Brief psychological treatment in mental care

Schäfer, B.A.

Citation for published version (APA):
Brief treatment in specialised community mental health care: a study among all Dutch Community Mental Health Centres

Barbara A. Schaefer
Aart H. Schene
Maarten W.J. Koeter

Original in Dutch;
Published in Maandblad voor Geestelijke Volksgezondheid, 9, 901-9, 1999
**Introduction**

In her Vision on Mental Health Care Policy paper of 1998, the then Dutch Minister of Health, Mrs. Els Borst, wrote that one of the most important challenges facing Dutch mental health care services at the start of the 21st century, was the steadily increasing rise in the need for ambulatory mental healthcare, in particular. A possible solution, she added, might lie in short-term treatment programmes, although in the current discussion the question as to whether or not this form of help actually belongs to the field of specialised mental health care is often bypassed. The Health Minister commented that in the new (locally organised) non-specialised front-line mental health care, the types of disorders requiring short-term and generalistic treatment, should be handled by the general practitioner (GP), the front-line psychologist or the social worker. In the event of multi-disciplinary treatment being required, patients should be referred to the regionally organised specialised community mental health care via the ‘gatekeeper’ GP and a protocolized indication-formulation procedure. We have not yet reached that point, however, but the question arises as to what future role there will be for brief treatment (this is a type of treatment in which the clinicians have the intention to end the brief treatment in six or fewer sessions) in specialised ambulatory community mental health care. This present article presents the results of a national inventorizing study of the extent, place and nature of short-term treatment available for adults in today’s Community Mental Health Centres (CMHC’s) in The Netherlands.

The number of people making their way annually to the CMHC’s has more than doubled since 1982 when these centres were first established (Ten Have et al., 1998). Increased budgets, greater efficiency and higher productivity, made it possible to absorb this growth initially, but the number of contacts per clinician per day, seems to have reached its limit. The gap between supply and demand is one of the main causes underlying the growing interest in all types of short-term treatments (see among others Bouwkamp, 1985; 1986). There are other reasons, however (Schene, 1995); it seems that patients are not only demanding that they be given faster access to treatment, but that the treatment be completed within fewer sessions (Van der Sande et al., 1992). In the CMHC’s too, there has been a need to provide short-term treatments without internal referral procedures. The clinicians have also changed their viewpoint on the treatment offered: it could, and must be, shorter, more problem-focused, and less extensive in terms of objectives. Finally, short-term treatment formalises part of what has become a growing practice: for several years now, 75% of all newly-registered CMHC’s patients have had ten, or fewer, previous contacts with clinicians (GGZ Nederland, 1998).

In 1995 the first-ever congress on the subject of short-term treatment was held under the title of ‘Short and Good’ (Wagenborg, 1995). The first official guidelines appeared two years later (Methorst et al., 1997). Interest in brief interventions is also broader than the specialised

---

2 In 1982 57 Regional Institutes for Community Mental Health Care (RIAGGs) were established in the Netherlands to guarantee a diversified set of ambulatory services. In the second half of the nineties RIAGGs started mergers with other regional organisations like mental hospitals and sometimes also psychiatric departments of general hospitals and regional institutes of sheltered living. In this article we will refer to these former RIAGGs and the ‘new’ organisation in which they have been incorporated, as ‘Community Mental Health Centres’ (CMHC’s).

3 This study was supported by a grant from the Nationaal Fonds Geestelijke Volksgezondheid.
community mental health care; it is also present in general social work (Van den Berg, 1998) and in GP practices (Van der Burg-van Walsum, 1999).

In 1994, Van Buuren and Schouten presented the results of a questionnaire sent to all CMHC's on the incidence of short-term treatment programmes. It became apparent that more than half of the 45 CMHC's which responded, were offering short-term treatment programmes spread over a maximum of five sessions (45 percent offered six to ten session, and 10 percent were offering eleven or twelve sessions).

In view of the rapid developments in this field, and within the framework of a larger study of short-term mental health care, we again carried out a survey among all the CMHC's. This present article, therefore, presents a picture of how things were in terms of short-term treatment programmes in Dutch CMHC's in 1998. The study focused primarily on the following aspects: the number of CMHC's actually offering such services, the date they were introduced, the embedding, each clinician's particular discipline, waiting times, the number of treatment sessions, the duration, treatment goals, content of the programme offered, therapeutic approaches on which the treatments were based, the type of patients who were (or might be) considered eligible, and any factors likely to influence the patient-influx.

Study design

Interview

The data were gathered by means of a telephonic, semi-structured, interview which had been devised on the basis of current literature (including Van Buuren & Schouten, 1994; Wijsbek et al., 1991; Te Vaarwerk, 1992; Stoffer, 1994; SOGG, 1995; Hazewinkel & Vrolijks, 1996; Hermens, 1996; Karsten, et al., 1996; Rijnders et al., 1996), as well as information obtained from the clinicians themselves. The interview had been put to the test in a pilot study (n=6) and amended on a number of points. The interview itself lasted fifty minutes on average.

All 57 CMHC's took part in the study. We asked for one or more contact persons for the short-term care-intervention services offered to adults. We also asked for a contact person in the case of there being no short-term intervention facilities available. Each of the 71 contact persons assigned to us was asked if he/she regarded the care offered as 'short-term', and whether in the CMHC concerned there were more kinds of care-intervention facilities on offer which could also be regarded as 'short-term'. This approach - as a consequence of the 100% response - produced a very complete picture of 'short-term' care types in operation at the beginning of 1998. It proved necessary to hold only very short talks with twelve of the contact persons, either because they felt the care on offer was not really 'short-term', or because the CMHC in question (still) had no short-term care-intervention facilities available. In the latter case, we posed a number of questions as to whether there were any at all plans for setting up such a service. The remaining 59 contact persons were all interviewed individually; in most cases they were either coordinators c.q.
chairpersons or project leaders of a short-term care-intervention team, in which they often also participated as clinicians.

Definition of a brief treatment programme

Not all short-term intervention programmes, to which our contact persons referred, have been categorised in this article as 'brief treatment' (BT). On the basis of the data produced, we concluded that the BT programme offered would have to satisfy the following three criteria: a) the programme itself must have been established within the CMHC concerned, and the clinicians providing the treatment must have constituted a separate team; b) the intention of each clinician had to be to complete the treatment within no more than six sessions; and c) it should be neither a crisis intervention programme, nor some kind of (brief) group treatment programme.

The fact that we limited ourselves to only those forms of care-intervention which satisfied the above-mentioned criteria, and which had been put into practice prior to 1998, meant in consequence that 16 interviews were removed from our on-going study. The remaining 43 interviews related to a total of 46 BT-programmes in 39 CMHC's (35 CMHC's with one BT-programme, one CMHC with two, and three CMHC's with three BT-programmes).

Results

A total of 39 CMHC's were operating a BT-programme at the beginning of 1998. Five CMHC's implemented a similar programme half way through 1998, and five were busy establishing one (at the time of the interview, it was not yet clear whether or not it would satisfy our criteria). Four other CMHC's had plans to develop a BT-programme in the near future. Only four CMHC's were offering no BT-programme, and also had no plans to develop one in the foreseeable future.

BT is a relatively new phenomenon in the mental health care service. The first CMHC which implemented the programme in 1986, remained the only one to do so for a long time. More followed post-1990, with the number of BT-programmes jumping from four in 1992 to 39 in 1997. A total of 27 CMHC's followed suit only in 1995 or later. The programme, in organisational terms, can be incorporated into two sections within a CMHC. In 30 such centres, it is available right at the 'front door', where it falls immediately into the hands of the intake team. In 12 other CMHC's, however, we find the BT-programme deeper in the 'house', as it were. Three CMHC's operate both BT types. Of the 30 CMHC's with a BT-programme at the front door, we find that in 16 of them it was the intakers themselves who operated the BT, whilst in another 14 centres only some of the intakers were actually responsible for operating the BT programme.

The team providing the BT is usually multi-disciplinary. In 12 of the BT-programmes we studied, all the clinicians shared the same discipline (they were usually psycho-therapists). In the remaining 34 cases, clinicians operating BT represented a wider selection of disciplines (see Table 2.1).
Table 2.1 The discipline from the clinicians participating in the brief treatment teams

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Percentage of the 46 brief treatment programmes in which one or more clinicians have the particular discipline.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- psychotherapist</td>
<td>93</td>
</tr>
<tr>
<td>- community psychiatric nurse</td>
<td>65</td>
</tr>
<tr>
<td>- psychologist</td>
<td>57</td>
</tr>
<tr>
<td>- psychiatrist</td>
<td>50</td>
</tr>
<tr>
<td>- social worker</td>
<td>41</td>
</tr>
<tr>
<td>- physician</td>
<td>9</td>
</tr>
<tr>
<td>- pedagogue</td>
<td>2</td>
</tr>
</tbody>
</table>

1 Can also be a psychologist or a social worker, but psychiatrists with a registration as psychotherapist are not regarded psychotherapists.
2 Without a registration as psychotherapist.
3 Can also have a registration as psychotherapist.
4 Apart from this 50%, there is within 11% of the 46 brief treatment programmes a psychiatrist available for consult.
5 Apart from this 9%, there is within 2% of the 46 brief treatment programmes a physician available for consult.

It was not possible to carry out a well-grounded study of the degree of experience each clinician had. Many respondents indicated that BT requires clinicians with a broad therapeutic and psychotherapeutic training, plus several years of practical experience; such clinicians, they say, are thus well equipped to quickly define both the problem and the objectives, and also to complete the treatment within five or six sessions, without any deficit to the patient. The respondents also feel it is very important to be able to use the expertise of the whole team.

Waiting times

The aim in most CMHC's was to restrict waiting times to four weeks or less, although only half of them actually succeeded in this. There are two main reasons for the longer waiting times. Firstly, the organisational embedding of the BT within the existing structures of the CMHC's themselves. The process was shortest when the intaker is also responsible for operating the BT programme, and where he/she can use the intake interview as the BT starting-block; it was thus possible to make an immediate appointment for the next contact-session, without any extra waiting time. This kind of procedure was applied in six CMHC's. In most centres, however, the intake was a separate entity from the subsequent treatment. Before BT appointments could be made with the patient, the intake-team had, first of all, to discuss the indication-criteria. Setting a date for the team-meeting obviously influenced the waiting-time between intake and the onset of the BT. This time was extended if the patient's case needed to be discussed twice - once within the intake-team and once within the BT-team (this was the case in ten of the CMHC's: seven of them had waiting-times exceeding four weeks, which were often extended to six or even eight weeks). The pre-BT road could become even longer if the patient needed to be referred to the BT-team after the intake, and was subsequently called in for a BT intake as well. It has to be said, however, that we met this procedure in only two BT-operating CMHC's.
A second reason for longer waiting times lies in the relationship between BT supply and demand. Many CMHC's have made clear stipulations regarding maximum waiting times. When the demand increases and the maximum waiting time seems likely to be exceeded, we saw that in 20 of the 46 BT-programmes we surveyed, steps were being taken to redress the balance by reserving more hours for the BT-programme (n=11), by temporarily blocking access to it (n=5), or by (temporarily) making minor adjustments to it (n=4). As far as the remaining 26 BT-programmes were concerned, it was not clear exactly what steps were likely to be taken in the event of excessive waiting times, or whether or not the centre - out of sheer necessity - would be forced to accept longer waiting times.

The number of sessions

According to our own definition of what BT is, it would be expected of each clinician - right from the start of treatment - to be committed to completing the BT within six or fewer sessions. In practice, however, there are usually two ways of limiting the number of treatment sessions (see Figure 2.1).

**Figure 2.1 Limitation of number of brief treatment sessions**

The first approach is to agree prior to onset to limit the maximum number of sessions to six or fewer. This agreed limit cannot (normally) be extended. This method is used in 34 BT-programmes, whereby in most cases the number of sessions is limited to five. Although some CMHC's admit to not keeping strictly to the agreed limit, the average number of sessions seldom exceeded the agreed five. Many of our respondents indicated that some kind of monitoring was needed if completion of the BT, within the agreed time span, was to be ensured.
The second method is to stipulate at the outset that the BT will be completed within six sessions, at the same time adding the (standard) option of extending the sessions to a maximum of eight or ten (this method is also known as the '5-plus offer', on the basis of the initial intention to complete the treatment programme within five sessions). Of the 46 BT-programmes currently operating, twelve offered this '5-plus' possibility; in two of these, three extra sessions were possible, and in ten other centres five. In practice, the average number of sessions, within which the BT-programme was completed, was usually slightly higher than five (often six).

The clinician knows at the start of the '5-plus' programme that it can always be extended. This is not necessarily true of the patient. In five out of the twelve '5-plus' programmes, the patient was informed about the extension option prior to the onset of the programme, whilst three other such programmes did not do so (there was no standard arrangement in the remaining four BT-programmes). It appears that the question of the 'to be or not to be' of informing the patient in advance regarding this option, ultimately had no influence on the number of treatment sessions.

It was felt in seven of the 46 BT-programmes surveyed, that once the patient had completed the BT-programme, he/she should not immediately be offered any other kind of treatment. In three of these seven CMHC's, it had also been agreed that the BT must be completed within the agreed time-spread of the short-term treatment, and that the patient could only apply for treatment again after a certain period of time had elapsed (e.g. three or six months later).

In most of the BT-programmes, it was customary to discuss the patient again in a team-meeting, and to give him/her a re-indication. Placing the patient on a waiting list or assigning him/her to another clinician is rarely ruled out. Real efforts are made in only five of the BT-programmes in offering any degree of care continuity, such as either allowing the clinician and the patient to move on together to some other kind of care-programme, or by guaranteeing the patient continued care without having to join a waiting list.

Our definition of BT incorporates no limitation in terms of the period over which the sessions may be spread, and the same also appears to be true of most of the CMHC's. Indeed a set time limit was applied in no more than five of the 39 CMHC's covered in our study; three applied a maximum limit of six months, another set the limit at four months, and another at two months. In five other CMHC's - in the event of the BT not being completed within six months - the patient's progress had to be discussed in a team-meeting. In two centres, this team discussion took place after a certain period of three months. In one of the centres, if a period of more than three months had elapsed between two sessions, the clinician was asked for clarification.

The most important reason for not applying a time limit was that, in the eyes of many clinicians, the patients themselves were responsible for the content and progress of the sessions - the idea being that clinicians wanted to ensure the possibility of negotiating with the patient on the question of the time-spread of the sessions. Some CMHC's gave their patients total freedom in choosing the date and time of the treatment sessions.
Nation wide survey

Each respondent was asked to give an average time span over which the BT-sessions were spread. Eighteen of the 29 CMHC's offering a maximum of six sessions (3½ months), as also for nine of the twelve CMHC's offering a '5-plus' option (4½ months), were able to give such an estimate.

Nearly all respondents stated that the BT often starts with a frequency of once every two weeks, followed by once every three weeks, and closes with longer time periods between the last sessions.

Purpose, content and theory

In three quarters of the 46 BT-programmes surveyed, the treatment could only begin once the treatment goals had been clearly formulated, in joint consultation with the patient and the treating team. The treatment goals mentioned differed from programme to programme; in descending frequency they were:

- In patients with minor psychiatric problems, solving or reducing the symptoms to a level agreed to at the onset of the BT. The change brings them back to their old level of functioning, or to an even higher level. Post-BT, they are no longer part of the (sub)clinical population.

- Giving patients insight into the possibilities open to them. The BT was not focused directly on reducing the symptoms, but rather on the patient's despair (e.g. in the case of a demoralised patient with sufficient skills).

- Solving or reducing acute symptoms in patients facing complex problems. By dealing solely with the acute problems, it is hoped that these patients will again be able to restore their old balance. When such patients have completed the BT-programme 'successfully', they still remain part of the (sub)clinical population.

- Adjusting the 'unrealistic' expectations of patients in terms of therapy, and help them - if necessary - to accept things as they are.

- Making patients aware of their problems, giving them an approach to, and/or insight into, their symptoms. Such patients usually present with somewhat vague symptoms, as well as a vague (possibly unrealistic) request for help, and with little insight into the situation they are in. An added aim might also be to motivate the patient to undergo further treatment.

Only one CMHC worked according to a specific model, theory or protocol. The clinicians initially offered patients four sessions on the basis of the Gilliéron (1989) psycho-analytical model. It was then decided whether or not further help was necessary. This model was also applied in a number of other CMHC's, but on a much smaller scale, and was operated by only one single clinician within the BT-team. In another CMHC we saw much greater use of solution-focused therapy, which has been described by several authors including Walter and Peller (1992) and De Shasher (1985). The stated intention from the outset was that this method would be short-term,
although no limits were set. Many more of our respondents referred to techniques taken from one or other of the solution-focused models, but did not regard them as their starting-off point. The clinicians in 33 BT-programmes had increased their expertise by following various training programmes or courses, or by calling in someone from outside their own CMHC to give the BT-team contextual support and advice.

The content of a BT-programme was closely related to the clinician group directly responsible for it. We can divide the BT-teams into three, almost equally large, groups: a) a very mixed team, in which each of the clinicians worked within his/her own frame of reference; b) a team in which all the clinicians involved were expected to work eclectically; and c) a team of clinicians who worked more or less in the same way, often with one or two particular therapeutic approaches predominating, whereby the word 'eclectic' is somewhat out of place. These clinicians were either the products of the same therapeutic approach or, by working intensively together, had developed the same working patterns.

Because each clinician had his/her own working method, respondents representing the first group found it difficult to say what BT actually entails. In the second group, respondents indicate that use was sometimes made of therapeutic approaches which could be incorporated well into a BT-programme. According to these respondents, nearly all clinicians worked directly, and much use was made of behaviour therapy techniques, cognitive behaviour therapy in particular. System-therapeutic methodological orientations were also favoured, especially in terms of clarifying the patient's problems. Techniques of a more psycho-dynamic nature were hardly mentioned at all, but were occasionally referred to as useful in thinking the problems through. It was apparent in the third group too, that their approach was based on directive, behaviour-therapeutic and system-therapeutic methods, although they were not always referred to collectively, as in the case of the second group. Mention was also made of working directly and behaviour-therapeutically - either separately or in combination - as the most important working method applied. The system-therapy theory was seldom mentioned as the only one in use, but was often referred to in combination with one of the other two approaches. Psychodynamic methodological orientations were also hardly mentioned here, with the exception of the respondent working with patients on the basis of the Gilliéron method.

The patients

It became apparent that respondents found it very difficult to say which patients were given BT, and for whom such a programme would suffice. In broad terms, it seems that roughly 40%-50% of the CMHC populations was contra-indicated for BT. This usually included patients with several complex problems requiring long-term care, and whereby it is not always wise to preclude certain problems from treatment. Patients facing acute problems (suicide risk, acute crisis) and with severe psychiatric problems (psychosis, serious mood, eating or cognitive disorders) were often given a contra-indication, in the same way as patients with certain kinds of personality disorder (paranoid or schizoid personality disorders, or a schizotypical personality). It is always inadvisable to offer short-term treatment to patients with whom it is likely to take considerable time to build up a proper working relationship. There is also a reasonable consensus surrounding the
adequateness of BT for patients with less severe psychiatric disorders (primarily adjustment disorders, mild depression or anxiety disorders) and/or with more serious relational, life-phase and occupational or study problems.

Whether or not a patient actually became eligible for BT, depended not only on the kinds of problems mentioned above, but also on patient-characteristics such as motivation to tackle the problem quickly and with a limited treatment goal (see Table 2.2). Most BT-programmes had little difficulty in 'allocating' 10%-15% of the CMHC population.

### Table 2.2 Patient characteristics used as selection criteria for brief treatment

<table>
<thead>
<tr>
<th>Patient characteristics used as selection criteria for brief treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- One can relatively quickly negotiate a (limited) treatment goal or focus with the patient</td>
</tr>
<tr>
<td>- The patient is able to be active in working on the problems</td>
</tr>
<tr>
<td>- The patient is being open for possible approaches to look at his/her problems</td>
</tr>
<tr>
<td>- The patient has some strengths</td>
</tr>
<tr>
<td>- The patient is functioning relatively well on other areas beside the problem areas</td>
</tr>
<tr>
<td>- The patient has a relatively stable life environment from where there is sufficient support for the patient</td>
</tr>
</tbody>
</table>

The remaining 35%-50% fall into a somewhat grey area. Some clinicians stated that such patients were admitted to BT programmes, whilst other clinicians said they were not. This was dependent on several different factors:

- **Clinicians who give BT.** On which problems were they able and willing to work? How many hours can, may, or must, the team assign to each patient? Who controlled the patient influx? In most BT-teams, it was usually one clinician who was the main driving force, and the one who motivated his/her colleagues. There were respondents who indicated that when there was no such person in a team, there were fewer BT patients.

- **People responsible for determining the indication.** When a CMHC declared itself willing to provide short-term treatment to as many people as possible, intakers would have had to present very strong arguments for offering a patient something else. The opposite was also true, of course.

- **The remaining treatment possibilities.** Some respondents felt they could help even more patients within their BT-team, but that patients were not referred to them because they had been offered an alternative form of treatment. It is also possible that certain patients entered the BT-programme because it was thought that other treatment types would offer them little potential. In some CMHC's, the BT influx increased in line with increasing waiting lists for other types of treatment. Because BT was frequently seen as a 'bridging-the-gap' treatment possibility for these patients, they were often not regarded as belonging to the primary target group.

- **Regional factors.** Whoever applied to a CMHC for help, was dependent on the population in the region, the front-line referral practices, what was available within the regional mental health care service, and the working-relationship between the CMHC and other mental health care institutions.
Many CMHC's have established BT-programmes in the course of the last five years; in early 1998, that was in fact two thirds of all CMHC's, and it is expected that this number will inevitably increase. At this point in time, BT is indicated for a considerable proportion of the 250,000 patients seeking the help of the CMHC's each year (GGZ Nederland, 1998). In defining what is understood as short-term, it appears that one yardstick is the explicit intention of the clinicians to complete a treatment within six sessions or fewer. Although there is no consensus in the literature on the precise upper limit of the number of sessions in such treatments, practice shows that any treatment offers extending beyond six sessions are seldom regarded as brief. Whilst there seems to be agreement on the number of sessions, the picture is less clear when we look at the time-spread of BT-sessions, the programme content, and the (contra-)indications. There were often no limits agreed on in advance regarding the time span over which the sessions could be spread; in order, on the one hand, to ensure a certain degree of freedom for the patient, and on the other hand because in practice the successive sessions take place with the same regularity.

It appears from our survey that respondents found it difficult to say whether or not the work was done within a particular framework. This is partly due to the fact that nearly all the CMHC's gave their individual clinicians considerable freedom in what they did, a situation which can, of course, result in a broad variety of working methods. There also appears to be no 'new' BT method emerging. Within the existing methodology, clinicians are looking for a working method which will enable the treatment to be completed within six sessions or fewer. There is also the question as to whether it is possible to devise a treatment programme - within which a broad selection of patients can be helped - on the basis of one model, one theory, or one protocol.

No clear picture emerged from our study on the question of which patients are eligible for BT, partly because patient selection for this type of treatment was dependent on all kinds of (CMHC, internal and external) factors. It was very apparent, however, that when a CMHC offered a BT-programme, some 10%-15% of those patients who had received a BT-indication were actually able to enter it. Dependent on the organisational embedding of the programme, and the nature of the treatment goals, this percentage could rise to anywhere between 25% and 35%.

The lack of clarity regarding the content of, and the (contra)indications for accepting a patient into the BT programme, can partially be explained by the fact that BT did not emerge on the basis of any one scientific theory or model-development, but that it was largely pragmatic and organisational factors which triggered the development of this type of treatment in the first place (Wagenborg, 1995).

Nearly all our respondents agreed that it is of essential importance that the clinician, together with the patient, reaches a quick definition of both the problem and the achievable treatment goals. These goals can be extremely diverse, dependent on the nature and duration of the problem in addition to the patient's own possibilities and capacities. What characterizes BT especially, is that it is not directed to 'total cure'; the most important aspect being to promote change processes until such time as the patient can move on independently.
Although the programme appeared to satisfy the wishes of a proportion of the CMHC patients - fast and focused interventions which enabled patients to get on with their lives (Bouwkamp, 1986; Wijsbek et al., 1991; Van der Sande et al., 1992) - and patients also gave every appearance, so far, of being satisfied with what a BT programme could offer them (e.g. Wijsbek et al., 1991; Van der Heyden et al., 1998) - an effect study is certainly called for. After all, although the patient may want it, a BT programme is not necessarily what he/she actually needs.

In addition to meeting the demand, the aim of the CMHC's in providing BT-programmes was also to shorten waiting lists, and reduce workloads. Although the consequences of a BT for the general waiting times in CMHC's have not been examined in this study, some respondents drew our attention to the fact that the BT-programmes actually provided no solution to the waiting list problems. In some cases, waiting times even increased, because there were less 'drop-outs'. Waiting times get shifted to other care-programmes or to the intake department. We wonder, in fact, how structural this problem really is.

Although our questionnaire contained no questions on the amount of time invested in each individual BT-session, some respondents felt it was important to note that clinicians needed more time to prepare themselves for BT-sessions than is necessary for unlimited treatments.

As has already been stated, the Minister of Health felt that the threshold to the second-line or specialized mental health care services should be raised, whereby part of the current care-giving programmes could be transferred from the second to the front line. It seems that the situation concerns patients who currently - within many of the CMHC's - constitute part of the patient group receiving BT. Within this field of tension between policy-vision and what has developed in practice, the question arises as to whether or not BT actually has a rightful place in the second-line mental health care services. This question can only be adequately answered when it becomes absolutely clear which patients are currently receiving BT in the specialised mental health care services. This present study has set the ball rolling. It appears that BT is not indicated solely for 'minor problems', is apparently very difficult to fit BT into a set protocol, and we see clear evidence that BT lies primarily in the hands of the more experienced psycho-therapists.

The follow-up study we began in 1999, will hopefully bring more clarity, in that we will have gone a step further; from beyond what is said to be done, towards what is actually done, for whom, and with what results. We hope in this study to be able to provide the answer to some ethical questions too, because although it is not so much a matter of putting totally new techniques into practice, there is an undoubted need to focus attention specifically on the effects of putting limits on both the number of sessions and treatment goals.
References


