PROJECT EVIDENCE

PROJECT EVIDENCE for Treatment of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[5] Early Treatment

a) Universal Health, Welfare and Educational agencies in the community [Tier 1]
b) Private practitioners and Community Mental Health services [Tier 2]
c) Specialist Mental Health services [Tier 3]

Mental health disorders occur throughout the community at various levels of severity. At present diverse private and public sector agencies respond to aspects of mental health need in an un-coordinated manner. MHYFVic proposes a coordinating framework to ensure that appropriate care is delivered. This is described in Project Evidence PE5 a.

[5 b] Private practitioners and Community Mental Health services

The Australian health care system provides a public sector network of hospitals and community health clinics, complemented by a parallel series of private fee-for-service facilities. Components tend to be separately funded and managed as individual silos with poor coordination and collaboration between components. Whilst maintaining the option of private treatment, the MHYFVic proposal focuses on Community Mental Health Centres (located within the established network of Community Health Centres) taking central responsibility for the care of all other requests for mental health assessment and management.

Community Mental Health Centres, then, would be the first port-of-call for all referrals in the public sector, of all levels of severity. This would require the availability of specialist expertise 24 hours daily for every day of the year. It can be done, without undue expense, by having a zero-waiting list intake system within office hours and the Community Assessment & Treatment Teams (CATT) of specialist services responding out-of-hours. This latter service is described in Project Evidence PE 5c.

Within office hours Tier Two Community Health services should provide:

- Face-to-face intake and brief intervention programs
- Family therapy programs
- Case management support and treatment monitoring
- Group therapeutic programs
- Specific purpose programs for substance abuse, domestic violence, parenting & child behaviour management.

Intake interviewing of referred clients is best undertaken by highly skilled clinicians. This is because the initial session lays the groundwork for the therapeutic contract, generally offering the greatest opportunity for establishing trust and rapport, and an indication of whether the problems can be ameliorated by brief intervention or will require an extended treatment program. This advantage is lost when the intake worker is insufficiently skilled, particularly if the case needs to be transferred to another worker for treatment.

Intake is best undertaken by face-to-face interview arranged as soon as possible after the request. With careful organization of staff time-allocation it is possible to offer a zero-waiting list time. This intake interview should be followed by an immediate offer of brief intervention (up to six sessions) or elective therapeutic programs.

A method of managing face-to-face intake and brief intervention programs within the context of a zero waiting list system is described in the downloadable pdf file available from the “Hot Issues in Mental Health” page of the MHYFVic website in the first section “Papers related to items elsewhere on the website”.

The proposal also sees this intake and brief intervention program as the initial screening for admission to Tier Three specialist mental health facilities, for cases other than those seen by CATT in hospital Emergency Departments and out

in the community. This enables Tier Three staff to control admission to their facilities whilst ensuring ongoing management within Tier Two of cases deemed not to need admission. Clearly, such decisions about specialist admission can only be made by Tier Three staff, which is resolved by the Intake and Brief Intervention tasks being undertaken by Tier Three staff deployed within the Community Mental Health Program alongside other Tier Two staff.

The scientific approach to treatment of mental health disorders requires a bio-psycho-social assessment leading to a diagnostic case formulation and management plan. The case formulation hypothesises the predisposing, precipitating and perpetuating reasons for the dysfunction and the changes needed to resolve the problems. The management plan developed collaboratively with the patient describes the actions to be undertaken to achieve those changes.

Every patient has a unique combination of bio-psycho-social factors but there are sufficient commonalities in patterns of response to enable classification in a lexicon of disorders for which evidence-based treatments can be offered. Predominantly biological treatments, such as medication, will ordinarily be combined with social treatments, such as dealing with relationship conflicts, and psychological treatments. There is a diverse range of psychological treatments which overlap in their effectiveness for various kinds of problems. The chapter headings in textbooks bear witness to this: psychodynamic psychotherapy, play therapy, behaviour therapy, cognitive therapies, group therapies, family therapy, parenting therapies, milieu therapy, etc.

“The power of one person to comfort, to teach, or to influence others is a universal part of human experience or, in short, has incontrovertible face validity. Psychotherapy is merely an attempt to capture this power within a healing context, to systematize it so it becomes transmissible (and researchable), and to regulate it in a helping professional relationship for the protection of the consumer and therapist alike.” [1]

No form of therapy has the universal answer. Best practice involves discerning which form is most likely to produce benefit for which patients with which problems in which circumstances by which therapist. Multidisciplinary specialist clinics are more likely to have a wider range of options whereas private specialists are generally highly skilled in a chosen form of therapy and may offer more personalised treatment than institutional settings.

Private practice and Mental Health Clinic practice both span a range of therapies. A key factor is the flexibility of the therapist to tailor the treatment to the needs of the patient. The following report from Scientific American illustrates that theme. [2]

“Psychotherapy is not what most people think of as a quick fix. From its early Freudian roots, it has taken the form of 50- to 60-minute sessions repeated weekly (or more often) over a period of months or even years. For modern cognitive-behavioural therapy (CBT), 10 to 20 weekly sessions is typical. But must it be so? "Whoever told us that one 50-minute session a week is the best way to help people get over their problems?" asks Thomas Ollendick, director of the Child Study Center at Virginia Tech.

For nearly 20 years Ollendick has been testing briefer, more intensive forms of CBT for childhood anxiety disorders and getting results that closely match those of slower versions. His centre often has a waiting list for treatments that include a four-day therapy for obsessive-compulsive disorder (OCD) and a three-hour intervention for specific phobias (such as fear of flying, heights or dogs). Around the U.S. and Europe, short-course therapies for anxiety disorders have begun to catch on, creating a nascent movement in both adult and child psychology.

The idea originated with Swedish psychologist Lars-Goran Ost, now professor emeritus at Stockholm University Some 40 years ago Ost got the impression that not all his phobia patients needed multiple weeks of therapy and decided to ask if they would like to try a single, three-hour session. His first taker was a 35-year-old spider-phobic woman. “She lived five hours away, so she was happy" he recalls, to be treated in one go. He later showed the efficacy of the approach in a clinical trial, although it took four years to recruit 20 participants. “People with a specific phobia rarely apply for treatment," he explains. "They adjust their lives [say, avoiding spiders] or think they can’t be helped." Ost

went on to work with a team in Bergen, Norway, to test an intensive therapy for OCD known as the Bergen four-day treatment. By the early 2000s Ollendick was adapting brief therapies for adolescents and kids.

The details vary but the quick treatments have some common features. They generally begin with "psychoeducation," in which patients learn about their condition and the catastrophic thoughts that keep it locked in place. In Bergen, this is done in a small group. With children, the lessons may be more hands-on and concrete. For instance, Ollendick might help a snake-phobic kid grasp why the creature moves in a creepy, slithering way by having the child lie on the floor and try to go forward without using any limbs.

A second part usually involves "exposure and response prevention," in which patients confront in incremental steps whatever triggers their anxiety: perhaps shopping, for agoraphobics, or having dirty hands, for people with OCD. With support from the therapist, they learn to tolerate it and see it as less threatening. Patients leave with homework to reinforce the lessons. Parents may be taught how to support a child's progress.

How well do these approaches work? A 2017 meta-analysis by Ost and Ollendick looked at 23 randomized controlled studies and found that "brief, intensive, or concentrated" therapies for childhood anxiety disorders were comparable to standard CBT. With the quicker therapies, 54 percent of patients were better immediately post-treatment, and that rose to 64 percent on follow-up -— presumably because they continued to practice and apply what they had learned. With standard therapy, 57 percent were better after the final session and 63 percent on follow-up. The severity of symptoms and whether the patient was also taking antianxiety medication did not seem to impact outcomes.

An obvious advantage to quick therapy is that it accelerates relief. Children with panic disorder, for instance, may refuse to leave home for fear of triggering an episode of shortness of breath, a racing heart and nausea. "They start to avoid places like the mall, the movies, the school dance," says child psychologist Donna Pincus of Boston University. Pincus developed an eight-day treatment for the disorder as an alternative to three months of CBT, which, she observes, "is a long time if you are not going to school or are avoiding doing things that are fun or healthy"

Making these briefer therapies more widely available could help address the sad fact that only about a third of patients with anxiety disorders get any kind of treatment. A weeklong therapy could be completed over a school or work vacation. Rural patients who cannot find CBT nearby could be treated during a short out-of-town stay. The intensive approach requires special training and a big shift for therapists — and health insurers - accustomed to the tradition of 50-minute blocks. But is there really anything sacred about that?"

References

[1] Werry, JS and Andrews, LK. "Psychotherapies: a critical overview" in Lewis,M. Child and Adolescent Psychiatry (2002) Lippincott Williams & Wilkins.

[2] Wallis,C. "Psychotherapy in a Flash: Brief, intensive treatments can work for phobias, OCD, and more" Scientific American, April 2019 p.16.

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