

Invited symposium: IFP 2018, June 9

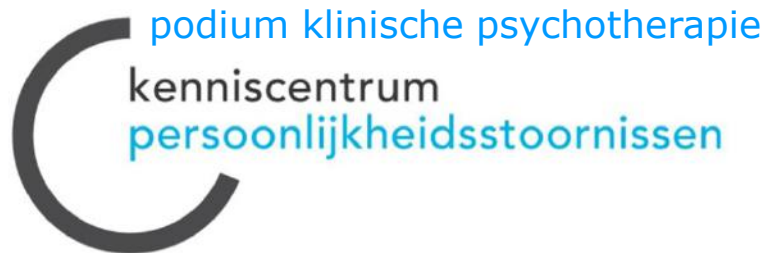
Psychotherapy within a day-hospital or inpatient setting: the strength of a therapeutic milieu

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, psychotherapeutic 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 and smooth reference
- Appropriate assessment & case conceptualization
- Personalized approach:
 - straight 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 assessment and organization
- Personalized (integrated)
- Strait forward (integrated care)
- To an evidence-based team
- With clear communication (multidisciplinary team)
- With clear communication (multidisciplinary team)
- In a clear communication (multidisciplinary team)
- Regular communication 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 model
- Within therapists competence/qualification
- Specific registration/requirements
- Appropriate remuneration
- Adequate resources
- Low administrative burden
- Nice working environment
- Good supervision/inter-vision sessions
- Good Christmas present
- No night 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

- Optimal mix of competent therapists (limited investments)
- Sufficient references to (production)
- Waiting lists (but not too long)
- enough dropouts (not too much!)
- Satisfied
- Adequacy of staff
- ROM
- E-h
- Satisfied with purchase by health care insurances
- No incidents (aggression, suicides); no complaints

flourishing business
management (profit)

Scientific and scholar interests

- More and larger research grants
- 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

- More and larger research grants
- High patient selections (High quality, high inclusion criteria)
- Informed consent (High quality, high inclusion criteria)
- High N for analysis (High quality, high inclusion criteria)
- Straightforward analysis (High quality, high inclusion criteria)
- Validated (High quality, high inclusion criteria)
- No conflicts of interest (High quality, high inclusion criteria)
- Methods (High quality, high inclusion criteria)
- Accepted in (high impact factor) journals
- High scientific and scholar status (Top-referent; Nobel price)

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 Qualities & 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 and
- Less expensive in
- Sound outpatient
- Lay man's (Bijzondere Ziekentafel)
- High O (to pay)
- No v
- Les
- Less
- Zero suicides

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 psychotherapy 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
Amstelland



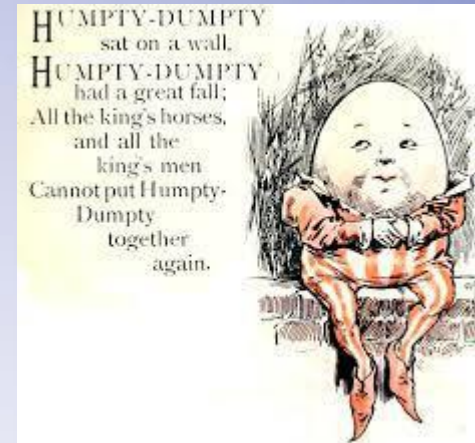
Jozef
De Oosthoek

Veluweland

De Viersprong

Therapeutic community: survival?





(Day-)Clinical Psychotherapy



Integrated Modular Treatment

Combining Effective Treatment Methods

(John Livesley, 2017)

Clinical Psychotherapy: nowadays

- 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: nowadays

- 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
- Personally 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

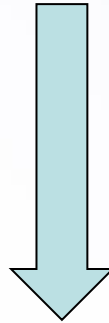
Therapeutic milieu for PD patients

- 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



GGNet

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?

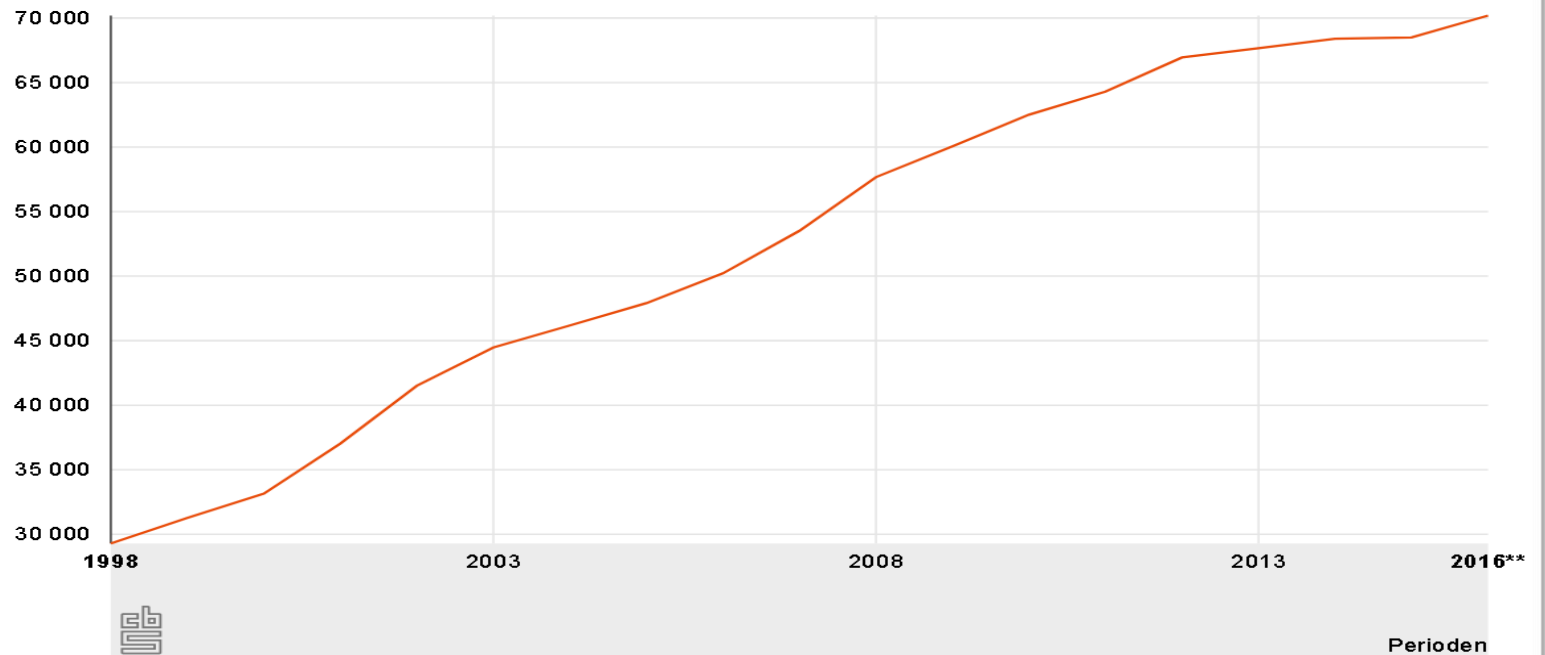
Contexts

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

Government

Zorguitgaven in drie benaderingen; aanbieders van zorg, 1998-2016

Aanbieders: GLZ: Totaal geneeskundige, langd. zorg
mIn euro



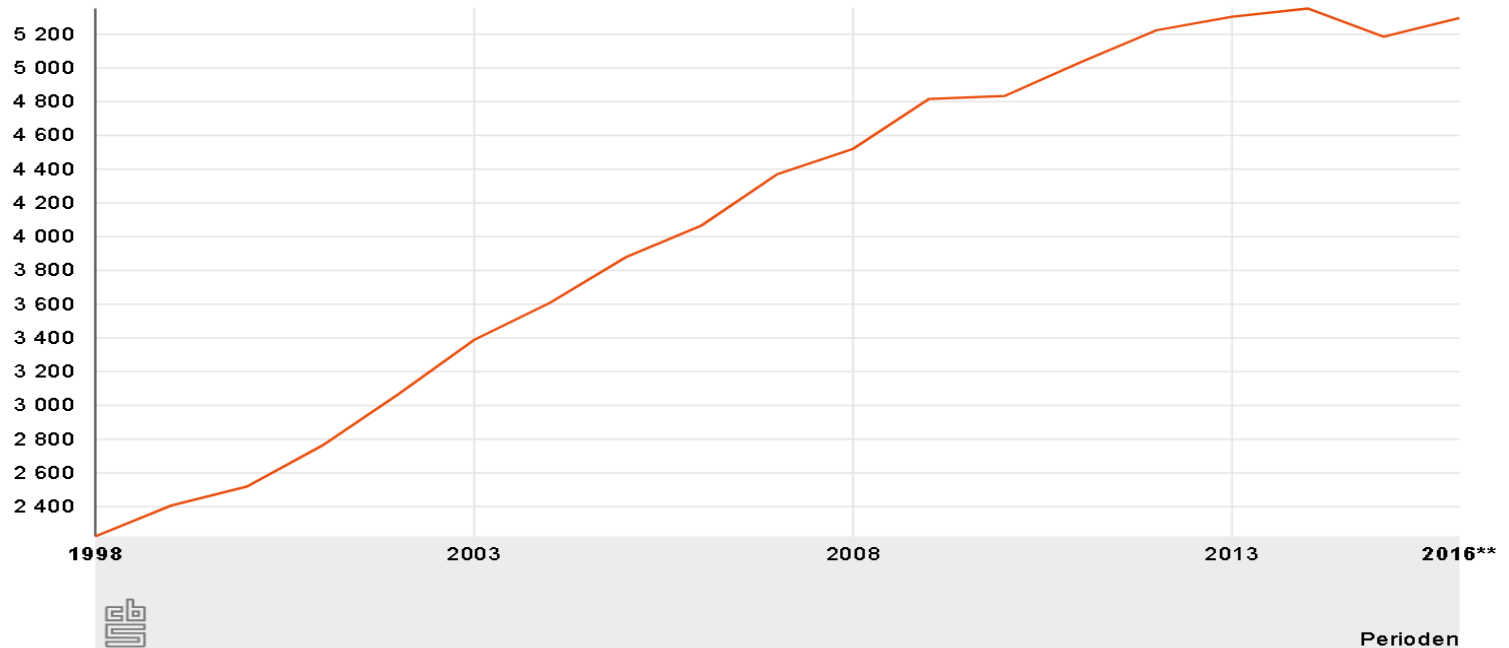
Onderwerp

— Uitgaven voor gezondheidszorg, int. def.

Mental Healthcare

Zorguitgaven in drie benaderingen; aanbieders van zorg, 1998-2016

Aanbieders: GLZ: Geestelijke gezondheidszorg
m In euro



Onderwerp

— Uitgaven voor gezondheidszorg, int. def.

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

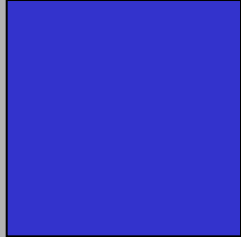
- Average price
 - € 100.000,- vs. € 7.500,-
- Use of beds
 - Long and stable vs. Short and decreasing
- New patients
 - Few relative to total number (50 vs. 16.000)
- Not very popular

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)?

What to do?

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



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



Theo Ingenhoven, psychiatrist
Arkin, Amsterdam

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.

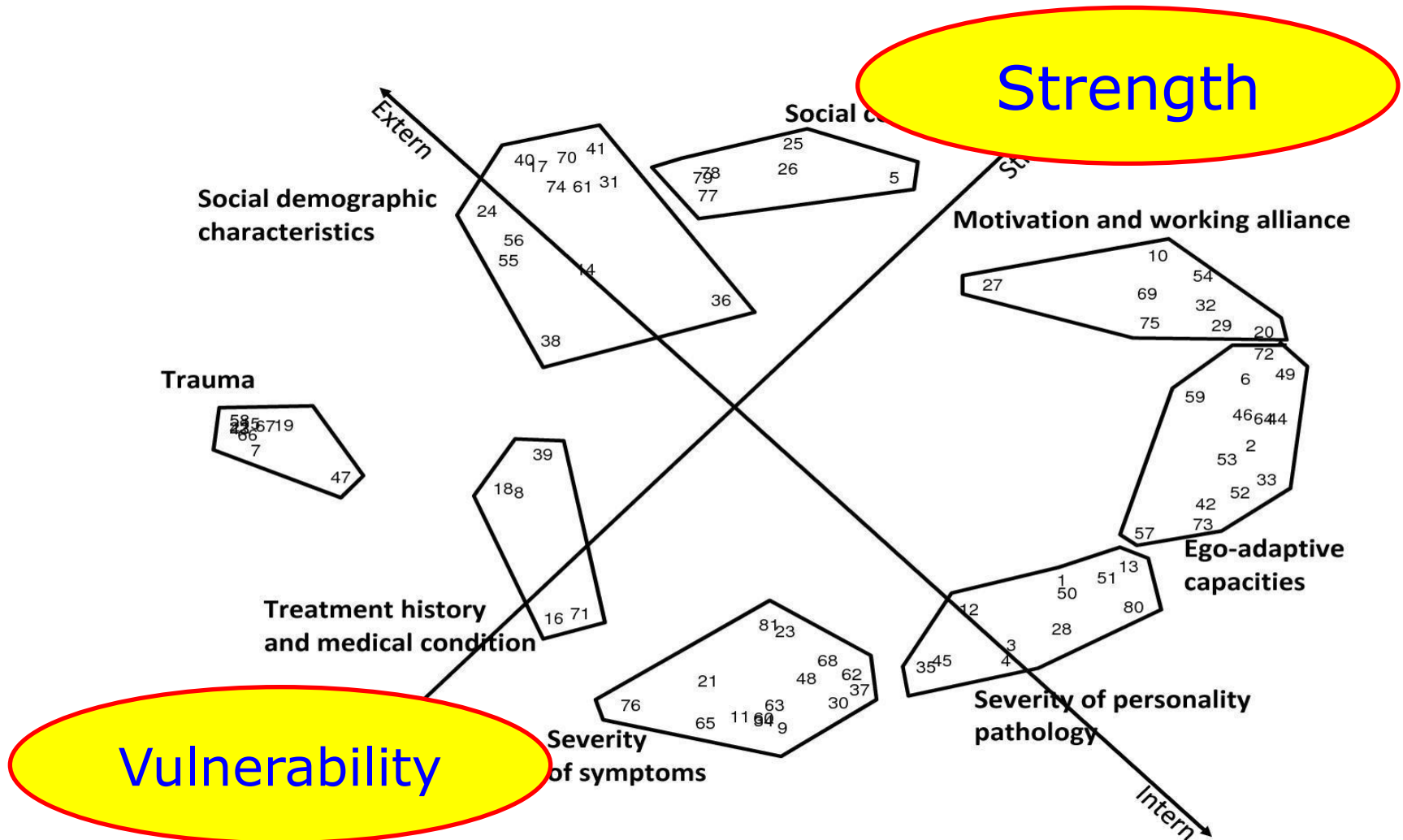
A concept mapping approach

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

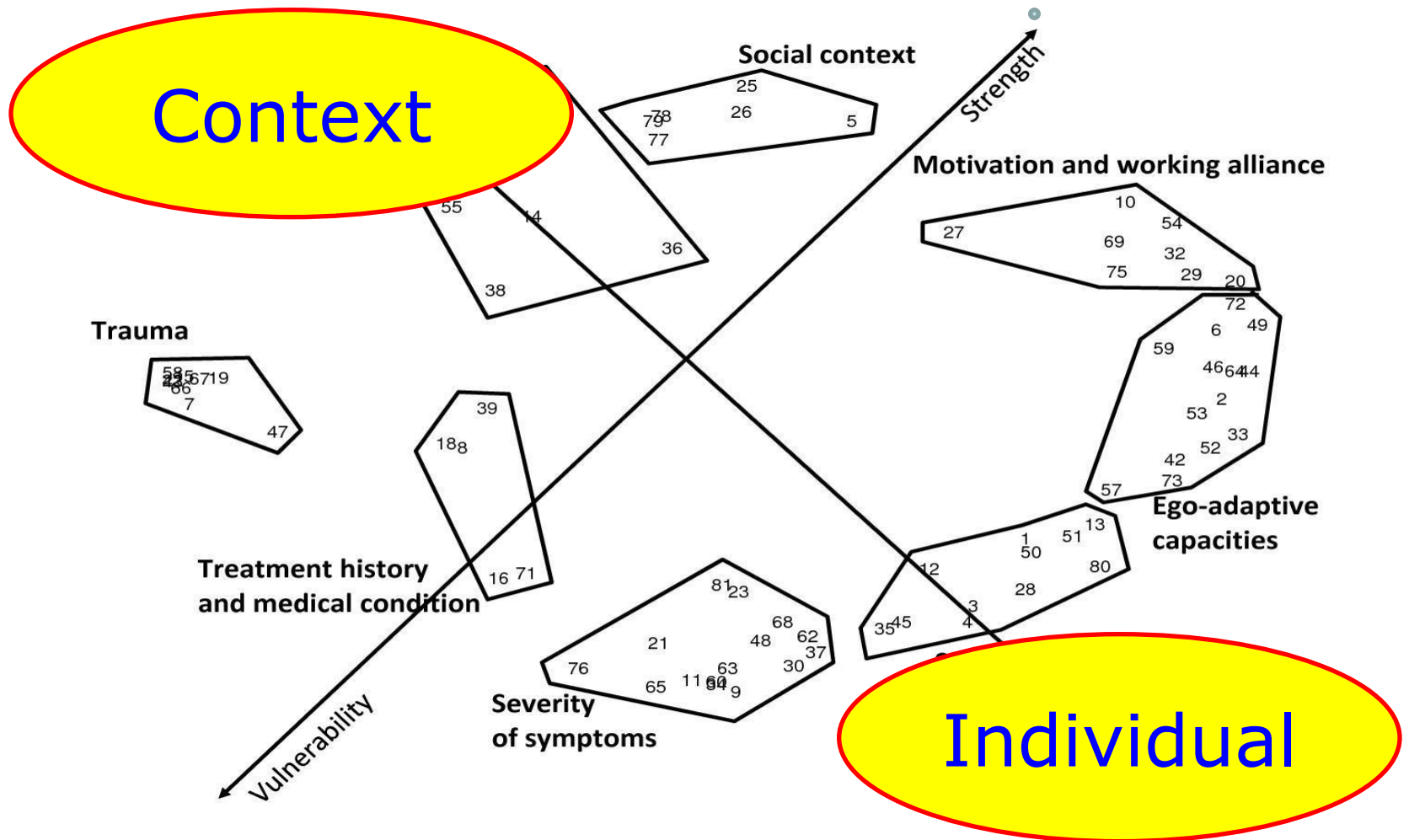
Van Manen, Kamphuis, Goossensen, Timman, van Busschbach & Verheul

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

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



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



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

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



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 too 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.

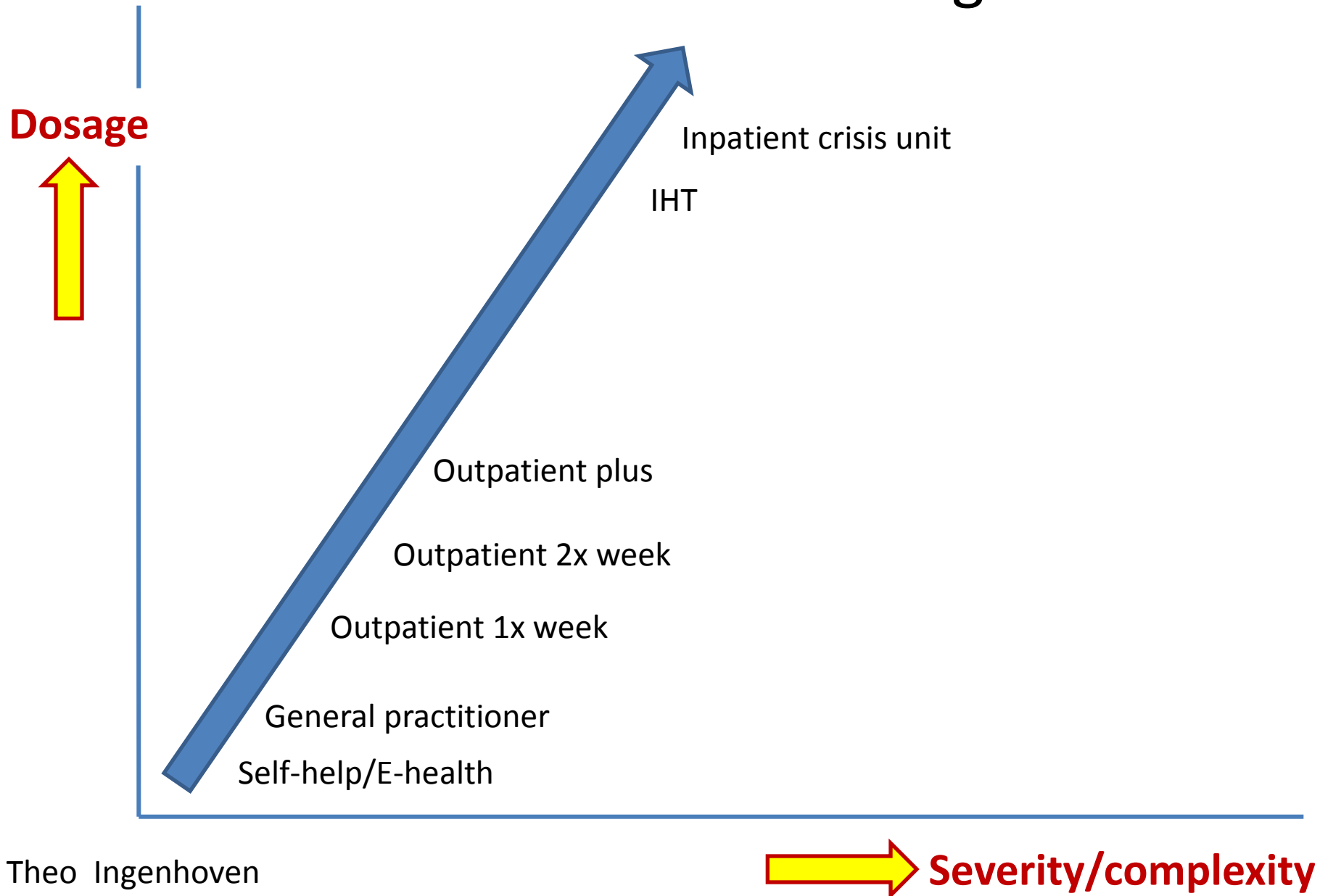
Some thoughts on
Demand of care
and
dosage of treatment

Theo Ingenhoven

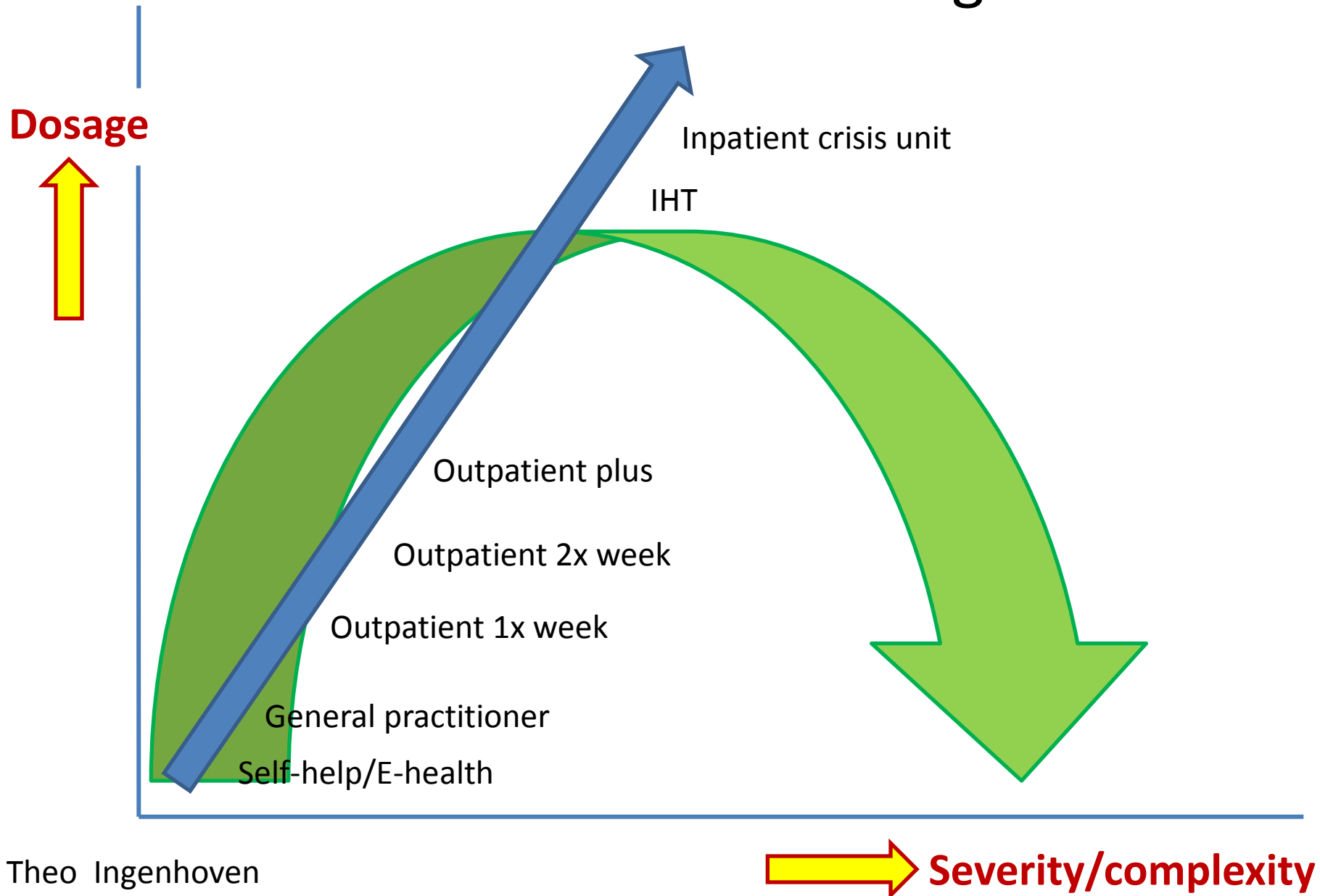
Demand of care & dosage



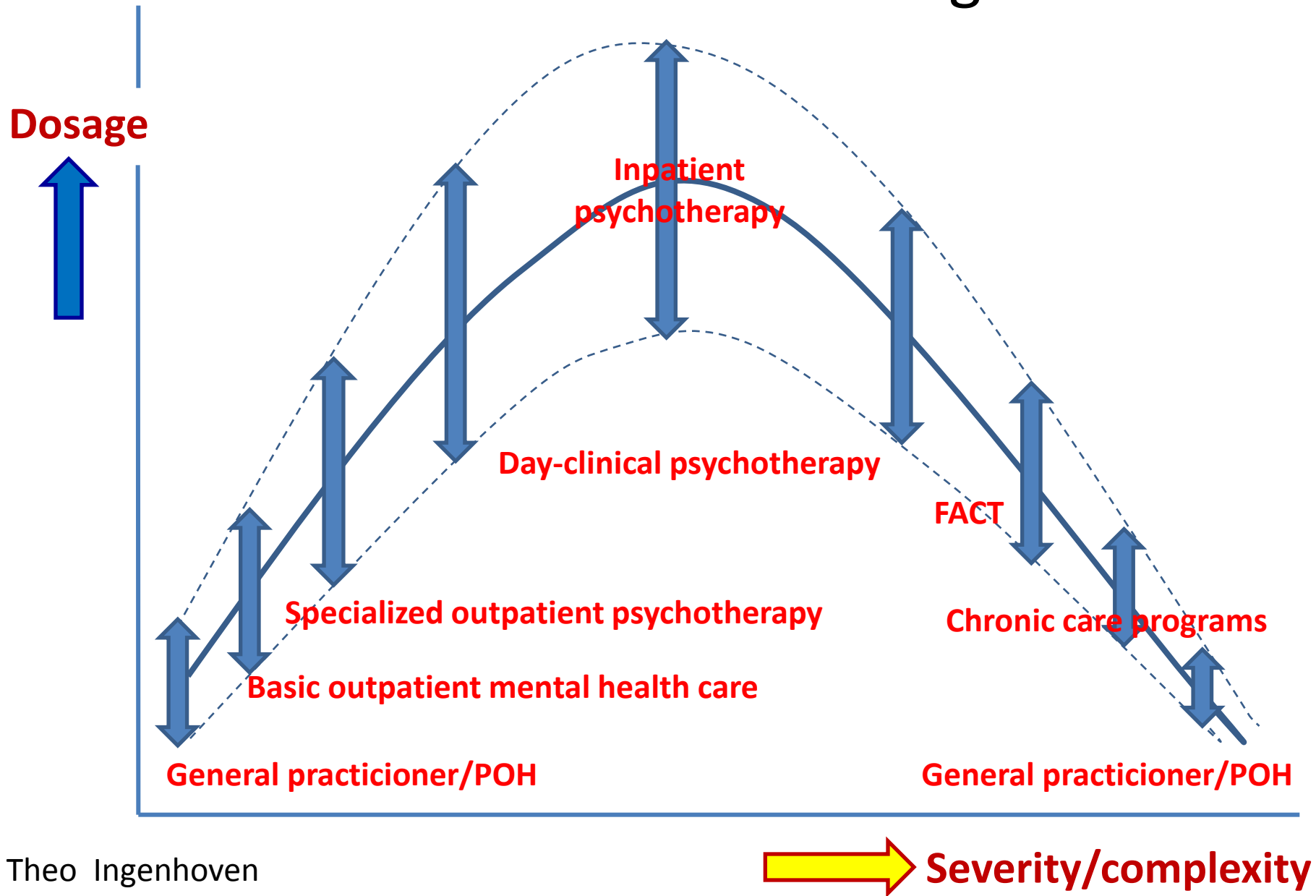
Demand of care & dosage



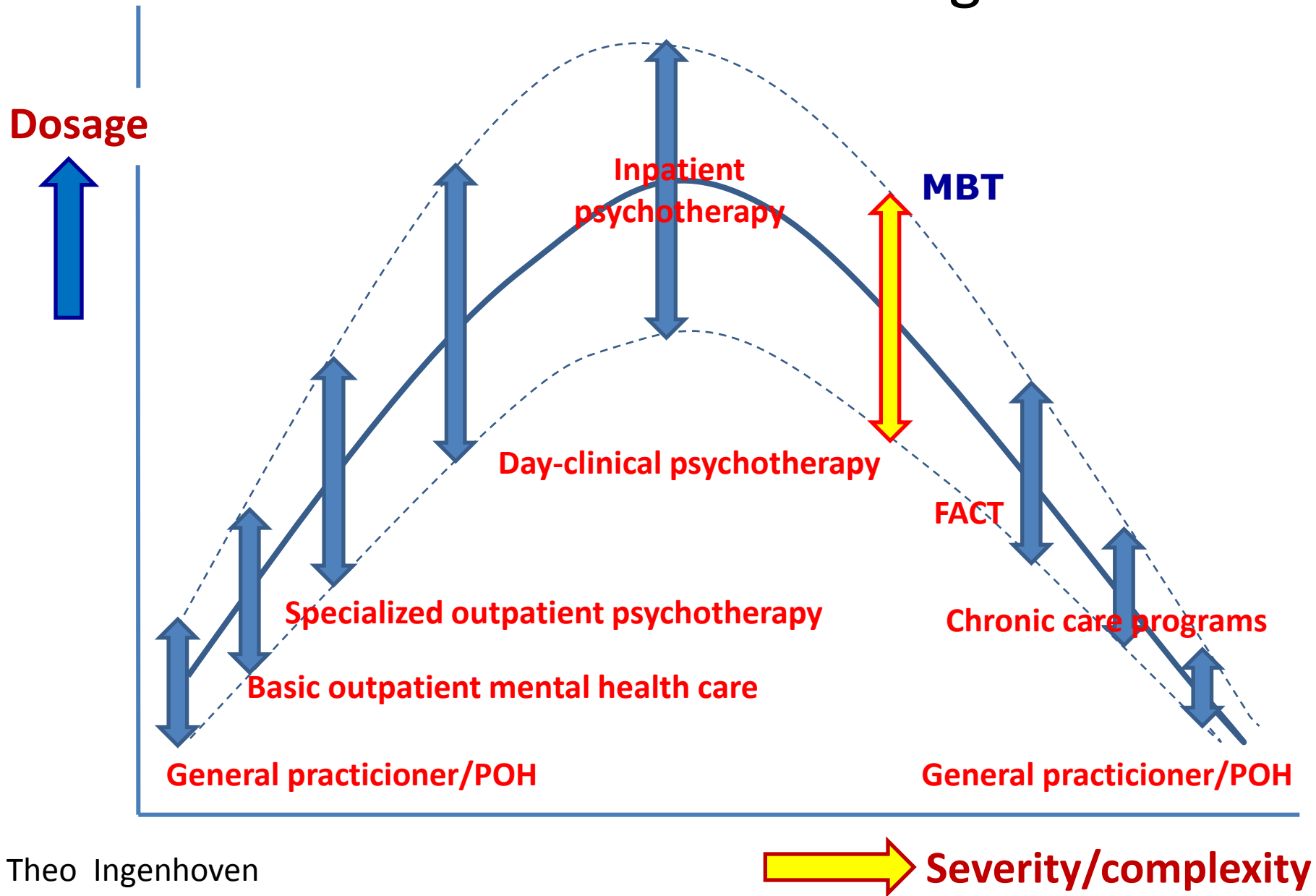
Demand of care & dosage



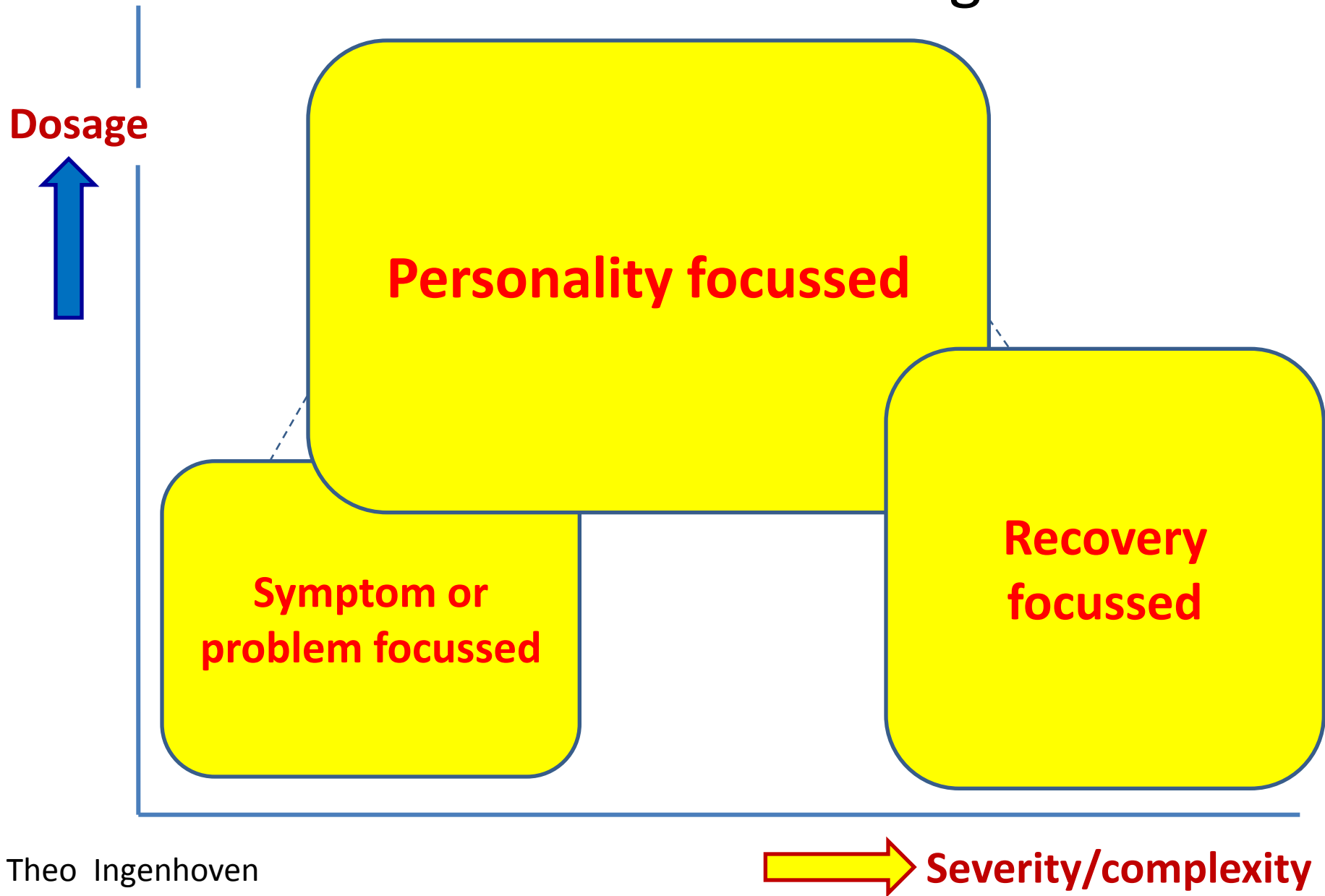
Demand of care & dosage



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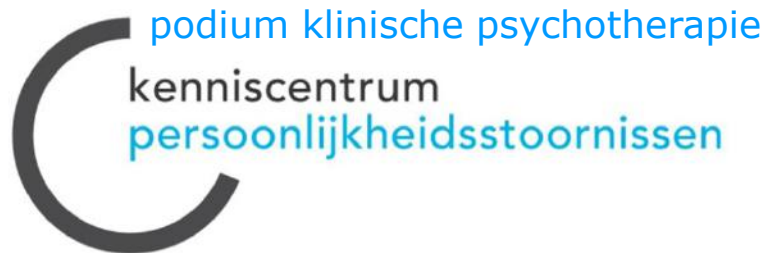
Psychotherapy within a day-hospital or inpatient setting: the strength of a therapeutic milieu

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Theo Ingenhoven (chair)



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?