booked.
- RA: Resident/Learner’s flight and accommodations booked.
- ED to ED contact made to “Save the Date” and obtain Program Managers (PM) contact info
- PM to PM contact made to “Save the Date” and to schedule followup phone call for more information
- RA: email invitation, poster, and registration forms to PMs for internal distribution
- Follow up phone call with PM (to discuss recruitment eligibility)

TWO WEEKS BEFORE WORKSHOP:
- RA & PM: Complete recruitment process.
- RA: Develop participants list; obtain emails and phone numbers (from registration forms)
- RA: email participants consent forms
- RA & ETC: execute trial run of video site connections
- ETC book OTN webcasting (for online storage/streaming of workshop)

ONE WEEK BEFORE WORKSHOP:
- RA & ETC: execute trial run of video site connections
- RA: Confirm all bookings
- Deadline for registration/consent to be obtained from participants
- RA: Finalize numbers (per site)
- RA: Finalize satisfaction/process surveys
- RA: E-mail Pre-Workshop questionnaire to participants for immediate completion.
- Facilitator, RA & ETC: Prepare mail-out packages for participants.
  - Finalize workshop materials/ppt slides.
  - Prepare any necessary handouts.
  - Gather brochures and resources.
  - Assemble packages in folder/duotang for participants.
  - Create troubleshooting document and include in package.
  - Mail via ExpressPost to videoconferencing locations.

DAYS BEFORE WORKSHOP:
- RA & ETC: execute trial run of video site connections
- RA: Obtain any/all outstanding documents (consents, registration, questionnaire…)

DURING WORKSHOP:
Day 1:
- Research team member available for contact via phone and email.
- RA: Take attendance.
- RA: Evaluate environment:
  - Adequate lighting
  - Chairs (count, comfort, placement)
  - No identifiable hazards/distractions
  - Amenities available (washrooms,
  - Connectivity:
    - Videoconferencing sites are on screen
    - Videoconferencing sites have sufficient audio
  - Other:

Day 2:
- Research team member available for contact via phone and email.
- RA: Take attendance.
- RA: Evaluate environment:
  - Adequate lighting
  - Chairs (count, comfort, placement)
  - No identifiable hazards/distractions
  - Amenities available (washrooms,
  - Connectivity:
    - Videoconferencing sites are on screen
    - Videoconferencing sites have sufficient audio
  - Other:
- RA: Satisfaction Survey and Post-Workshop Questionnaire emailed to all participants.
EDG 1327

EFFECTIVE TRAINING AND EDUCATION
FOR EARLY PSYCHOSIS INTERVENTION

FOCUS GROUP GUIDE

FOCUS GROUP MODERATOR: Andrew Howlett
FOCUS GROUP RECORDER: Carole Lem

FOCUS GROUP LOCATION: __________
FOCUS GROUP#__________ : __________

FOCUS GROUP PARTICIPANT #1: _________________
FOCUS GROUP PARTICIPANT #2: _________________
FOCUS GROUP PARTICIPANT #3: _________________
FOCUS GROUP PARTICIPANT #4: _________________

Absent: _________________

EDG 1327: Effective Training and Education for Early Psychosis Intervention
Cheng, C. 1,2,3; Hanson, M. 4; Dore, K. 3; Fortin, M. 1; Howlett, A. 4

1. Canadian Mental Health Association – Thunder Bay Branch
2. Centre for Addiction and Mental Health (CAMH)
3. McMaster University
4. University of Toronto – Department of Psychiatry

Research Associate: Dr. Marie-Josée Emard
ROOM SETUP:
- Quiet place, small “round” table.
- Removal of background noises, removal of telephones, etc.
- Comfortable temperature
- Name cards
- RECORDING Setup: battery charged, proper high quality settings, on stand/book, in center of room.
- Refreshments before or after.
- Washroom!
- Since we only have 90 minutes we would like to avoid any distractions so if possible please turn off your phones.
- There will not be any breaks so we would encourage you to use the washroom now if necessary.

INTRODUCTIONS
- For the purpose of the recording, I would like to state that today is __________ and this is focus group __________ with Group __________.
- Present we have myself the moderator Andrew, recorder Carole, and participants: ________________.

STATEMENT OF PURPOSE AND CONFIDENTIALITY
Thank you for agreeing to participate in this focus group. This focus group is part of an ongoing evaluation project of the two-day workshop you received on Early Psychosis Intervention in March of this year.

The purpose of this focus group is to understand your experience of the workshop and how it may have affected your capacity to assess and manage individuals with early psychosis. In particular, I will ask about the features you believe facilitated or interfered with your ability to learn from this workshop and to integrate this knowledge into your clinical practice.

We see each of you as a major stakeholder in this evaluation project and we look forward to your input. The format of our discussion is informal. I will ask you 7 leading questions as well as some related questions over the next 90-minutes and also give you a chance to share anything that you think is important but that I didn’t quite ask about. In order for you to have a chance to respond to all the questions and for each of you to provide input, I may interrupt from time to time. Carole will be recording the discussion and as you can see there is a tape recorder on the table so that will ensure we record all information correctly. Your comments are completely confidential from the facilitator of the workshop and the EPI front-line staff. I will also ensure that no individual’s comments can be traced back to the participant; only group or collective data will be discussed with the research team. Your name will not be associated with any comments you make during this discussion. There are no right or wrong answers, please feel free to be totally honest. Your opinions and feedback will be reviewed and summarized and will provide a richer understanding of this educational experience and have an impact on future workshops and training.
FOCUS GROUP GUIDE

REVIEW GROUP RULES/NORMS

1. When it comes to the questions, if you are unsure about any part of the question please don’t hesitate to ask for clarification. Again, this is meant to be informal.
2. I would like to remind you to support one person talking at a time.
3. You each have a pad of paper and a pen in case you want to jot down any thoughts or notes while someone else is speaking.
4. Please speak in a clear, loud voice so that we can all hear you and to ensure your responses will be recorded.
5. The goal is to hear from everyone regarding every question. Please share any differences in opinion or add to what someone has already said. We want to capture as much information as possible.
6. Refreshments are available, please enjoy after the focus group.
7. Is there anything either of you would like to add, or do you have any questions before we begin?

This is the beginning of Focus Group #___. The time is ____. We will finish at _____.

1. I would like to begin the focus group by asking you to tell me a bit about your community? (10-min; 80-min remaining)
   a. What is the main source of industry?
   b. What % of the population are youth?
   c. What does the future have in store for the youth here?

2. Can you tell me a bit about your comfort level and experience in assessing and managing individuals with psychosis before the EPI Training Workshop? (10-min; 70-min remaining)

3. 6 months ago each of you participated in the Early Psychosis Intervention Training Workshop and I am curious what aspects of the workshop stood out for you? (25min; 45-min remaining)
   a. What parts contributed to your knowledge about early psychosis?
   b. What parts contributed to your skills in assessing and managing early psychosis?
   c. What parts were not helpful or relevant?
   d. Can you describe your experience with receiving this workshop via videoconferencing?
   e. How do you think your groups' workshop experience compared to the workshop experience of the other communities who participated?
   f. What do you think would have improved your workshop experience?

4. What have been your experiences in integrating this new knowledge around early psychosis assessment and management into your daily work here in _________? (20-min; 25-min remaining)
   a. How has this workshop changed your clinical practice?
   b. What are some barriers you currently face or expect to face in the future around the assessment and management of individuals with psychosis?
   c. In the future, what do you believe will make it easier for you to assess and manage individuals with psychosis?
d. Despite your skills, what do you think makes it difficult for clients with psychosis to engage with mental health services in your community?

5. You have participated in evaluating the workshop by completing surveys, tests and now the focus group. Can you tell me about your experience of this evaluation process? (10-min; 15-min remaining)
   a. What are your thoughts about playing a role in evaluating this training workshop?
   b. Has your participation in the evaluation process affected your overall EPI training experience?
   c. What do you think would have improved your experience in the evaluation process over the past 6-months? (10min; 20min remaining)
   d. The final 3-month phase of the evaluation process includes TEST and Survey? Would you suggest any changes to enhance the remaining evaluation phase?

6. What are your thoughts about future mental health workshops in your community? (8-min; 15-min remaining)
   a. What are your thoughts about using videoconferencing for future workshops?
      i. What are the benefits?
      ii. What are the drawbacks/pitfalls?

7. Is there anything else you would like to add about your workshop experience, the evaluation process, or your clinical experiences? (7-min; 0-min remaining)

CLOSING

This is the end of focus group #_____. I would like to thank you all for participating. If you need to reach us regarding any matter related to the Focus Group please contact us through Carole Lem.

I will turn the recorder off as this is the end of our focus group on ____________.

EXAMPLES OF CLARIFYING QUESTIONS
“Please tell me (more) about that...”
“Could you explain what you mean by...”
“Can you tell me something else about...”
“We have had an interesting discussion, but let’s explore other ideas or points of view. Has anyone had a different experience that they wish to share?”
### Project Timeline

**Stage 1: Groundwork**
- **January 2011**: Ethics approval received

**Stage 2: Workshop (Intervention)**
- **February 2011**: Funding approval by OCE
- **March 2011**: Pre-workshop questionnaire: KASQ

**Stage 3: Evaluation**
- **April 2011**: Ethics approval process
- **May 2011**: “Psychosis 101” Training Program. © 2006 Birmingham, UK.
- **June 2011**: Post-workshop questionnaire: BAQ
- **July 2011**: 3 month follow-up: KASQ & Satisfaction Survey
- **August 2011**: 6 month follow-up: BAQ; Focus Groups & Satisfaction Survey
- **September 2011**: 9 month follow-up: KASQ & BAQ

**Stage 4: Knowledge Exchange**
- **October 2011**: Feedback with stakeholders
- **November 2011**: Project end point
- **December 2011**: Final report

**January 2012**
- **January 2012**: FEBRUARY
- **February 2012**: MARCH

**APPENDIX: K**