

Fixed Values and a Flexible Partial Hospital Program Model

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Since the 1990s, societal and economic factors have constrained mental health care service delivery in the United States. Partial hospital (PH) programs have been presented with the challenge of using limited resources to treat complex patients in very short time frames; yet predominant psychosocial models and evidence-based treatment approaches have not adjusted sufficiently to the combined demands of patient care and the new health care environment. An updated PH model can advance existing psychosocial theory and practice. The basic assumption of the model is that both clinical and organizational aspects of a PH program must be inherently adaptable to maintain consistent effectiveness. The set of fixed values described here are instrumental in establishing priorities, guiding decision making, and creating a proactive, flexible organization. These values are drawn from the history of psychosocial and milieu treatments from the 1930s to the present and from assumptions and practices of cognitive-behavioral therapy, and are augmented by insights from psychodynamic psychiatry, business management, and leadership. The PH treatment approach aims to translate evidence-based cognitive-behavioral treatments into pragmatic interventions with emphases on psychoeducation and skills training. The context is brief treatment (i.e., one to two weeks) for mood, anxiety, and personality disordered patients in a private sector, managed care environment. Elements of this model may be generalized to inpatient, residential, and intensive outpatient programs, as well as to those that are starting up or being reorganized. (HARV REV PSYCHIATRY 2006;14:1-14.)

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The clinical approach and organizational structure of a partial hospital (PH) program must be adaptable to meet the demands of both patient care and the mental health

system. Over the past three decades, psychosocial models have been refined for inpatient,¹⁻¹¹ partial hospital,¹²⁻²⁷ and outpatient treatments,²⁸⁻³¹ especially with the emergence of evidence-based treatments for specific diagnostic groups.³²⁻³⁸ Yet these models are not inherently designed to adapt to the vicissitudes of our current health care environment. The updated PH model elaborated here both illustrates the challenges of delivering psychosocial treatment in this context and offers specific ways that these challenges can be met to attain effective real-world practice of hospital psychiatry.

It is essential to begin by clarifying the concept of partial hospital because it has had various connotations. From the 1970s to the 1990s, PH programs emerged as an alternative to inpatient treatment to deliver comprehensive psychosocial treatment with greater time flexibility and less cost.^{5,12,14,16,18,20-22} By definition, "partial hospital" implies psychosocial milieu treatment, with group therapy as the primary treatment modality. Two main subtypes are

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cited in the literature: “day hospital” is short term, with acute stabilization as the primary treatment objective; “day treatment” includes stabilization, although the ultimate objective is substantial functional recovery, with the consequence that treatment continues longer than in the case of day hospital.^{18,25} These subtypes do not go far enough, however, to clarify the current state of PH research. In order to delineate future directions, greater specificity is needed.

Seven elements determine the context of PH: types of patients (e.g., psychotic, mood and anxiety disorders, personality disorders), theoretical orientation (e.g., psychodynamic, cognitive-behavioral), treatment objectives (e.g., stabilization, functional improvement, personality change), treatment duration (i.e., length of stay), treatment intensity (i.e., hours per day and days per week), setting (e.g., private or public sector), and the payer of services (e.g., managed care, government-supported national health care, such as national health insurance systems in Canada and Europe, and Medicare in the United States). Thus, when PH issues are addressed, it is necessary to explicate the ways in which these elements are combined^{25,39} (e.g., a PH program for borderline personality disorder with a long-term, low-intensity, psychoanalytic approach designed to improve functioning and effect personality changes in a government-funded, public sector setting).²⁴

The context for this article is private sector PH programs in the United States that are heavily subject to the influence of managed care. In this type of PH program, a large percentage of the patients form a complex, heterogeneous population having severe mood and anxiety disorders and a notable frequency of comorbid personality disorders. Such programs face enormous pressures to stabilize and discharge patients in compressed time frames, with cost containment at a premium. Many PH programs have even closed because they are not financially viable in the current market place. While much has been written about changes in mental health care^{5,15,29,40–43} that have cost-effectiveness as the primary concern,^{5,41,44} a wide gap still exists between the literature and the specific demands of current PH practice (i.e., brief treatment and rapid turnover) with this patient population.

Thus, the aims of this article are to describe (1) a wide range of studies not typically brought to bear upon PH treatment, (2) a set of fixed values that establish the foundation for a flexible PH program model, (3) the application of these values for clinically effective treatment of these complex patients in short time frames (i.e., one to two weeks), and (4) the use of these values to frame the ways in which the program’s organization can adapt, develop, and maintain continuity in response to changing circumstances.

HISTORICAL AND CONCEPTUAL FOUNDATION

Principles of Psychosocial Treatment

Through different eras in psychiatry, psychosocial treatment has been implemented from a wide range of theoretical perspectives and approaches with varying descriptors. The concept of psychosocial treatment represents both an approach and a value system that address psychological, interpersonal, and behavioral areas of functioning. Such treatment was provided originally only on inpatient units where patients remained for extended periods, and later in other institutional milieus and community settings, including therapeutic communities, residential programs, partial hospital, intensive outpatient programs, and outpatient clinics.

It is important to view psychosocial treatment historically in the context of milieu therapy, which posits that the environment in which treatment occurs is a central therapeutic vehicle.^{1,45–47} The origins of a therapeutic milieu date back to the eighteenth century with the advent of moral psychiatry and the belief that treatment should move beyond containment.^{40,45,48} In the 1930s Sullivan used both psychoanalytic and sociological principles to guide the treatment of seriously mentally ill patients in a hospital milieu.^{45,47,49,50} He also introduced a research perspective to document the importance of the social environment in understanding and treating schizophrenics.⁵⁰ Shortly thereafter, Menninger⁵¹ described the necessity of organizing the treatment environment into a predictable structure. Although improvements in treatment outcome were not empirically validated by either Sullivan or Menninger, core principles for psychosocial treatment began to solidify in hospital psychiatry.

By the 1950s Stanton and Schwartz⁴⁶ formalized a comprehensive, psychosocial approach for an inpatient milieu. Their model integrated principles of sociology, social psychology, psychoanalysis, and psychobiology. Stability of an inpatient milieu relies on predictability of person, place, and time (e.g., roles of staff, scheduling, location of certain activities). The milieu itself can be inherently therapeutic for patients as long as it is actively maintained—which requires an awareness of what is therapeutic (e.g., open communication, respect) and what is not (e.g., covert disagreements among staff members, poor conflict resolution). A process must also exist to address issues interfering with the milieu.

Gunderson^{1,45} elucidated five factors (containment, structure, support, involvement, validation) for effective, milieu-based, inpatient treatment. Nothing therapeutic can occur without containment and safety. Structure and support foster one’s cognitive organization. A patient’s involvement in the social environment promotes ego strength and

interpersonal functioning. Validation often helps patients endure emotional pain experienced in treatment. Jones's concept of a "therapeutic community"^{52,53} used these basic factors, with added emphases on collaboration and patients' involvement in, and responsibility for, their own treatment as well as for that of their fellow patients.

In the 1970s and 1980s, the usefulness of milieu therapy was debated mainly with respect to schizophrenics,^{3,45,48,54,55} with some discussion of the potential benefits for nonpsychotic patients.^{4,45,53} Guthel⁴¹ described how long-term, psychoanalytic milieu therapy on inpatient units became less viable due to deinstitutionalization, closings of public hospitals, the "pharmacotherapeutic revolution, and the community psychiatry movement." Since that time, psychodynamically oriented programs have shifted away from treating psychotic disorders. Recent successes are documented for nonpsychotic patients¹⁹ and for long-term day treatment of personality disorders.^{18,24,25}

In the 1980s and 1990s, a new literature on cognitive-behavioral therapy (CBT) models emerged in hospital psychiatry. The CBT milieu treatment was originally designed for inpatient care,^{4,6-8} and later for PH.^{5,23,26} Levensky's "therapeutic contracting program"^{4,5,56} and Wright's "cognitive milieu"⁷ were the most prominent models. They were largely empirically derived, shorter term, designed to be goal directed (with measurable outcomes), and intended to be more cost-effective than conventional psychosocial models.^{5,6,8} Interventions were pragmatic and collaborative, and concentrated directly on improving a patient's functional level. Wright and colleagues⁷ also described various organizational frameworks, including a fully integrated cognitive milieu and an "add-on" model that pragmatically and strategically incorporated cognitive therapy elements into an otherwise noncognitive therapy milieu. Previous behavior modification token-economy models (i.e., before 1980) had been seriously criticized^{48,55} because they required rigid control structures with inadequate generalizability outside the hospital environment.⁴ These new CBT models represented a dramatic advancement. Cardinal principles from psychodynamic psychiatry were also incorporated, including transference, countertransference, and the utility of a program structure serving many therapeutic purposes.⁷

The proliferation of a rehabilitation model, exemplified by Liberman's work with the chronically mentally ill,²⁸ has greatly advanced psychosocial, practical life-skills training in both institutional and community-treatment settings. Life-skills training has also been adapted by programs from both CBT and psychodynamic perspectives.^{5,6,18}

Despite questions raised about treatment effectiveness and appropriateness regarding patient type, objectives, and length of stay,^{48,57} psychosocial treatment represents a broad and established value system in hospital psychiatry.

Partial Hospitalization

PH programs established themselves in the 1970s in order to offer psychosocial treatment in a milieu without a residential requirement. A PH program may serve the continuum-of-care model for treatment following discharge from an inpatient unit, or may be used as an alternative to inpatient care altogether. Early and more recent research demonstrated its clinical utility compared to inpatient treatment.^{12-14,16,58} Current standards for PH in the United States concentrate on short-term crisis stabilization,²² with intensive psychosocial treatments—including group and individual therapies, case management, and pharmacotherapy. The literature on PH has focused mainly on the two subtypes described earlier—day hospital and day treatment.^{14,18,43} *Day hospital* is viewed as an alternative to inpatient care and, by definition, is short term. Stabilization, resumption of functional level, and transition back to the community are primary objectives.^{13,14} *Day treatment* connotes longer-term treatment, incorporating day hospital objectives, with additional rehabilitative and psychosocial components to improve patient functioning.

The current designations of subtypes have inconsistencies that create some confusion when comparing one program to another. For example, day treatment programs may range from 3 to 18 months, be high or low intensity, with different treatment objectives depending on the patient populations. Explication of the seven PH elements (types of patients, theoretical orientation, treatment objectives, treatment duration, treatment intensity, setting, and the payer of services) allows for a more finely tuned analysis of the current state of PH.

Treatment duration is arguably the driving force that is shaping the context for changes in PH programs, with ever shortening lengths of stay in the U.S. private sector. Short-term PH hospital treatment appeared in the literature in the 1990s—reflecting the changes during this new era of health care. In 1992 Hoge¹⁶ asserted that in order to remain viable, PH programs must treat acutely ill patients in a short-term, goal-directed manner.

Two issues are worth noting with respect to treatment duration. First, "short-term" has proven to be a mutable concept. Beginning in the early 1990s, "short-term" programs were typically designed for six weeks to four months. This trend included programs with various theoretical orientations, most prominently cognitive-behavioral^{5,26} and psychodynamic.^{17,18,21,25} Though such lengths of stay were a breakthrough at that time for PH, those stays would be considered long term by current standards in the United States.

Second, after the initial push for short-term PH treatment, little has been written to advance treatment for the very brief stays so common today. Two exceptions are short-term PH programs based on dialectical behavior therapy

(DBT) for borderline personality disorder.^{23,59} Simpson and colleagues²³ describe a program with a one-week length of stay, after which patients made a transition to an affiliated DBT outpatient program, where many of them had been before entering the PH program. Most recently, McQuillan and colleagues⁵⁹ report on a three-week DBT program. Most notably, depressive symptoms were reduced, and impulsivity diminished.

Longer lengths of stay, according to current standards, are common in psychodynamic and psychoanalytic PH programs for personality disorders. Treatment duration ranges from several months^{18,25,27} to 18 months,²⁴ with substantial improvements in symptoms and life functioning. One example is Piper and colleagues¹⁸ construct of psychological mindedness defined as “the ability to understand people in psychological terms.” This construct is correlated with positive outcomes in areas such as social adjustment, use of treatment, and work.^{18,60} For the treatment to promote and realize the benefits of psychological mindedness, several months of PH treatment are required.

A new psychoanalytic approach developed by Bateman and Fonagy^{24,61,62} is mentalization-based treatment (MBT), which is empirically supported for long-term partial hospitalization (i.e., 18 months) for borderline personality disorder. The aim of MBT is core personality change evidenced by increased cognitive capacities to understand the intentions, emotional states, and behaviors of oneself and others, all of which should facilitate improvements in functioning and diminish maladaptive behavior patterns.

These long-term programs report robust findings on comprehensive outcome criteria aimed at enduring stability of functional improvements and lower utilization of inpatient services.⁶³ One point of note: these programs are maintained in countries supported by national health care systems without the constraints of managed care so pervasive in the United States.³⁹

It is apparent from the above review that in recent years the most prevalent type of PH program cited in the literature involves the treatment of personality disorders. Valuable implications for treatment and programming can be learned from these writings. Ogrodniczuk and Piper²⁵ summarized this research area with a list of “practical implications” that included: select patients to optimize patient-treatment matching; encourage personal responsibility and active participation in treatment; promote an ethic for patients to participate in each other’s treatment; define a treatment philosophy and enact it with stable leadership; and coordinate with referral sources and systems outside the local program.

Evidenced-Based Treatments and Partial Hospital

In the PH literature there are two signature programs. Bateman and Fonagy’s MBT²⁴ is the only fully integrated

PH model for borderline personality disorder. The approach utilizes quasi-protocol MBT interventions with empirical support for low-intensity treatment over an 18-month time frame. Piper, Azim, and colleagues^{17,18,43,60} have strong empirical support for their several-month, high-intensity, psychodynamic PH program for personality disorders.

There is no evidenced-based, short-term (i.e., 1 to 2 weeks) PH model in the literature for nonpsychotic, heterogeneous Axis I patients, with some comorbid Axis II, as seen in many PH programs today. The closest model is Levensky and colleagues⁵ therapeutic contracting program for PH that adapts empirically supported CBT treatments into group and individual interventions for a three-month program. Thus it is the best available template for a current short-term PH program model.

That said, evidence-based treatment protocols do not lend themselves well to the patient population typically encountered by PH programs. In this context, three characteristics of evidence-based treatments need to be considered: (1) evidence-based treatments are designed for homogeneous diagnostic groups (e.g., depression, anxiety disorders, and borderline personality disorder); (2) the approaches are largely cognitive-behavioral, with interventions determined by detailed protocols to match the diagnostic group; and (3) protocols have been tested in outpatient settings with either individual or group therapy, or both.^{31–36,38,64,65} It is important to emphasize that protocols tend to be rigid since they have been tested under controlled conditions on homogeneous populations. Thus, in providing effective care to patients outside the laboratory, the challenge for practitioners is to systematically adapt evidence-based approaches to real-world conditions.^{66–68} And since protocols are typically complex, it is essential that they be simplified to make the treatment accessible to the PH population in a short time frame.

For the purposes of the PH program model being considered in this article, the target patients are diagnostically heterogeneous: mood disorders or anxiety disorders with comorbidity of personality disorders and substance abuse disorders. Many patients are admitted to PH after being evaluated at emergency rooms or treated on inpatient units; others, in acute distress, have come directly to the PH program. These conditions are substantially different from the careful selection of patients typically employed for research, in general, and for the evaluation of evidence-based treatments, in particular.⁶⁹

Two guidelines provide effective strategies for matching evidence-based treatment to the patients in PH programs. The first is to identify interventions that are shared by different protocols (e.g., for depression, for generalized anxiety, for panic disorder). The second is to identify priorities to be treated (e.g., symptoms, problematic behaviors, negative thought patterns, and skill deficits, rather than an exclusive focus on diagnosis) and to find interventions to address

these particular areas. In short, the combination of these two methods distills the most relevant aspects of protocols with the goals of facilitating basic skill acquisition and stabilization of patients.

Organizational Principles

Consistent delivery of effective psychosocial treatment requires a resilient organization with effective leadership and management. Organizational principles of successful business and management practices are directly relevant here. Peters's empirical study⁷⁰ of successful companies concluded that these companies ascribe to a value-driven approach with a clear vision and purpose. Consistent success in business and management requires that members of the company adhere to an agreed mission and to the means by which that mission is pursued.⁷¹ Stanton and Schwartz⁴⁶ described the now classic concept of "covert disagreement and manic excitement," in which conflicts of interest not openly addressed among staff members lead to maladaptive behavior by the patients and diminish the therapeutic effect of a milieu.^{43,46} In an analogous way, Collins and Poras⁷¹ concluded that employees, however talented, who do not share the program's vision will most likely deter group cohesion and progress toward the mission, and cause decreased efficiency and productivity. Thus, a leader and staff who embody the values of the program and who work collaboratively to espouse those values at all levels of the program are essential. Collins and Poras's findings are especially noteworthy in that they performed an empirical inquiry about elements of successful companies going back over 100 years, ascertaining what may be, in some cases, "timeless management principles."

FIXED VALUES FOR PARTIAL HOSPITAL TREATMENT

The rapid pace of treatment, combined with an unpredictable world, necessitates a rethinking of clinical and organizational priorities. A values-based approach is employed as an alternative. Two types of values are distinguished: those pertaining to (1) end states and (2) instrumental steps, or means.⁷² An end-state value is an ultimate goal that is sought after but will never be permanently achieved. Here, the desirable end state is a PH program model that is inherently flexible—so that the clinical approach and the organization effectively adapt to the changing world. Values of the second type are ones referring to "beliefs or conceptions about desirable modes of behavior that are instrumental to the attainment of desirable end-states."⁷² Thus, in the present context, a set of ten fixed values (i.e., instrumental values) are derived from the aforementioned historical and conceptual foundations.

The main points of reference for these ten fixed values are Stanton and Schwartz's conceptualization of hospital systems,⁴⁶ Levensky's cognitive-behavioral approach,⁵ Gunderson's formulation of psychiatric milieus,¹ and the practical implications described by Ogrodniczuk and Piper²⁵ in their review of PH programs for personality disorders. These fixed values are constants to guide priorities, inform decision making, resolve conflicts, and maintain continuity while changes occur in the environment. The ten fixed values are as follows:

1. A pragmatic skills-training approach optimizes the ways in which short-term PH treatment matches the various needs of patients to improve their functioning.
2. Collaboration between patients and staff is necessary, which is optimized by a treatment contract guiding priorities and evaluating progress.
3. Interventions are adapted from evidence-based cognitive-behavioral approaches.
4. Treatment is a learning process, and a patient's skill acquisition is enhanced by a stage model.
5. Patients are duly informed of their diagnoses and supported with psychoeducation and information about the treatments available.
6. Aftercare planning evolves from psychoeducation and skills training to facilitate continued use of skills and coordination with outpatient treaters.
7. Program structure is predictable yet flexible.
8. Program leadership is oriented to solution-focused and proactive management decisions.
9. Accountability according to one's role is apparent at all levels of the organization; staff are trained in the skills-based approach and adhere to the program's mission.
10. An effective psychosocial treatment milieu promotes mutually respectful interpersonal connections among and between staff and patients alike.

In short, while none of these fixed values is new to PH, as a "set" they maximize the conditions for attaining an inherently flexible and effective PH program.

A FLEXIBLE PARTIAL HOSPITAL PROGRAM MODEL

The fixed values are operationalized in flexible ways with respect to treatment approach, program structure, organizational vision, and continuous quality improvement. Text box 1 provides a schematic view of how fixed values are operationalized in the flexible treatment approach. Text box 2 outlines how fixed values are operationalized in an adaptable program organization.

1. Fixed Values Operationalized into a Flexible Treatment Approach

Fixed Values	→	Flexible Treatment Approach
<ul style="list-style-type: none"> • Pragmatic skills training to match treatment interventions to patients • Treatment contract to facilitate collaboration • Interventions derived from evidence-based, CBT skills training • Treatment as learning process, with skill acquisition maximized by a stage model • Patients informed about diagnosis; psychoeducation provided • Aftercare enhanced by psychoeducation and skills training • Program structure predictable yet flexible 		<ul style="list-style-type: none"> • The objective is to set concrete goals to acquire skills according to a patient's functional needs and available resources. Focus is on what <i>can</i> be accomplished in a specific time frame. • Patients and clinicians mutually set priorities and reassess according to progress. • Heterogeneous patients enter at various functional levels. Treatment contract establishes priorities for interventions. • Relevant interventions of evidenced-based protocols are distilled into the principles of psychoeducation, self-assessment, behavioral coping, self-care, and interpersonal connections. • Patients are taught core skills pertaining to the principles. • Individual and group therapy interventions are organized by stages, starting with basic skills training in stage 1, followed by practice in stage 2 to facilitate mastery. • Patients will continue progressing on skill mastery in the stage after discharge. • Patients receive validation and support. • Information about diagnosis can promote a greater sense of control over one's life; patients are more likely to make informed decisions about treatment and significant life issues. • Objective measures of patients' progress highlight strengths and weaknesses. Difficulties and recommendations are communicated to outpatient therapists. • Patients can continue to utilize printed worksheets that they used while in PH. • Patients are more informed about treatment options and how to pursue them after PH (e.g., skills-based group therapy if available, books, Web sites). • In short-term PH, the staff must carry much of the load of communicating to patients about the culture and structure. • A priority of stage 1 is to orient patients to program structure (e.g., group schedule, expectations/requirements for patients) to facilitate smooth transition into treatment. • Structure facilitates stability and support. Changes are done systematically to minimize confusion for patients and staff (e.g., weekly group schedule is updated monthly to keep up with expected changes in group leaders and groups; program changes are announced to patients proactively).

2. Fixed Values Operationalized into an Adaptable Program Organization

Fixed Values



Attributes of Adaptable Organization

- Stable and resilient structure
- Accountability of staff roles at all levels of organization
- Psychosocial milieu that promotes healthy interpersonal connections

- Leadership that is solution-focused and proactive
- Accountability according to roles and mission at all levels of the organization
- Treatment that is pragmatic and sensitive to context
- Respectful working relationships

- Solution-focused, proactive management decisions
- Treatment that is pragmatic, with goals in line with contextual demands
- Accountability at all levels
- Respectful working relationships

Program Structure

- Program structure adapts according to staffing changes, patient volume, institutional demands, financial changes
- Preparation allows for effective improvisation
- Despite changes, structure remains predictable (e.g., meetings occur as scheduled, weekly group schedule is regularly updated for accuracy, coverage system for groups is in place proactively, groups start and end on time)
- Role definition of staff keeps organization in balance, and cross training for different responsibilities maximizes flexibility
- Staff are trained in skills approach and “buy in” to this model, which promotes, in turn, effective therapeutic relationships with patients

Organizational Vision

- Create and sustain culture of program
- Focus on flexible program structure that adapts to changing circumstances
- Encourage “ownership” of the program among all staff in line with one’s role
- Buy in to theoretical approach and mission
- Encourage innovation
- Encourage disagreement, with healthy conflict resolution
- Maintain decisive and accountable leadership
- Engage in ongoing contingency planning (e.g., program development to address changing needs of patients) as essential to anticipate and prepare for environmental changes

Continuous Quality Improvement

- Strategic planning for 6–12 month cycle
- Program development sensitive to patient population and to strengths and weaknesses of staff (e.g., offer new groups as applicable)
- Monitoring of clinical effectiveness and patient satisfaction
- Clinical training of staff (e.g., monthly meeting for in-service training, clinical supervision, peer supervision) provided and encouraged
- Innovation encouraged, though without unsettling program structure
- Respect in therapeutic relationships enhanced via sensitivity to patients as consumers of services intended to improve their health and well-being
- Good customer relations maintained with referral sources and with managed care organizations; changing needs identified and clarified

Treatment Approach

PH treatment is designed to help patients address the life circumstances and specific behaviors that brought them into treatment. A pragmatic focus identifies concrete ways (i.e., skills) to stabilize and improve functional capacities, which, in turn, will enhance one's quality of life. Based on my experience with a PH program treating nonpsychotic patients in a managed care environment, patients typically present with several of the following characteristics: problems of unipolar and bipolar mood disturbance; suicidality; anxiety and panic; anger; impulsive behavior; social isolation; interpersonal difficulties; and inadequate stress management. Diagnostically, one or more Axis I diagnoses are common, as is comorbidity with Axis II.

The time frame for treatment is very short, measured in days or weeks; treatment must therefore be time-efficient, with realistic goals. A stage model maximizes learning by prioritizing what patients can reasonably accomplish in the program within the time frame allotted; long-term issues are secondary. Thus, each stage has its own interventions and outcomes. A treatment contract,⁴ now used in a wide range of therapeutic and empirical protocols,^{5,33,34,36–38,56,64,73} is the vehicle by which patients and treaters collaborate on goal setting for each stage. For example, the purpose of stage 1 is to concentrate on basics and to simplify complex problems into manageable pieces so that even small changes can be observed and appreciated. Stage 2 is for extended treatment of two weeks or more. The treatment program is flexible enough to provide patients with opportunities to implement and practice skills, while providing support through a trial-and-error process.

Five principles guide patients to set priorities and match their problems with the treatment offered: psychoeducation, self-assessment, behavioral coping, self-care, and interpersonal connections. These principles are constructs formed by distilling complex treatment concepts and empirical protocols into simple and straightforward terms that are accessible to patients.

Psychoeducation serves multiple purposes. It provides factual information about diagnosis, course of illness, risk factors, treatment interventions, and recommended lifestyle changes. Patients educated in a respectful and supportive manner improve their sense of control, leading to better treatment outcomes.^{56,74,75} Psychoeducation also validates a patient's experience and, in turn, strengthens the connection with treaters. Patients are educated about the treatment approach and about how the program can match their individual needs in relation to the diagnostic formulation and prognosis; as informed consumers, patients will have an improved capacity to make good life decisions concerning their illness and treatment.

Self-assessment refers to a set of skills that promote a structured self-awareness to help one anticipate problems and learn healthy alternatives. These skills facilitate an awareness of self and environment, and a capacity to identify patterns and risk factors associated with life crises. In effect, self-assessment bridges the gap between psychoeducation and one's unique life experience. This construct is comparable to the cognitive element of CBT skills^{32,34–38,64,65,76–79} and is akin to the psychodynamic construct of ego awareness. One core self-assessment skill is chain analysis,³⁷ which breaks down events (e.g., situations, thoughts, feelings, behaviors) in a sequential order. A useful way to begin teaching self-assessment is to conduct a chain analysis of the history of present illness (i.e., events leading to admission; see text box 3) *with* the patient, and to highlight factors critical to decompensation.

Behavioral coping and *self-care* entail learning and using specific behavioral skills.^{10,28,32,38,64,65,76,80–82} Priorities are placed on self-care (e.g., sleep hygiene, physical exercise) and behavioral scheduling (i.e., planning one's time in advance), which address the practicalities of daily living outside the treatment environment. In the author's experience, most patients will say that life structure has broken down prior to admission, and the tendency is to say "I'll do that when I feel better." Unfortunately, this logic delays recovery. Behavioral scheduling is perhaps the most direct way for a patient to reinstitute activities into his or her life and to push through depressive and anxious symptoms.⁸¹ Planning is done in advance, with the goal of completing the activity even if one "does not feel like doing it"; in effect, this approach reduces emotionally driven decisions that would likely result in no action. Concrete behavioral strategies are also taught for symptom management (e.g., monitoring mood in writing, working through cognitive-restructuring exercises, impulse-control plan), relapse prevention, and crisis planning.

Social isolation and disconnections in relationships are often significant causal factors in seeking treatment. The principle of *interpersonal connections* is most directly realized in the supportive milieu and then augmented with pragmatic strategies (e.g., assertiveness, learning how to ask for help, conflict negotiation, anger management) that offer patients concrete and healthy ways to connect with others and cope with their experiences in problematic relationships. From a psychoeducational angle, patients are taught that interpersonal connections can promote improvements in functioning and quality of life, which is illustrated for them by the negative effects of social isolation. Two primary goals are to stay connected with others even if one is distressed, angry, or in conflict, and to learn specific ways to ask for help.

In sum, treatment outcomes are measured by the combination of (1) skills that patients actually learn (i.e.,

3. Chain Analysis and Skills Training (for Case Discussed in Text)

Sequence of events over one month, leading to admission for 50-year-old married white male:*

1 month prior

Increased job stress → sleep disturbance → less productive at work → more irritable → support from wife perceived as criticism →

mood worsens → sleep worsens →

2 weeks prior

Social isolation → missed days at work → more avoidance/self-critical →

1 week prior

Shame escalates → more hopeless → alone with feelings → further isolated →

1 day prior

Suicide attempt by overdose, “to go to sleep and not feel the pain”

*As described below, these events become target areas for skills training.

Stage 1: “Learning Week”

Self-assessment

Identify triggers (e.g., job stress, decreased productivity) and warning signs (e.g., sleep disturbance, irritability, social isolation, avoidance behaviors, shame). Focus on sequence of events with requirement to “catch things early” and to notice spiraling, negative thought patterns, all of which promote relapse prevention.

Behavioral Coping

Focus on improving current functioning: behavioral scheduling to resume daily structure, written mood monitors to track thoughts/feelings daily, maintain good sleep hygiene and self-care, design impulse-control plan/crisis plan if suicidal. Maintain regular schedule for taking medications, using med cassette to facilitate adherence.

Interpersonal Connections

Participate in groups for support and validation, and offer others support. Learn concept of staying connected even if distressed (e.g., learn specific ways to ask for help).

Stage 2: “Begin Mastery of Skills and to Feel Better”

Self-assessment

Use chain analysis as basis for relapseprevention plan, crisis plan (if necessary), and realistic transition plan for returning to work.

Behavioral Coping

Establish part-time schedule to return to work, make realistic plan for self-care and exercise, keep track of negative thought patterns (and consider alternative views).

Interpersonal Connections

Establish routine of checking in with wife about daily mundane events (from there, able to move on to more emotional issues). Contact one friend and set time to meet for brief socializing. Contact one “safe” person at work. Practice “asking for help” as a skill to improve.

Aftercare Plan (Final Stage of Program, to Build on Existing Skills, Maintain/Improve Interpersonal Connections)

Self-assessment

Strengthen skills to promote structured awareness and enhance relapse prevention. Need to understand ongoing risk of becoming suicidal again. Identify high-risk situations that may trigger suicidality. Identify behaviors and thought processes that may serve as warning signs (e.g., social isolation, avoidance behaviors). Develop relapse prevention/impulse-control plan that emphasizes “catching things early.”

Behavioral Coping

Need to maintain daily structure, with a crisis plan written down and reviewed by patient and wife. Develop and coordinate plan for outpatient therapy (including, e.g., the identification of situations when therapist should be contacted).

Interpersonal Connections

Continue routine of checking in with wife (and others) and of practicing asking for help that was established in stage 2 of PH program.

skill acquisition), (2) symptom reduction, and (3) improvements in functioning. This approach posits that in stage 1 (week 1) patients learn skills, with some reduction in symptoms and modest improvements in functioning; whereas in stage 2 (week 2 and beyond) it is expected that patients feel significantly better and actively improve functioning. Gains should continue after discharge if patients use and build on the skills learned in the program that are known to correlate with positive outcomes (e.g., behavioral scheduling and reframing cognitive distortions to alleviate depression).

A case example is provided below. It is important to note that while the case may appear oversimplified, that simplicity is the very crux of basic skills-oriented treatment in PH that can be reasonably accomplished in a week or two. The case represents a composite profile of a typical patient seen in a PH program.

The patient, a male in his 50s with a history of depression and anxiety who was admitted for inpatient treatment after a suicide attempt by overdose, was stepped down to a PH program for two weeks (see text box 3 for more detailed description of treatment).

Week 1. The stage 1 treatment contract begins with three goals: (1) to clarify the diagnosis and learn basic information about risk factors and course; (2) to describe the chain of events leading to admission, and (3) to learn basic coping strategies for depression and anxiety. Psychoeducation addresses the first goal. The patient is informed of his diagnosis and learns about his risk factors (e.g., positive family history, previous episodes) by psychoeducation groups on depression and anxiety. The second goal relies on self-assessment skills, with a chain analysis describing the chronology of events that led to this admission (see text box 3). The chain analysis helps organize priorities for stage 1 since it highlights problem areas and targets for coping skills.

Week 2. Stage 2 builds on the foundation learned the preceding week. Trial and error of coping skills, increased mastery, and symptom reduction are target outcomes for this stage. There is a push for more interpersonal contact, but in a gradual way. The discharge plan incorporates relapse prevention with continued use of skills after discharge. Particular attention is placed on warning signs of suicidality, and crisis planning is coordinated with the outpatient therapist.

Program Structure

Structure is central to milieu treatment^{1-3,5,7,18,45,46,51,74,83,84} since it is the framework within which treatment occurs, and serves as the foundation for containment and coherence of treatment. The structure is also resilient: mechanisms are in place to anticipate and implement changes through a predictable process.

The structure of a therapeutic milieu does not just happen; it must be actively constructed, proactively maintained, and routinely updated. The structure must be explicitly defined with two considerations in view. First, “structure is all aspects of a milieu which provide a predictable organization of time, place, and person.”¹ Second, and of equal importance, the program must inform patients as efficiently and supportively as possible about the structure so that they can utilize the program optimally.

An efficient orientation to the program structure is necessary in the initial stage of treatment.¹⁸ Patients are in a life transition when they begin treatment. Transitions tend to exacerbate anxiety and to cause some disorganization and uncertainty⁸⁵ as patients experience changes with respect to people, place, time, task, and overall life adjustment. In previous eras patients had time (i.e., weeks to months) to get settled in a program; now, no such luxury is permitted. Clear and concise information (e.g., description of treatment approach, treatment team members, expectations of patients) provided upon entry can allay a patient’s anxiety and facilitate immediate involvement in treatment. Brief descriptions of groups further orient patients to treatment and promote memory of what they have done, and are doing, in the program.

A resilient (i.e., stable and flexible) program structure anticipates changes and withstands inevitable pressures. Now more than ever, systems and organizational structures providing care are mutable, and patients face obstacles other than their own as they strive to attain stability. Even seemingly small things can undermine the structure. For example, inaccurate information erodes patients’ sense of stability in the program and breeds mistrust. Timely efforts to provide written and verbal updates about changes should be routine (e.g., with monthly updates of group schedules and designations of group leaders).

Another example of a resilient structure relates to staff roles and responsibilities. While roles must be clearly defined,^{1,46} everyone should assume that job descriptions will change as demands dictate. Plans must be in place for cross-training, job sharing, and coverage, all of which contribute to systematic and adaptive processes of change. Effective improvisation under pressure is possible only with creative preparation.

Organizational Vision

An organization defines itself by its mission, which is implemented on a daily basis. The mission states essential values and purposes (i.e., the vision) to facilitate an attitude and culture^{70,71} that establish the foundation for the therapeutic milieu. Because of their short lengths of stay—and unlike previous examples of therapeutic communities^{41,52,53}—PH programs have no stable cohorts of patients, thereby placing

an added burden on the staff to maintain the program's culture over time. Thus, the mission can be realized only if the organization and its members are accountable to its values.^{70,71,86} Based on empirical management studies,^{70,71} accountability is measured by the extent that staff adhere to their roles and perform according to the program's specific mission (i.e., staff are trained in a CBT model and are invested in treating patients with this approach). By the same token, a very skilled therapist who does not buy into the model would be a detriment to the program.

Those in leadership positions are responsible for articulating how the program's values^{70,87} guide administrative and clinical decision making; programs do not run themselves. Leaders facilitate open communication among staff members and between staff and patients.^{43,46} Open debate and disagreement are encouraged, with the aim of using dialectical tension between disparate opinions to create a new approach and move the program forward. This climate encourages innovation, but discipline is important in order to maintain the integrity of the program's structure and mission.⁸⁸ An open process does not imply the endless processing of issues, however; eventually, leaders must be decisive and accountable. Accountability, in turn, breeds trust in the organization.

A solution-focused bias for action is an inherent component of a flexible organization.⁷⁰ It integrates decisive leadership, group cohesion, and contingency planning. For example, a program director anticipates fluctuations in patient volume with two plans. One addresses staff roles during periods of high patient volume (e.g., redeployment of one staff member to assist with admissions); the second redeploys staff when volume is down (e.g., more individual contacts with patients).

Continuous Quality Improvement

The present mental health care environment presents PH programs with a long list of challenges: staff changes, high patient turnover, unpredictable lengths of stay, fluctuating daily census, demands for new programming, changes of group leaders, changes in managed care contracts, consumer demands for more time-efficient treatment, and institutional reorganizations. Thus, programs grow, develop, downsize, or reorganize to maintain viability and sustain success. Effective programs can become stale, yet resistance to change is expected. All areas therefore need to be continuously evaluated, nurtured, and developed in order for the program to be continually adaptable over time.

Program development and staff training are essential, even with limited resources. Small efforts can go a long way if they become a predictable component of program organization and structure. Task forces are effective means by which to incorporate staff members systematically into pro-

gram development (e.g., through a pilot for a new group). The critical point is to create an ethic in the program that values the professional growth and involvement of each staff member.

High-quality customer service is essential for patients and their families, referral sources, and third-party payers. Many clinicians may wince at the idea of customer service since it is not a traditional way to characterize a therapeutic relationship—and thus is likely to be seen as controversial. The point here is to build on the foundation of the therapeutic relationship, which should already be focused on collaboration, support, and empathy. In short, the goal of customer service is not to create a sterile relationship that approximates that of a retail store; instead, it is to enhance respect for patients as consumers of mental health services that are crucial to their well-being. For example, in milieu treatment, questions or complaints about a program can easily be subject to clinical interpretation. While this response may be relevant, patients are consumers, and the program and staff should be accountable for answering questions according to the mission and policies of the program.

Furthermore, direct contact is encouraged between program leaders and patients in order to solicit their feedback about the program. While patient satisfaction questionnaires are valuable, they do not substitute for a live dialogue with patients about their experience in the program. Leaders must be good listeners.^{70,87} Structures need to be in place (e.g., community meetings, an open-door policy for contacting program managers) in order to give patients opportunities to ask questions of, make suggestions to, and lodge complaints directly with, someone in a leadership position. These opportunities serve two functions: patients' concerns can be validated publicly, and patients can provide input for future program development.

Effective customer service includes collaborative and productive relationships with referral sources such as hospitals, agencies, emergency rooms, outpatient clinicians,⁸⁹ and managed care organizations.⁹⁰ Those relationships must be nurtured and strengthened to withstand inevitable disagreements and conflicts under high-pressure conditions. It is also necessary to clarify their changing needs in order to determine ways in which the program can adapt.

CONCLUSION

The model of fixed values and a flexible PH program draws on the strengths of hospital psychiatry to create an institutional ethic, or culture, to advance psychosocial milieu treatment. In turn, treatment needs to be as accessible and useful as possible, even if a patient has only four or five days to address a major life crisis. The treatment approach is to simplify problems and tasks, and to focus on what one

can accomplish in a brief time, thereby maximizing a patient's experience of progress. This method instills hope and facilitates a greater sense of control over one's life by making available to the patient tangible ways to manage what before seemed unmanageable. In this context even small changes can significantly enhance a patient's quality of life.

Fixed values are starting points, not end points, and therefore can be generalized to PH programs with a range of economies of scale, as well as to inpatient and intensive outpatient programs. For example, this treatment model's adaptation of evidence-based treatments is portable; the key is to articulate a program's mission, in its unique context, with the available resources. A program needs to systematically evaluate what is effective, and to discard what is not.

Uncertainty hangs over our heads daily in the current mental health care environment—even when things are going well. Programs will change, grow, downsize, close, merge, and reorganize. Nonetheless, it is still possible to create opportunity out of adversity. The model of a flexible partial hospital program with fixed values offers a way to avoid complacency and embrace the changing world.

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