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PROGRAM EVALUATION OF A NEW BRIEF TREATMENT UNIT: AN EXAMINATION OF TREATMENT VARIABLES, PATIENT VARIABLES, AND THEIR INTERACTIONS

by

Michael R. Kandle

A Doctoral Project Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology in the Department of Psychology at Pace University

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PSYCHOLOGY DEPARTMENT
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FINAL APPROVAL FORM

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ABSTRACT

In September of 1986, a new "Brief Treatment Unit" (BTU) was opened at the Dutchess County Department of Mental Hygiene (DC/DMH) in Poughkeepsie, NY. The principal goal of this unit was to reduce strain on the Poughkeepsie Mental Health Clinic (PMHC) by; (a) providing an alternative model of treatment to meet short term needs, (b) reducing levels of premature termination, and (c) improving the efficiency of treatment delivery. In order to asses the level of success the BTU achieved in reaching these goals, this program evaluation was undertaken.

Data was extracted from the DC/DMH computer archives on a total of 716 patients treated the PMHC and the BTU during a three year period. This data was broken down into 15 variable categories representing (a) treatment unit, (b) patient characteristics, (c) efficiency measures, and (d) treatment outcome. Hypotheses were analyzed through the computation of (a) zero-order correlations, (b) a series of 2 X 2 Analyses of Covariance, and (c) hierarchical regression analysis.

There were several important findings, some confirming and others disconfirming the program hypotheses. The BTU was found to produce significantly more effective treatment outcomes than the PMHC, despite patient demographics or diagnoses. The BTU was also found to be significantly

more effective in treating patients with "situational" disorders than the PMHC. There were no significant differences found between the units in terms of the efficiency variables.

The results of the program evaluation are discussed on both theoretical and practical levels. Several recommedations are provided to enchance the delivery of treatments services at the DC/DMH, which include expanding the services of the BTU, and setting time limits on treatment in addition to a limit on the amount of treatment provided. Lastly, a diagnostic classification system utilized in this program evaulation is recommended for future research on similar topics.

Chapter I

Introduction

This chapter breaks down the background of this project of study into five sections. Section 1 consists of a general description of the problems this study intends to investigate. Section 2 follows with a detailed description of the agency involved in the study, along with the micro-structures of the two treatment units under investigation. Section 3 presents a list of the detailed questions that the program evaluation focuses on answering. Section 4 entails a comprehensive review of the relevant literature in five key areas: (a) needs for increased efficiency in treatment administration, (b) history of the development of the brief treatment modalities, (c) characteristics of brief treatment, (d) effectiveness of brief treatment, and (e) selection criteria for brief treatment. Lastly, Section 5 (a) defines the specific variables examined in the study, (b) details the hypotheses pertaining to these variables, and (c) presents the theoretical and practical implications of the findings.

General Problems Under Investigation

The purpose of the program evaluation was two-fold. First, a specific goal of the study was to provide an

increased understanding of the general effectiveness of the new Brief Treatment Unit program to the Commissioner and administrators of the Dutchess County Department of Mental Hygiene (DC/DMH). This information can then be utilized in making programming decisions within the department.

A second goal of the program evaluation was to contribute to the research literature examining the best applications of time-limited therapies, taking into consideration variations in patient characteristics. Although there is an abundance of literature providing evidence on the effectiveness of brief-treatment modalities (see Literature Review below), this same body of literature calls for greater specification of the types of client characteristics and treatment issues that are most suited to these modalities.

The information gathered in this study to address the issues outlined above represents contributions to (a) the pragmatic functioning of an existing brief treatment unit, and (b) the larger theoretical base of literature aimed at understanding the specific values of the brief treatment modalities. Or to borrow Paul's (1966) famous dictum, "What treatment, by whom, is most effective for which client?" It is hoped that the results herein will advance this field of study a little closer toward insight into this important question.

Structure of the DC/DMH and Treatment Units

The DC/DMH is located in Dutchess County, NY, and is centralized in the city of Poughkeepsie. It was founded in 1968 and organized around the goals of providing a broad range of mental health services in the areas of prevention, treatment, and rehabilitation for the county residents The DC/DMH provides outpatient services in the areas of (a) adult mental health, (b) substance abuse treatment, (c) partial hospitalization services, (d) day treatment for the severely and chronically mentally ill, (e) case management, and (f) psychiatric emergencies services.

In 1977 the dDC/DMH was accredited by the Joint Commission on Accreditation of Hospitals, and in 1989 was approved by the American Psychological Association for its Pre-Doctoral Psychology Internship Program. It employs approximately 250 people, of which approximately 80 are clinical staff.

The DC/DMH is comprised of multiple offices, divisions, and treatment units, however only those units which were subject to investigation in this study are described. The Poughkeepsie Mental Health Clinic (PMHC) and the Brief Treatment Unit (BTU) are two adult outpatient mental health units from which data was drawn for the study. Both units are located in the central office building of DC/DMH (Poughkeepsie) and have provided similar services to similar populations. The descriptions and fundamental distinctions

between these two unit are outlined below.

The PMHC clinical staff consists of psychiatrists, psychologists, and social workers who are responsible for providing time-unlimited treatment to adult outpatients with acute or chronic mental illness. Patients are self-referred, referred by other DC/DMH units, or by other agencies, and the unit will typically see over 1,000 different patients each year, generally from lower to upper-middle socio-economic brackets. The treatment provided is generally eclectic in nature and includes chemotherapy if warrented. The patient population seen on this unit consists of adults, age 18 and over, who are able to function on an outpatient basis. The only restriction in terms of diagnostic classification is that no alcohol or substance abuse disorders will be treated in the PMHC.

The BTU is one of the newest units developed at DC/DMH. It was founded in September of 1986 in order to ease the burden of increasing case loads on clinicians in the PMHC. Specifically, the BTU was designed to provide treatment to those patients who could benefit from short term treatments who would otherwise be receiving services at the PMHC. Ideally it was hoped that this would free the PMHC clinicians to focus their efforts primarily on the seriously and chronically emotionally impaired. Because the PMHC was originally structured to provide long-term care, the inclusion of patients in short-term crises had the

effect of elevating the PMHC's rate of premature terminations. One of the specific goals of establishing the BTU was to reduce the rate of premature terminations by separating and treating those patients who could be identified as having short-term needs. Theoretically this plan would result in fewer premature terminations in both units, given that early terminations would be expected and planned for in the BTU.

The clinical staff of the BTU was similar to that of the PMHC in composition, yet on a much smaller scale due to the experimental nature of the unit. During the period from which data was culled from this unit, there was an average of 2 to 5 clinicians providing services at any one time in the BTU. One other difference from the PMHC was that, even though there would be psychiatric coverage available for the patients seen in the BTU, regular visits to a psychiatrist were rare due to a screening procedure which limited the number of seriously emotionally impaired patients assigned to this unit.

Neither the PMHC nor the BTU have rigidly structured guidelines for the models of treatment provided therein. Rather, there existed room for variations in therapeutic style between individual clinicians. There were, however, a number of variables by which the two units could be meaningfully distinguished from one another, and these are presented in Table 1. The rationale behind these treatment

unit distinctions is consistent with the theoretical underpinnings of most short-term treatment models (to be outlined in Literature Review section).

The system by which patients were assigned to one treatment unit or the other occurred at the "pre-intake" stage of treatment. The pre-intakes took place over the phone or in face-to-face contact with staff members specifically assigned to this function. While there were no "hard and fast" criteria for determining which of these two units a patient would be assigned to, there did exist some guiding principles. First of all, patients having primary alcohol or substance abuse problems were segregated out from both units and assigned to a division within DC/DMH specialized for such treatment. All patients otherwise capable of functioning on an outpatient basis (excluding day treatment and partial hospitalization) would be assigned to either the PMHC or the BTU (provided they reside within the catchment area for these units). The general guidelines for assignment to one unit over the other included; (a) patients with chronic histories of serious emotional disturbance would be assigned to the PMHC, (b) patients indicating a need for long-term chemotherapy would be assigned to PMHC, (c) patients exhibiting symptoms of time-limited crises would be assigned to the BTU, and (d) patients having well defined problems or goals, or who expressed an interest in short term treatment, would be

Table 1

Distinctions Between the Brief Treatment Unit (BTU) and the Poughkeepsie Mental Health Clinic (PMHC)

Treatment Variable	Unit: BTU	Unit: PMHC
Contract	Therapist contracts with each patient for treatment goals and treatment length.	Therapist contracts with each patient for goals only.
Length	Contracts range between 6-14 sessions.	No treatment length is pre-determined in contract. No minimum or maximum number of sessions is defined.
Goals	Oriented to re-establishing previous level of emotional and/or behavioral functioning. Personality change not pursued.	Goals vary by clinician. Personality change may be pursued.
Focus	Treatment focuses closely on specified goals of contract.	Focus of treatment may be broader and more inclusive.
Therapist Orientation	Varies according to clinician. Therapists more active and directive. Transference issues minimized.	Varies according to clinician. Less emphasis on directive treatment. Transference issues may be explored.

assigned to the BTU. To date, no systematic investigation has taken place within DC/DMH to evaluate the adequacy of these selection guidelines.

Goals of Program Evaluation

As stated earlier, this program evaluation had two general goals for its investigation: (a) To provide an increased understanding of the general effectiveness of the BTU for the purposes of making programming decisions, and (b) to contribute to the research literature examining the best possible applications of time-limited therapies. Each of these general goals are broken down into the more specific questions addressed in this study.

Regarding the evaluation of the BTU, the following questions are examined: (a) In what areas was the BTU effective or ineffective in comparison with the PMHC?; (b) Should the BTU be expanded, discontinued, or modified in specific ways?; (c) If the BTU represents a viable treatment program, which patients should be assigned to it?; and (d) What, if any, modifications in the BTU format would enhance its effectiveness?

Regarding the contributions this study aimed to make to the theoretical base of literature on brief treatment issues, the following questions were examined: (a) Can certain patient variables be identified to determine who is likely to benefit from short term treatment vs. long-term

treatment?, and (b) Are there any interaction effects between these patient variables and treatment modality?

Review of Literature

The Need for Cost Effective Treatment

Among several strong arguments for the expansion of brief treatment models is the need for increased cost effectiveness in service programs. There are two key factors which represent pressures in the direction of brief treatment models: (a) increasing economic pressures from insurance and other funding sources, and (b) waste of service resources in the form of premature terminations. Each of these factors are further delineated below.

The rise in economic pressures on both private and public mental health institutions is widely recognized (MacKenzie, 1988; Shulman, 1988; Karasu, 1986; Karasu, 1984; Budman, 1981), and it is chiefly the result of increased demands for accountability by insurance agencies and public funding sources. In his forty year appraisal of psychotherapy, Garfield (1981) declared, "The period of accountability is clearly upon us," thus signaling a call for increased research on the effectiveness and viability of alternative approaches to treatment, such as short-term psychotherapies. Budman (1981) echoed this call, arguing that; "As the informed public, legislative groups, and third-party payers become increasingly concerned with the cost effectiveness of mental health treatment, brief