Invited symposium: IFP 2018, June 9

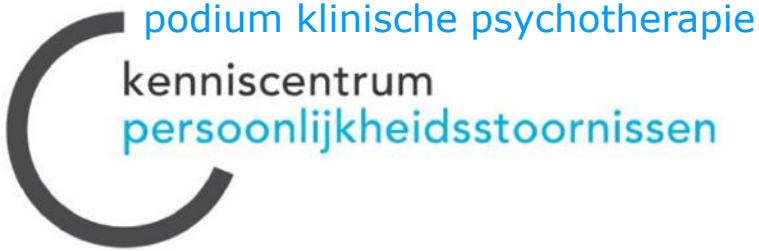
Psychotherapy within a day-hospital or inpatient setting:
the strength of a therapeutic milieu

Jaap Segaar

Anna Bartak

Frans Kamsteeg

Theo Ingenhoven (chair)



Why this invited symposium?

- Dutch long tradition with inpatient psychotherapy
- Number of beds decreased dramatically past decade
- Increase of outpatient EBM psychotherapies:

  "Big Four" (DBT, TFP, SFT, MBT) ……and others
- But…not everywhere available, exclusion criteria, long waiting lists (> 1 year), limited effect sizes, high dropping out, high pushing out, psychotherapeutric side effects, psychiatric decompensations…
- Question is: (for whom?) do we need more (expensive?) intensive psychotherapeutic programs? Why should we willing to pay for it?

Necessity for intensive psychotherapy: from which perspective???

- Patients health perspective (patient/relatives)
- Treatment program perspective (therapist/team)
- Organization perspective (hospital staff/management)
- Scientific perspective (research department/PhDs)
- National mental health perspective (government politics/ assurance companies policies, associations of health care professionals)

Patients (and their relatives) interests

- Fast an smooth reference
- Appropriate assessment & case conceptualization
- Personalized approach:
- strait forward treatment allocation (matched care)
- to an evidence based treatment program
- with competent therapists (treatment team)
- with no waiting lists: direct access
- in appropriate dosage (intensity and length)
- regular evaluations with flexible adjustments
- carefully planned termination
- appropriate available aftercare (whenever necessary)

Patients (and their relatives) interests

- Smooth reference
- Appropriate assessmen zation
- Personalized (int
- Strait forward ed care)
- To an evi am
- With c nt team)
- With cess
- In a ntensity and length)
- Regul ions with flexible adjustments
- Carefully planned termination
- Appropriate available aftercare (whenever necessary)

Wat is the best choice of treatment in my case ??

Therapists (and team) interests

- Patients fitting therapists favorite treatment model
- Within therapists competence and specialization
- Specific registrations and accredited schooling
- Appropriate references to treatment by others
- Adequate production and financial income
- Low administration tasks
- Nice colleagues and inspiring intervision sessions
- Good salary; beautiful Christmas present
- Not to much night shifts
- Spacious training budget + freedom to choose
- Lots of spare time and exiting holidays

Therapists (and team) interests

- Patients fitting therapists favorite [illegible] model
- Within therapists compe[illegible]tion
- Specific registrati[illegible]ng
- Appropriate r[illegible]ners
- Adequat[illegible]me
- Low a[illegible]
- Nic[illegible]intervision sessions
- G[illegible]ristmas present
- N[illegible] shifts
- Spacious professional training + freedom to choose
- Lots of spare time and exiting holidays

Which are the best patients and conditions for my favorite/specialized treatment offer ??

Organizational (management) interests

- Optimal mix of competent therapists (limited investments)
- Sufficient references towards programs (production)
- Waiting lists (but not too long); beds in use
- enough drop-outs (= initial DBC's), but not too much!
- Satisfied external quality requirements
- Adequate client satisfaction feedback
- ROM & benchmark
- E-health (blended care)
- Satisfactory purchase by health care insurances
- No incidents (aggression, suicides); no complaints

Organizational (management) interests

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chase by health care insurances

flourishing business
management (profit)

Scientific and scholar interests

- More and larger research grands
- High patient selections (Homogeneity ->exclusion criteria)
- Informed consent and randomization (RCT)
- High N for acceptable power (statistical significance)
- Straightforward classification (SCID-5; BPDSI…..)
- Validated assessment procedures
- No drop-outs
- Methodological & high tech ICT services
- Articles accepted in (high impact factor) journals
- High scientific and scholar status (Top-referent; Nobel price)

Scientific and scholar interests

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How (cost)effective are our EBM treatment programs ??

Mental health policies

- Market economy with competition
- Cost-benefit analysis and control
- Less expensive inpatient care beds
- Sound outpatient mental health system
- Lay man’s help (buurvrouw aan de keukentafel)
- High Qualies & society willingness to pay
- No weird people in the streets
- Less violence
- Less murders
- Zero suicides

Mental health policies

- Market economy with competition
- Cost-benefit analysis ap
- Less expensive in
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- Lay man'
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to pay

Proper care
"Zinnige zorg"

Which perspectives are we going to present:

Jaap Segaar: A milieutherapeutic approach in psychotherapeutic treatment of personality disorders

Anna Bartak: Effectiveness of day-hospital and inpatient pychotherapy for personality disorders: a systematic review on outcome research

Frans Kamsteeg: Positioning inpatient psychotherapy in the Dutch mental health care system: from a single solution policy towards a network framework perspective

Theo Ingenhoven: Rational treatment selection for personality disorders in outpatient and (day)clinical settings: what is indicated for whom?

A milieutherapeutic approach in psychotherapy treatment of Personality Disorders.

Jaap Segaar

Not

"One model fits all"

Or

"One model fix all"

But:

"Personalized treatment"

Tailoring

Creative/Flexible

Embedded in:

Containing and holding environment

“Living learning” environment

Integrating:

(group)psychotherapy

experience based (art) therapies

social psychiatric support

skills training

system therapy

Integrated Modular Treatment

Combining Effective Treatment Methods

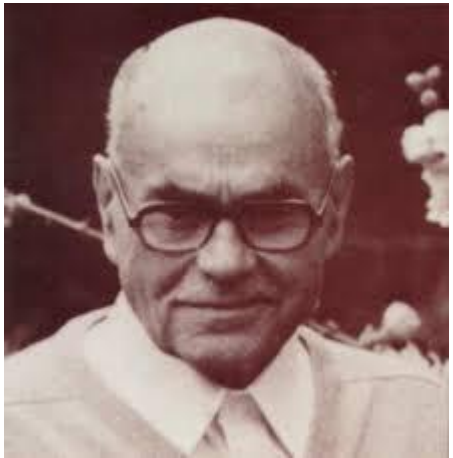
(John Livesley, 2017)

Historical overview

- Changing perceptions of madness: Deviance as sin, deviance as crime, deviance as sickness
- 'Golden age' of the asylum (1794 -1930):
  1. Moral treatment of madness (“troubled minds”)
  2. Medical treatment of madness (“diseased brains”)
- World War II

Therapeutic community: origins

- 1938 Army Psychiatric Services: Tavistock Clinic, Northfield Hospital (Wilfred Bion, Tom Main, Sigmund Foulkes)
- Maudsley Hospital, Mill Hill, Effort Syndrome Unit, Henderson hospital therapeutic community (Maxwell Jones)



Therapeutic community: origins

- Changing society and movement towards more democracy
- Pressures produced by war (influx of neurotic/psychosomatic patients, shortage of staff, threats of ongoing bombing, etc.)

Therapeutic community: principles

Basic principles of therapeutic communities:

- Shared leadership by both patients and staff (democratic principle)
- Decision-making at all levels
- Consensus in decision-making
- Two-way communication at all levels
- Social learning by social interaction here-and-now.

(Jones, 1953)

Therapeutic community: pioneering

During the sixties and seventies multiple TC were founded in The Netherlands, pioneering in inpatient groupwork: Ideological phase

De Spiegelberg

Jozef

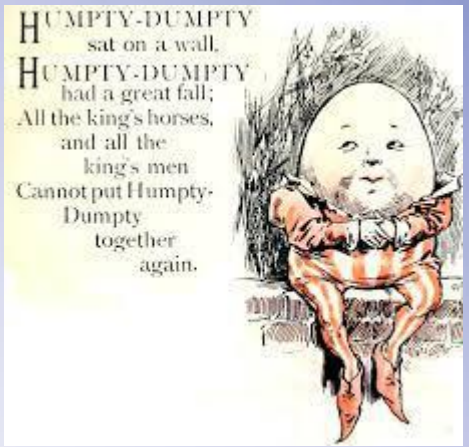
Amstelland

De Oosthoek

De Viersprong

Veluweland

Therapeutic community: survival?



(Day-)Clinical Psychotherapy

Integrated Modular Treatment

Combining Effective Treatment Methods

(John Livesley, 2017)

Clinical Psychotherapy: nowaday

- Integrated Treatment Program, high dosage, with 'common factors' as well as 'individually tailored modules' targeting specific problems.
- Embedded in an "*living learning*" and *psychotherapeutic* environment/milieu that is focusing on social roles, social skills and interpersonal interaction
- Within this overall framework, different “theoretical working models" can be used, such as MBT, SFT, TFP, DBT, APhT or TA

Clinical Psychotherapy: nowaday

- Combining different treatment modalities (verbal therapy & experience-based therapy & learning skills)
- Time limited (between 3 and 12 month)
- Using treatment contract as focus of treatment

Common features

- Clear structure
- Integration
- Consistency
- Continuity
- Personaly attuned
- Goal-directed
- Targetting motivational and commitment issues
- Handling crises
- Promoting reflection on one’s own thoughts and feelings
- Involving family and other relevant people

Therapeutic milieu for PD patients

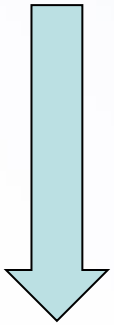
- An organized treatment unit in which a client is offered space to shape relationships with other clients, groups, practitioners, the department and/or the institute.
- These relationships offer the client opportunities, within its possibilities and limitations, to find new solutions to its problems and to develop more adaptive behavior patterns.

(Janzing & Kerstens, 1997)

Treatment process

self-actualization

(adaptive)



Actualisation of pathological themes

(disadaptive)

Treatment program

- Living environment
- Patient-staff-meeting (27 patients + staff)
- Sociotherapy (9 patients)
- Grouppsychotherapy (9 patients)
- Art-therapies: Creatieve therapie, Psycho MotorTherapy, Musictherapy, Psychodrama
- Skills training
- Systems therapy
- Farmacotherapy

Thank you for your attention

Bad weather: who is to blame?

Different stories about inpatient psychotherapy

Frans Kamsteeg, Directeur Specialismen GGNet

Paradox

- Evidence for effectiveness
- Difficult position in institutions for mental healthcare

- What's the logic?

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Contexts

- Government
- Healthcare Insurers
- Boards of Mental healthcare Institutions
- Professionals and researchers

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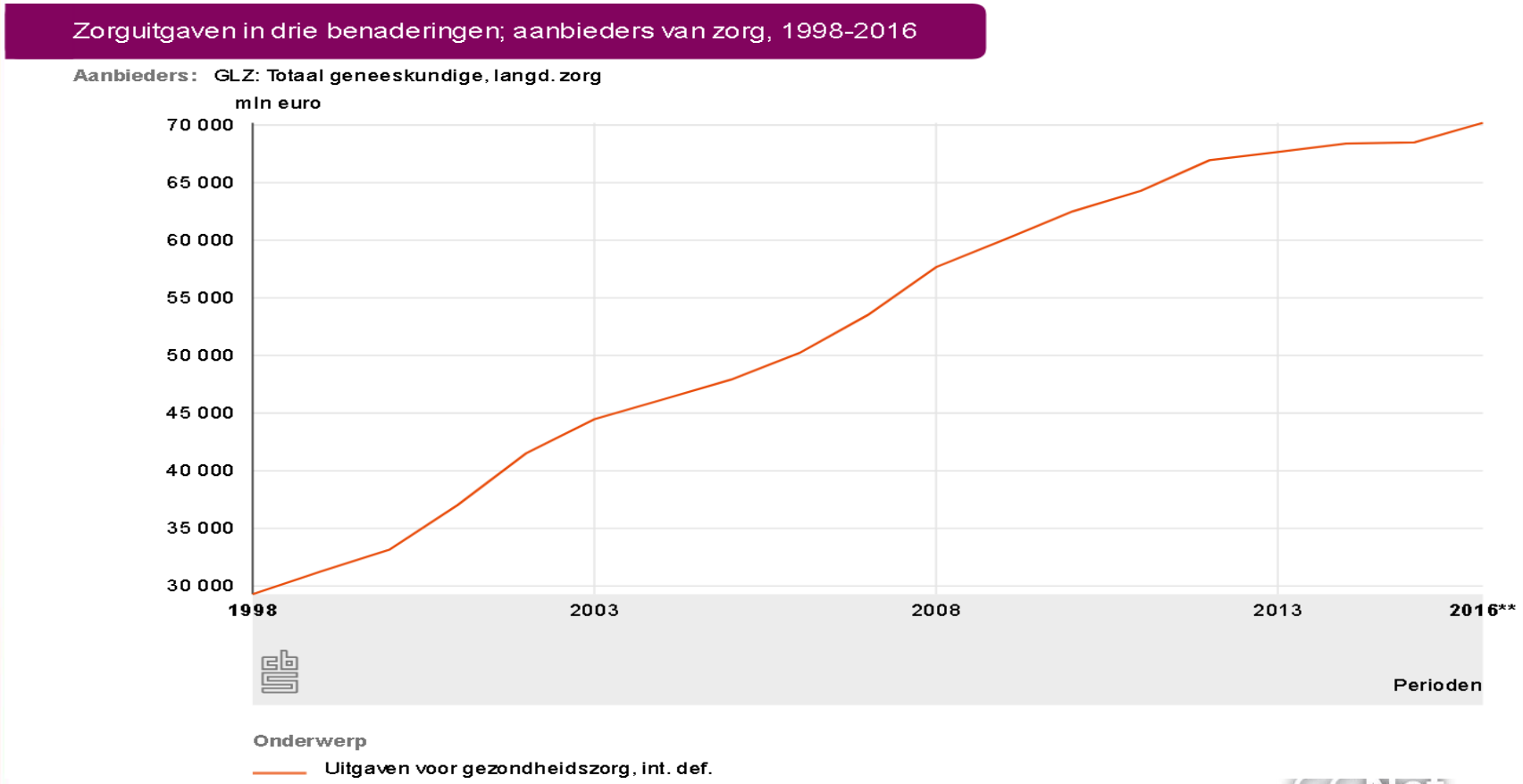
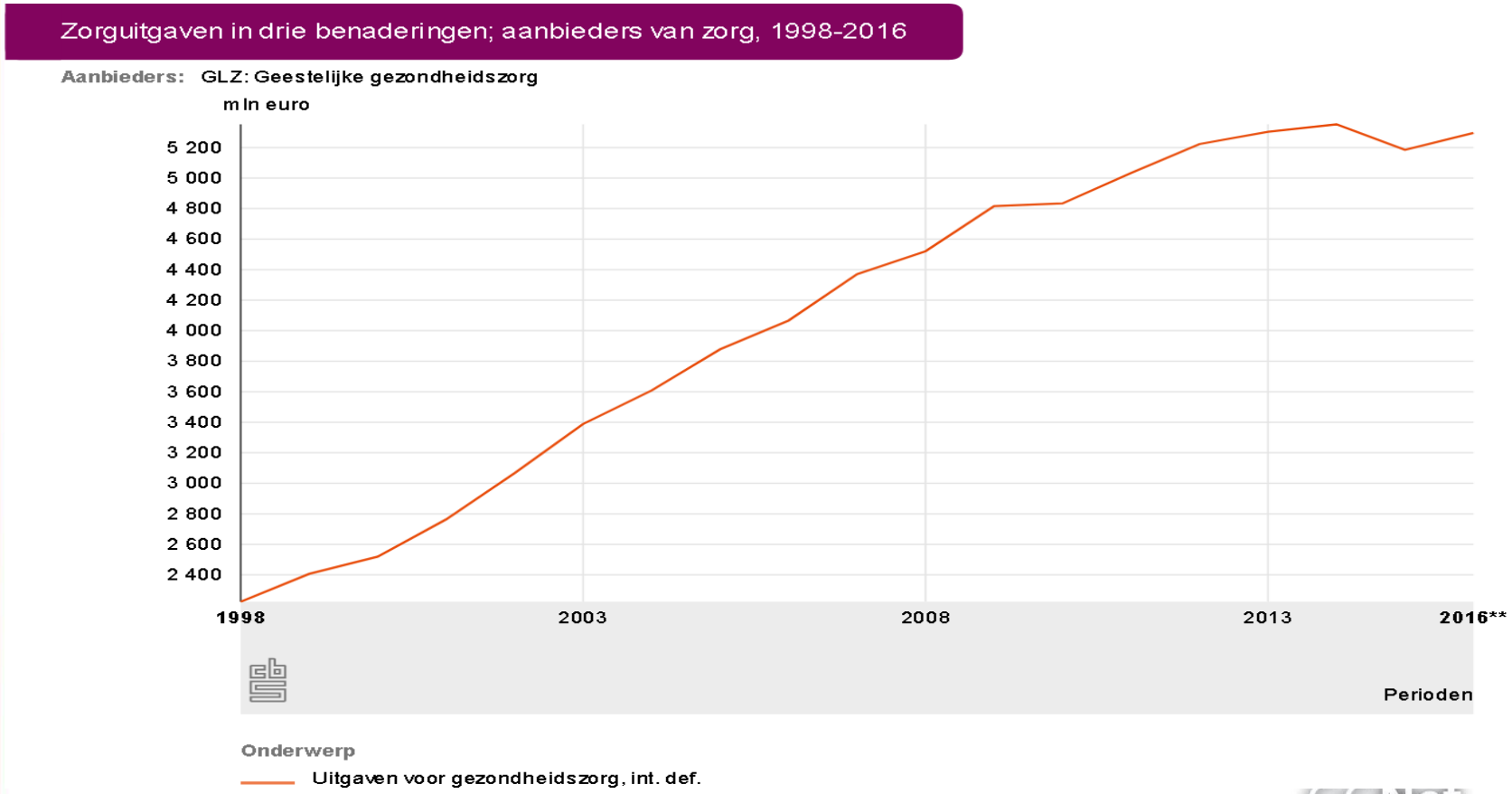
Government


Zorguitgaven in drie benaderingen; aanbieders van zorg, 1998-2016
Aanbieders: GLZ: Totaal geneeskundige, langd. zorg
mln euro
70 000
65 000
60 000
55 000
50 000
45 000
40 000
35 000
30 000
1998
2003
2008
2013
2016**
Perioden
Onderwerp
Uitgaven voor gezondheidszorg, int. def.

Mental Healthcare



Healthcare Insurers

- Simplification of complexity
- Just look at a period of 1 year
- Average price per single insured patient
- Use of beds in bed-days
- New patients

Institutions

- No more growth in healthcare costs
- No business as usual
- Choices based upon criteria insurers

Inpatient psychotherapy

- Average price
  - € 100.000,- vs. € 7.500,-
- Use of beds
  - Long and stable vs. Short and decreasing
- New patients
  - Few relative to total number (50 vs. 16.000)
- Not very popular

Professionals and researchers

- Convinced
- But not sure
- Oriented on own programs
- Knowing that patients in other programs could profit from knowledge and expertise
- What will the future look like (if not the same)?

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What to do?

- Accept the logic of the current system
- Create a new storyline to get a different assessment:
  - Lifetime perspective on patientlevel
  - A networkperspective by organising collaborative care, work from your knowledge base

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Rational treatment selection for personality disorders in outpatient and (day)clinical settings: what is indicated for whom?

Theo Ingenhoven, psychiatrist
Arkin, Amsterdam

theo.ingenhoven@npsai.nl

Indication for treatment

" ***What*** treatment,
by ***whom***,
is most effective for ***this*** individual
with ***that*** specific problem,
under ***which*** set of circumstances ?"

Paul, 1967

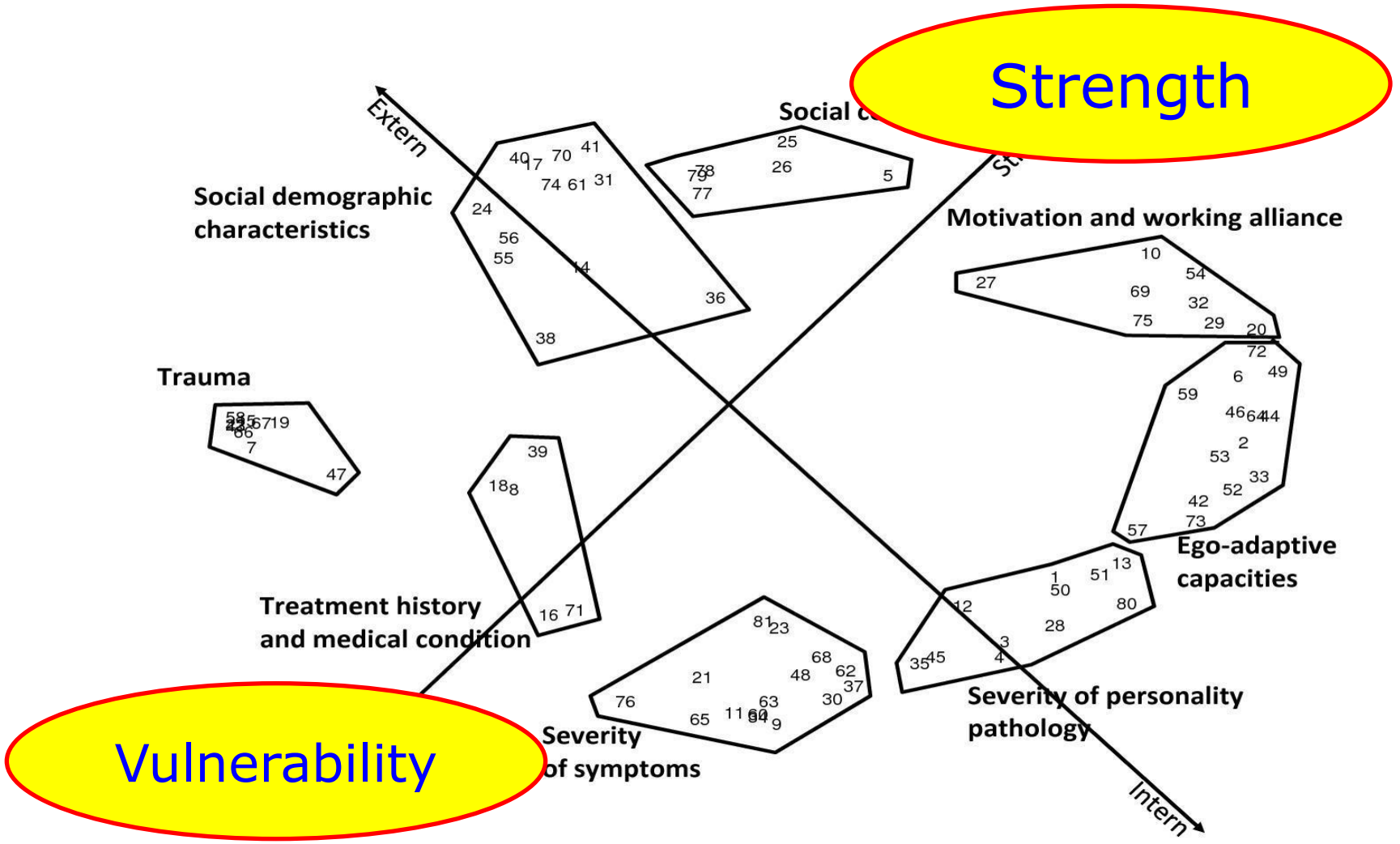
2018:
more research than ever…..
…but this question isn't answered

In search of patient characteristics that may guide empirically based treatment selection for personality disorder patients. A concept mapping approach

- Systematic review literature: 310 variables
- Selection by experts: 81 variables
- Conceptmapping: 8 clusters
- Interpretation by 29 Dutch experts

Van Manen, Kamphuis, Goossensen, Timman, van Busschbach & Verheul
Journal of Personality Disorders, 2012, 26, 481-497

Concept mapping of indicators for treatment allocation in patients with personality disorders



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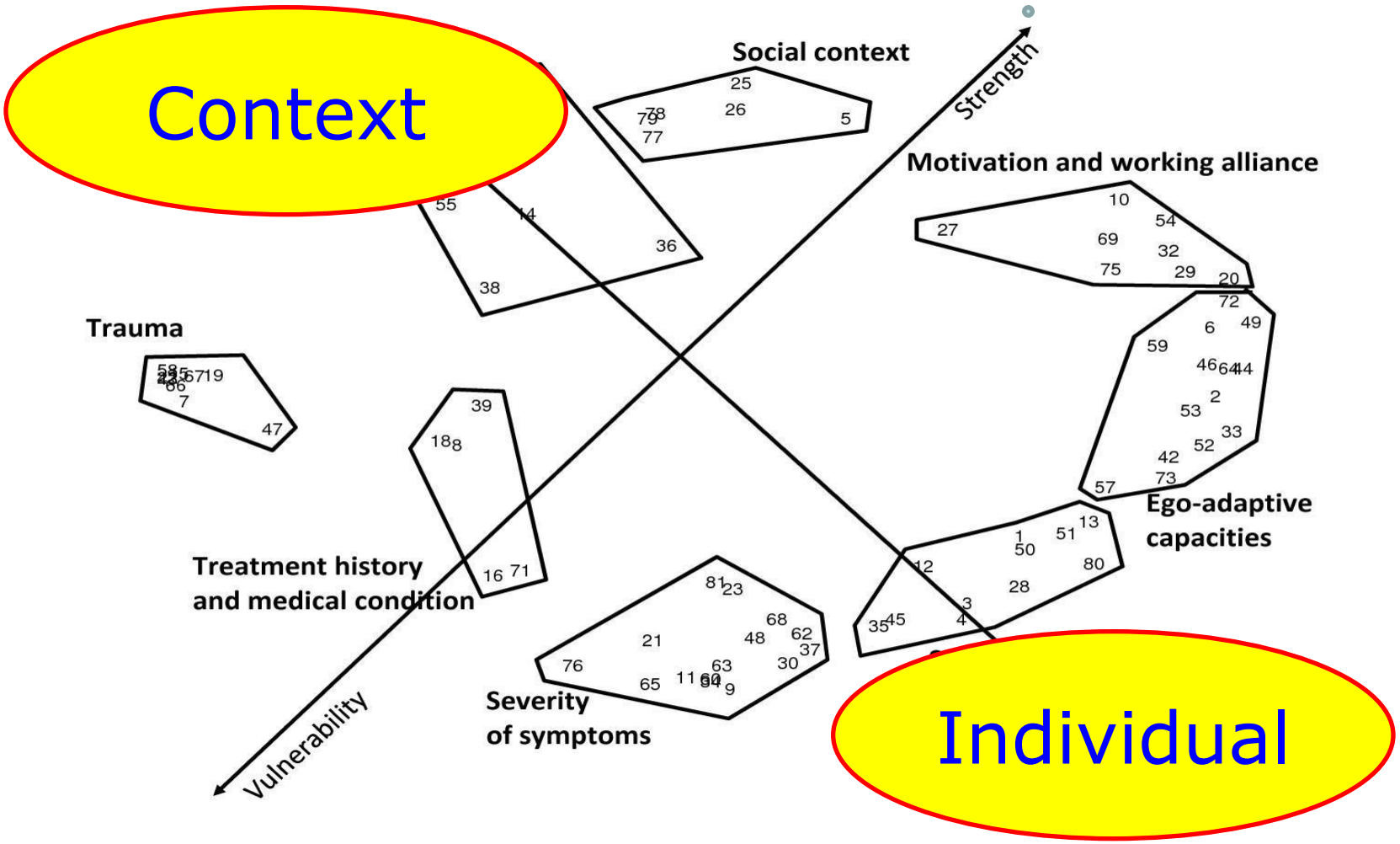

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Journal of Personality Disorders, 2012, 26, 481-497

Concept mapping of indicators for treatment allocation in patients with personality disorders

1. Severity of symptoms (distress)

   Depression, anxiety, psychotic symptoms, self harm, suicidality

2. Severity of personality pathology

   Structural personality organization, severity personality disorder, maladaptive traits

3. Ego-adaptive capacities

   Ego strength, identity integration, secure attachment, mentalizing capabilities

4. Motivation and working alliance

   problem recognition, commitment, responsibility for own treatment, therapy allegiants, willingness, trust

5. Social functioning

   Work, education, family, network, support system

6. Social demographic characteristics

   Age, gender, living situation, finance

7. Trauma (past and present)

   Physical and sexual abuse, emotional neglect, divorce parents, losses, being bullied

8. Treatment history and medical condition

   Effect of former treatments, pharmacotherapy, dropping out, somatic problems tat interfere

Van Manen et al. (2012)

Concept mapping of indicators for treatment allocation in patients with personality disorders

1. Severity of symp
   Depres
2. Severity
   Structural personality organization, severity personality disorder, maladaptiv
3. Ego-adaptive
   Ego s ng capabilities
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Vulnerability

Strength

Individual

5. Social functioning
   Work, e
6. Social d
   Age, gender, living situation,
7. Trauma (past and
   Physi s, losses, being bullied
8. Treatmen tion
   Effect of former treatments, pharmacotherapy, dropping out, somatic problems tat interfere

Strength

Vulnerability

Context

Van Manen et al. (2012)

Treatment allocation in patients with personality disorders

Conclusion I:

- The patient should be examined in terms of the amount of emotional **pressure or stress** she/he can tolerate and handle.
- Decide whether the patient needs a primarily **stabilizing or** supportive treatment (e.g. more like DBT) or, alternatively a more **destabilizing** or confrontational/expressive treatment (e.g. more like TFP).
- Expressive therapy is primarily focused at relational and conflictual issues by (cognitive and emotional) insight and emotional corrective experiences.
- A supportive approach is primarily focused on change by pacification and stabilization of the patients inner structure, by external support and structuring the environment.

Treatment allocation in patients with personality disorders

Conclusion II:

- Even more than outpatient psychotherapy, (day-)clinical psychotherapy can be classified as both supportive and expressive, both stabilizing and destabilizing within one program/milieu.
- Within the therapeutic milieu the amount of emotional **pressure or stress** can be handled carefully, also between sessions, within certain limits.
- More vulnerable patients need a more supportive and stabilizing (holding) environment than outpatient psychotherapy and the patients own context can offer.
- Moreover, interventions should also focus on systemic problems, such as family problems and lack of social support at home.

Treatment allocation in patients with personality disorders

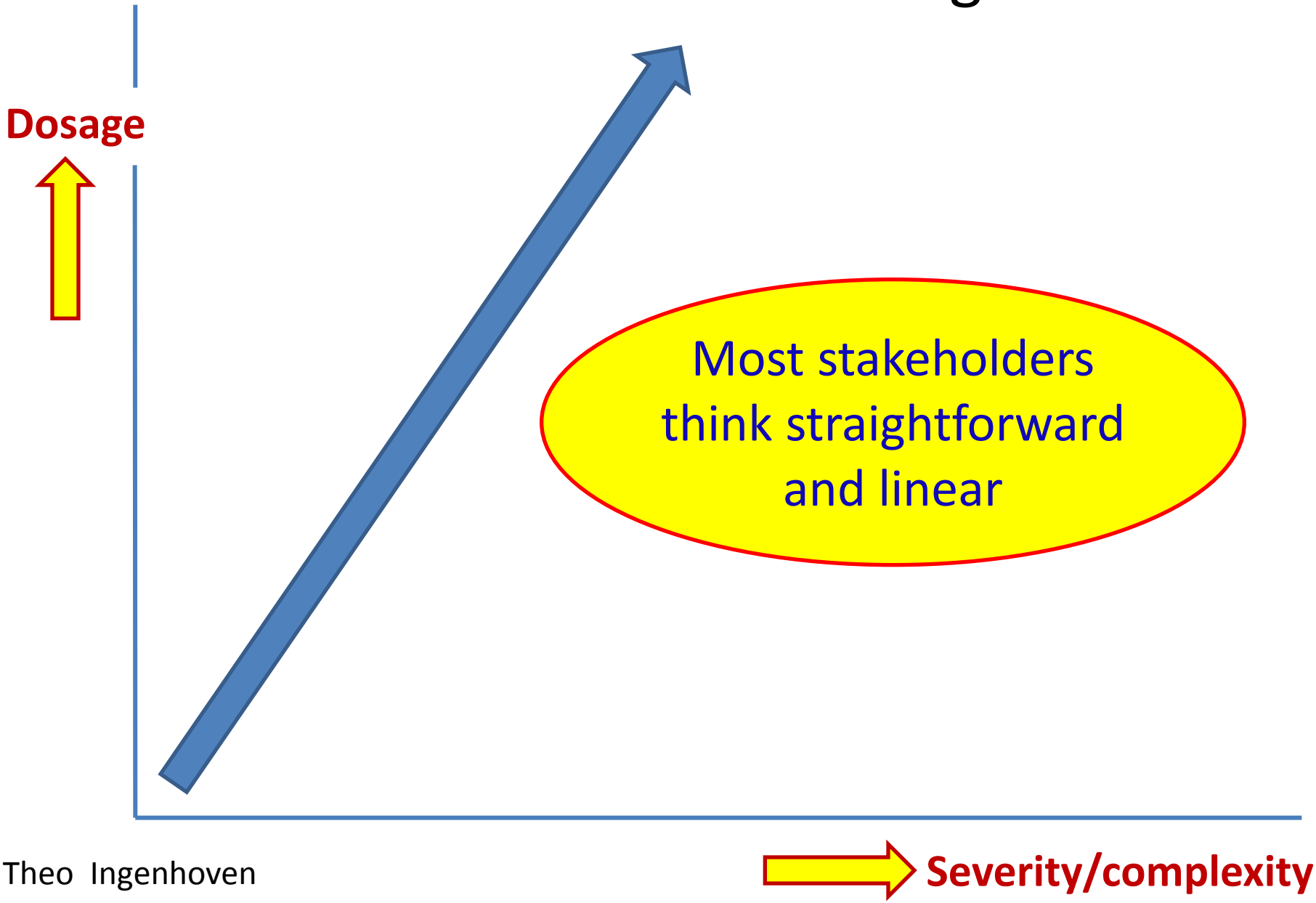
Conclusion III: prevent iatrogenesis and non-response:

- All eight factors have to be carefully weighted since clinicians tend to focus to much on individual factors and underestimate the influence of context factors in treatment selection.
- Individual factors (both vulnerabilities and strengths) are important for case conceptualization and case formulation.
- Context factors (both vulnerabilities and strengths) are important screeners for available options for treatment selection and dosage.
- The eight clusters of patient and context characteristics can bring empirically based treatment selection a step closer.

Some thoughts on Demand of care and dosage of treatment

Theo Ingenhoven

Demand of care & dosage



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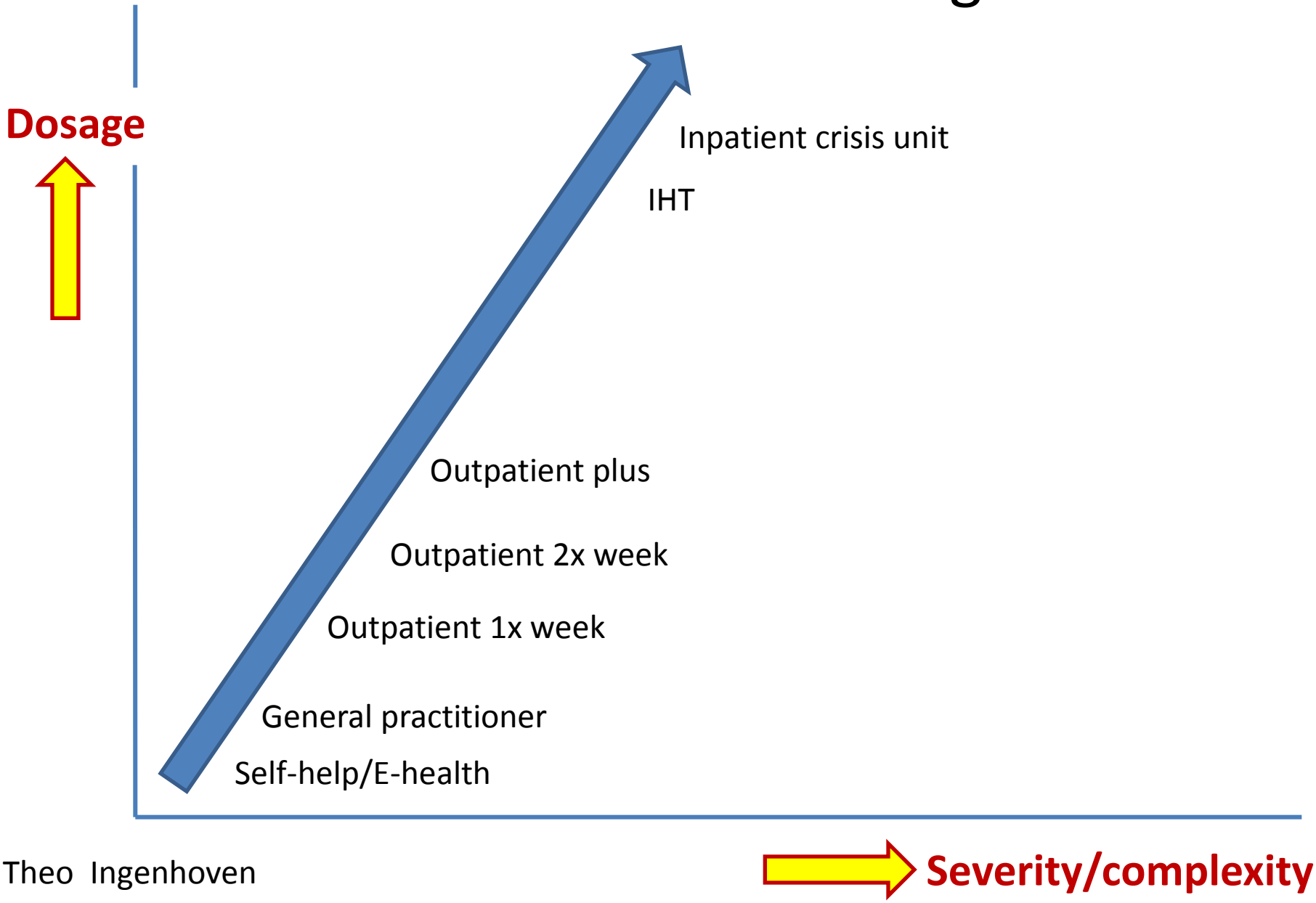
Demand of care & dosage



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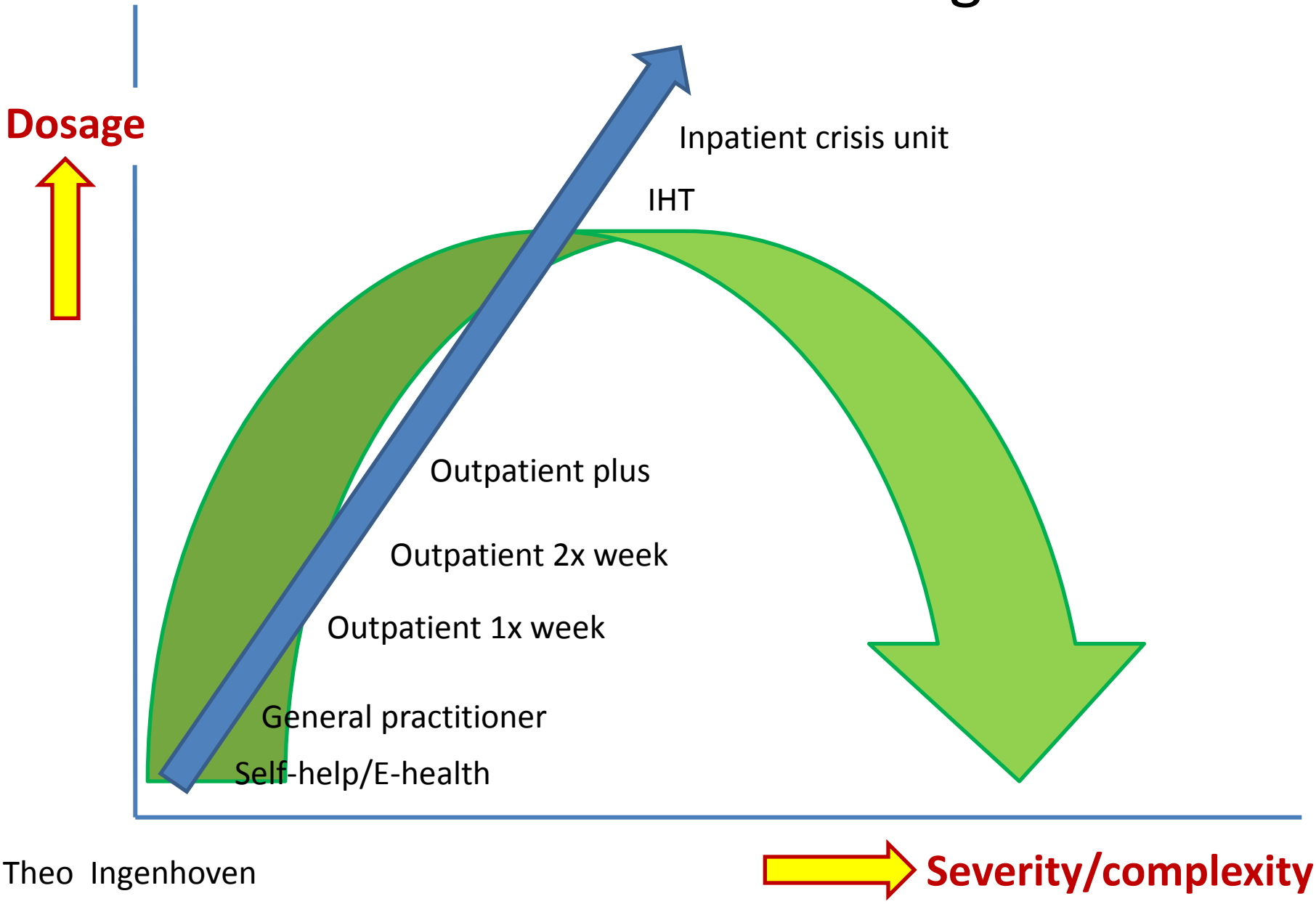
Demand of care & dosage



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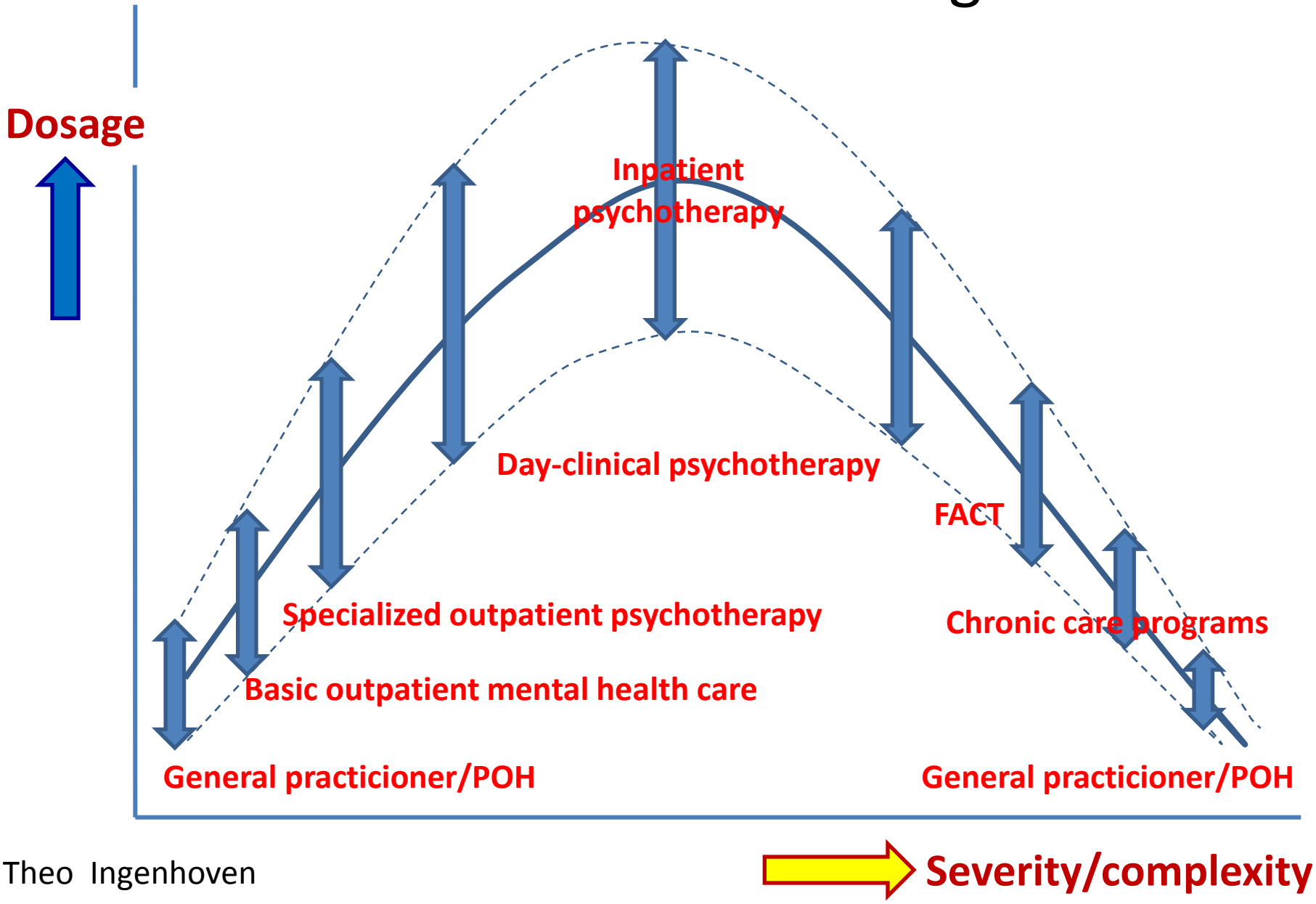

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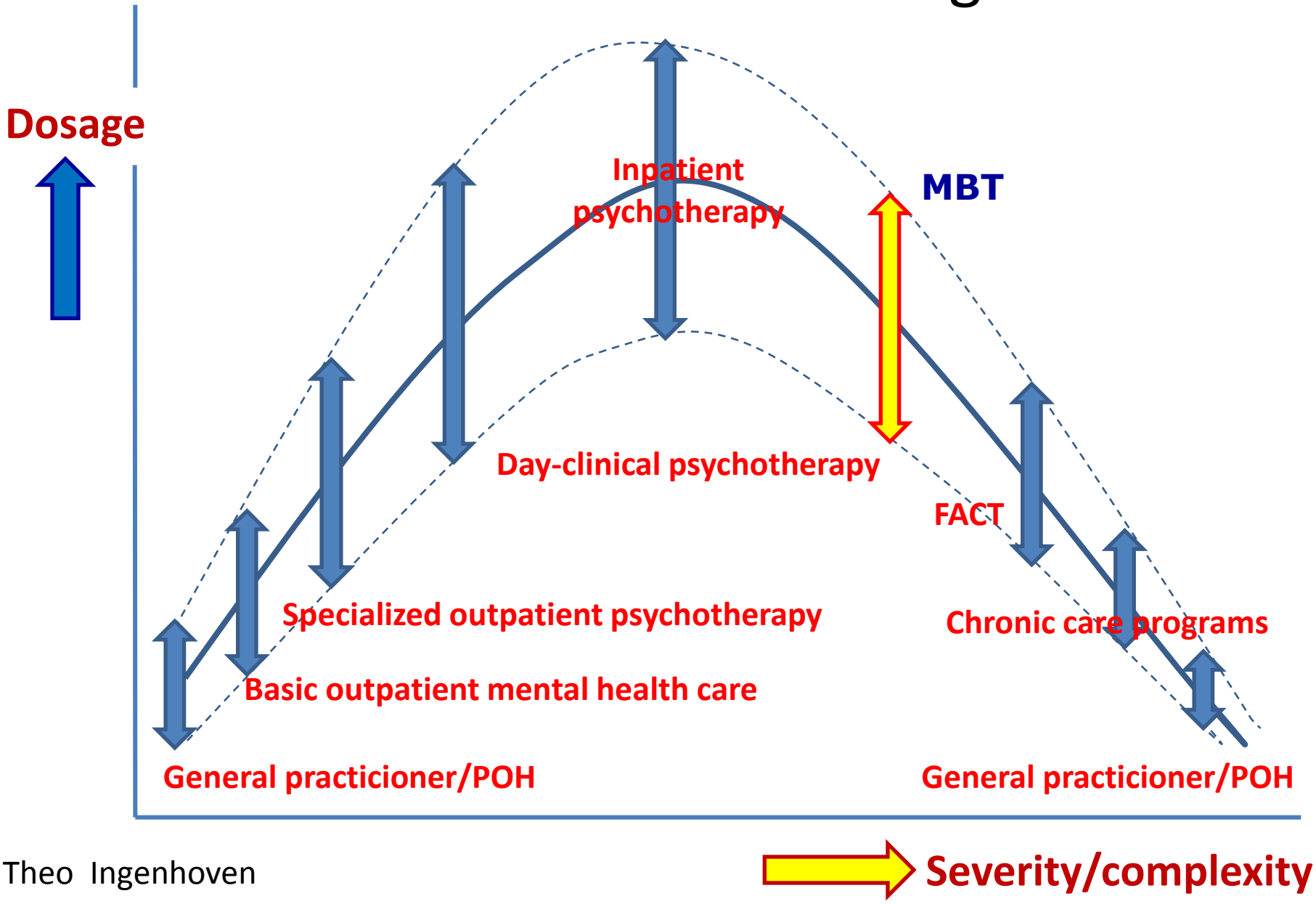

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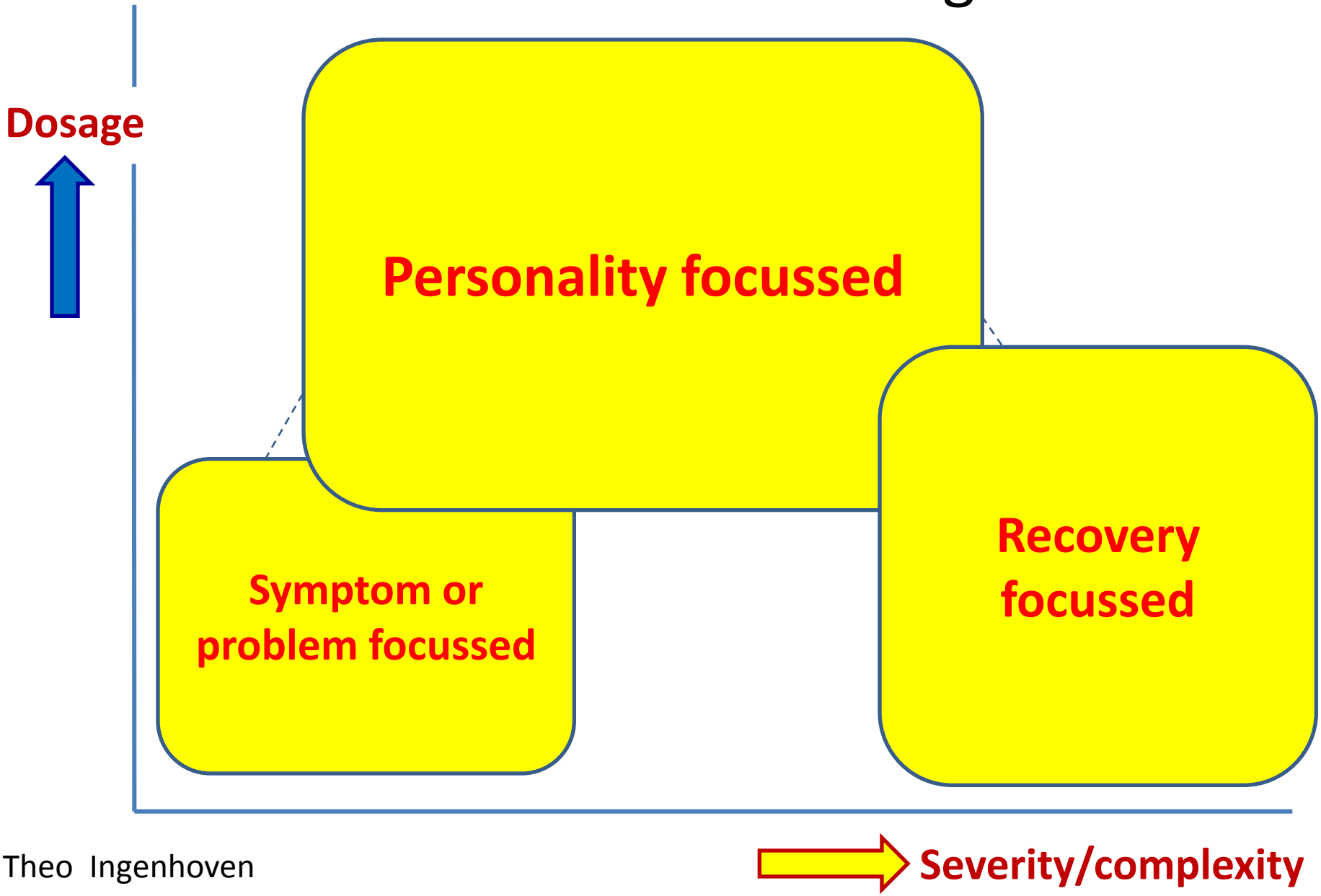

Theo Ingenhoven

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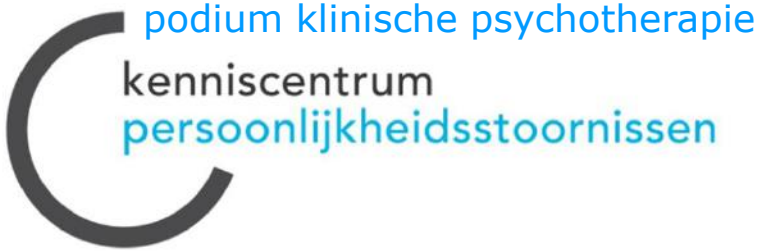

Day-clinical and inpatient psychotherapy

- Represent an unique and (cost)effective EBM treatment offer in treatment of personality disorders and comorbid conditions.
- Can be carefully indicated for severe patients
- Can prevent deterioration into a chronic course (one-way ticket out of psychiatry)
- Is indicated stepped care as well as matched care

- Main (political and ethical) question is: (for how long) are we willing to pay for it?