

**AN EVALUATION OF THE
PSYCHOTHERAPEUTIC MILIEU THERAPY
PROGRAMME OF THE WILLIAM SLATER
CENTRE FOR ADOLESCENTS AND YOUNG
ADULTS**

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Abstract

In recent years there has been increasing recognition of the turmoil of the adolescent developmental period. This has primarily been the result of research demonstrating high morbidity, and at times mortality, for this age group. With the acknowledgement of adolescent mental health problems, and adolescent depression in particular, came the application of a range of treatments for adolescent problems and disorders. This in turn gave rise to a need, from funders and practitioners alike, to demonstrate the efficacy of the interventions. While traditional social science methods were utilised for this purpose, the rise of the field of evaluation brought new vigour to the area of efficacy of psychological treatments. It was this new approach that informed the structure and methodology for the present thesis. The aim of this thesis was to evaluate the William Slater Centre for Adolescents and Young Adults' psychotherapeutic milieu treatment programme. The efficacy of this milieu treatment programme was determined by analysing the following: (i) the structure of the programme; (ii) the process of the programme; and (iii) the short-term outcome of the programme. A combination of qualitative and quantitative methods were used. Results of the evaluation are manifold, with each chapter of the thesis providing insight into varying aspects of the Centre's therapeutic programme. Detailed descriptions of the structure and process of the William Slater Centre and its therapeutic programme is provided. This is followed by an in-depth account of the implementation of the therapeutic programme, where details of the day-to-day functioning of the programme is provided. The final part of the thesis is a brief examination of the short-term outcome of the programme and the staff and adolescent patients' perceptions of the strengths and limitations of the Centre's programme. The thesis provides a comprehensive overview of the structure and functioning of the William Slater Centre and its programme. Emphasis is placed on the concordance of the therapeutic programme with milieu therapy principles. The thesis demonstrates that while the Centre provides an essential service to the adolescent psychiatric population, significant organisational problems of the Centre and the programme require attention.

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INTRODUCTION

Adolescence brings with it a range of significant and challenging situations affecting almost all aspects of an individual. This period of transformation has historically not received much attention, but in recent years considerable research has been conducted in the area of adolescent mental health. This research, demonstrating the psychological morbidity, and at times mortality, associated with the developmental phase of adolescence, has alerted researchers and clinicians to the significance of youth and youth-related problems and disorders. Of the mental health problems associated with youth, depression appears to be the area of most concern. This is primarily a result of the research demonstrating a host of co-morbid factors associated with depression in adolescents.

The increasing recognition of adolescent depressive symptoms and disorders resulted in a need for effective intervention. Few attempts were made at developing treatments tailored for adolescent problems. Instead, the range of psychological treatments used with adults and children were applied to adolescents. However, as with all forms of intervention, came the recurring question of cost-effectiveness and efficacy of interventions and services provided. That intervention is needed in this age group is indisputable. What is important is determining whether the service is efficient and effective. While social science methods provide tools with which to conduct research in this area, the rise of evaluation and more specifically, programme evaluation, offered an opportunity to not only focus on the efficacy of programmes, but also to consider a range of factors which impact on the functioning of programmes. Broadly defined, programme evaluation aims to assist in improving the quality of human services, by determining whether the service is needed, whether the service is offered as planned, and whether the service helps individuals in need at a reasonable cost.

Numerous studies and meta-analyses have been conducted focusing specifically on therapeutic intervention treatment programmes with children and adolescents. However, progress in evaluating treatments for children and more specifically for adolescents has been relatively slow compared to adults. One of the reasons for this is that the evaluation of adolescent depression treatments is complex and inundated with practical, ethical and methodological problems which are not always present in the evaluation of treatments conducted with adults.

The aim of this thesis is to conduct an evaluation of an adolescent psychotherapeutic milieu treatment programme. Prior to outlining the structure of the thesis, a few preliminary comments on this study may provide the reader with an indication of the context in which the evaluation took place. The author worked at the William Slater Centre for Adolescents and Young Adults for a period of three years, in the capacity of a research assistant and for a period of a year as an observer. During this time interaction with the staff and patients led to the author becoming acquainted with the structure and functioning of the William Slater Centre for Adolescents. The proposal for an evaluation of the Centre's programme was met with enormous support and co-operation by the staff, thereby setting the scene for an evaluation with minimal restrictions and resistance.

A comprehensive evaluation of the William Slater Centre and its therapeutic programme is an enormous undertaking, and beyond the scope of this thesis. This study therefore attempts to evaluate the most important aspects of a milieu therapeutic programme, as suggested by Liberman (1983), namely, the structure, the process and the outcome of the programme.

Chapter one provides an outline of adolescence and the implications of this developmental period. The case will be presented that the period of adolescence is a significant one requiring attention. The chapter highlights the debates around adolescent symptoms and disorders and concludes with the notion that adolescent mental health and more specifically adolescent depression has, and will continue to, be a priority for

researchers and clinicians. A review of the literature evaluating psychotherapeutic treatments is provided in Chapter two. This chapter sets the scene for the thesis in that it outlines the work conducted and the methodological difficulties and limitations associated with research in the area of mental health, and more specifically with adolescents.

Chapter three provides an overview of the aims and methods utilised in the thesis, elaborating on the suggestions of Liberman (1983). The thesis is broadly divided into three sections: the first focuses on the structure of the William Slater Centre and the therapeutic programme, with emphasis placed on its context and functioning. This is the content of Chapter four.

The second part of the thesis is concerned with the process of the therapeutic programme. This is covered in Chapters five to seven. Chapter five provides profiles of adolescents who were assessed at the Centre, highlighting those adolescents successful in being admitted to the programme. In this manner an attempt is made to provide an indication of the characteristics of adolescents most likely to be treated at the Centre and be admitted to the therapeutic programme. Chapter six is dedicated to a literature review on milieu therapy or therapeutic communities since this therapeutic modality is adopted by the William Slater Centre and forms an integral part of the functioning of the therapeutic programme. The contents of this chapter is referred to throughout the remainder of the thesis. This is followed by a rich, detailed description of the monitoring of the therapeutic programme. This lengthy chapter attempts to convey a sense of the everyday functioning of the Centre and the therapeutic programme. Furthermore, the application of the principles of milieu therapy to the Centre's programme can best be provided through a dense description of the programme.

The third section of the thesis pertains to the short-term outcome of the programme. While an outcome evaluation is not the intention of this thesis, Chapter eight attempts to provide *some* indication of the outcome of the programme. This is achieved through

examining adolescent patients' progress over the period of the therapeutic programme by utilising depression rating scales as measures of outcome. The thesis draws to a close with a brief look at the staff and patients' perceptions of the Centre and its programme. In this manner a comprehensive account of the programme is provided from the perspective of those involved in the programme as well as by the observations made by the author. The thesis concludes with a brief discussion of the central themes arising from the above mentioned chapters.

CHAPTER 1

ADOLESCENT MENTAL HEALTH

The past few decades has seen major advances in the recognition of adolescent mental health problems and disorders. Historically, the focus has been on adults and to a lesser extent children, with few attempts to research adolescent health. This chapter provides a brief review of the literature on the features of adolescence, adolescent mental health, and more specifically adolescent mood disorders. The chapter demonstrates the potential for adolescents to be subjected to serious mental health problems and highlights the concern of adolescent depression and its associated morbidities.

1. AN OVERVIEW OF ADOLESCENT MENTAL HEALTH

Almost all cultures throughout the Western world recognise the developmental period of adolescence. This second decade of human life signifies the transition from childhood to adulthood and is determined by the onset of puberty, which involves biological changes, sexual maturation, hormonal changes, physical growth and skeletal maturation (Philotheo & Rosen, 1995; Steinberg, 1987). The World Health Organisation defines adolescence as between ages 10 and 19, youth as between 15 and 24 years and young people as those between 10 and 24 (Philotheo & Rosen, 1995).

That each phase of human development presents with a range of difficulties and adaptations, is known. Thus, adolescence as a transitional period, fraught with challenging situations, could be perceived as merely one of those phases which individuals have to traverse. However, research in the area of adolescent health has resulted in an awareness of adolescents' increasing inability to deal with the pressures of this developmental period, so much so that adolescent deaths are on the increase.

While numerous psychological theories have attempted to explain the development of the infant and child, only some have extended their theory to include the period of adolescence. Erik Erikson (1963), for example, proposed a series of eight stages of development, adolescence being described as a period of 'Identity versus Role Confusion' and young adulthood as one of 'Intimacy versus Isolation', where the individual begins to deal with issues of identity formation, independence and relationships. Piaget (1970) conceived of adolescence as a period when formal operational thought processes begin to develop, allowing individuals to think in abstract terms. While theories may differ in the emphasis placed on the developmental period of adolescence, there appears to be agreement that adolescence is a time of profound changes, emotional turmoil, mood lability, rebellion, experimentation, the formulation of self-identity, the need for intimacy and independence, changes in eating and sleeping patterns, concentration difficulties, fatigue, irritability, withdrawal, and numerous other changes (Brown & Pedder, 1979; Deykin, Buka, & Zeena, 1992; Petersen, Compas, Brooks-Gunn, Stemmler, Ey, & Grant, 1993).

Although the above-mentioned features of adolescence may be considered normal adolescent behaviour, and in fact are typical features of adolescence, there are levels at which these behaviours interfere with the daily functioning of the adolescent. It is at this juncture that adolescents inability to cope with these behavioural and emotional changes results in serious psychological or psychiatric problems. Furthermore, with the period of adolescence comes exploration and experimentation with eating, smoking, alcohol, drugs and sex which may have lifelong consequences (Philotheo & Rosen, 1995). These risk-taking behaviours, coupled with the exposure of youth to conditions such as violence and abuse, result in adolescents being at risk for mental and physical health.

Research conducted over the past two decades has demonstrated concern about adolescent mental health, although work has lagged behind that of adults and children. Possible reasons for the neglect of adolescent mental health include firstly, that adolescent emotional and behavioural problems were considered to be age- and stage-

specific and therefore likely to pass with time; and secondly, that there were numerous theoretical and methodological problems in the research of adolescents (Kazdin, 1993).

There has been an increased awareness of adolescents in need of mental health care. It has been estimated that 8% to 22% of individuals under the age of 18 meet the diagnostic criteria for a mental disorder in the United States (Institute of Medicine, 1989; Saxe, Cross, & Silverman, 1988), with the latest epidemiological studies estimating that 17,6% to 22% of children aged 6-18 years suffer from some type of mental disorders (Costello, 1989). This implies that approximately 7,5 million children and adolescents suffer from significant mental health problems and could benefit from effective treatment (Kazdin, 1990; Weisz & Weiss, 1993). However, only about a third of these receive some form of mental health treatment (Kovacs & Lohr, 1995). As a result, adolescence has now come to be perceived as a very special period in its own right (Kazdin, 1993).

Adolescent mental health has been a neglected area in South Africa as well. There has been much documentation on the need for primary health care systems aimed at addressing youth problems. However, there is a dearth of research on the emotional or psychological well-being of the adolescent population. A limited number of studies focus on the prevalence of psychiatric disorders, although it is estimated that the incidence among this age group is relatively high and underdiagnosed (Lewin & Williams, 1994). The paucity of research into adolescent health has been highlighted by Flisher, Ziervogel, Chalton, and Robertson (1993), who indicated the high prevalence of several risk-taking behaviours of school-going adolescents in the Cape Peninsula. Furthermore, they comment on the need for further local research into adolescent behaviours, as well as the need for health-promotion and preventative action. While literature abroad has demonstrated that adolescent depression is a major mental health problem which needs to be addressed, no attempts have been made to determine the prevalence of depression in South African adolescents (Lewin & Williams, 1994).

2. ADOLESCENT MOOD DISORDERS

2.1. ADOLESCENT DEPRESSION

Over the past two decades there has been a considerable amount of research in the area of mood disorders in adolescents. More specifically, adolescent depression has received much attention and has been widely documented. Initially the notion of depressive disorders among youth was at the centre of controversy (Garrison, Schluchter, Schoenbach, & Kaplan, 1989) with adolescent depression not being viewed as a specific disorder (Harrington, 1994; Reynolds, 1994). As a result, significant adolescent difficulties such as adolescent depression, have been underidentified or overlooked and therefore not treated. Possible reasons for this include firstly, the myth that clinical levels of depressive symptoms are normal for adolescents which they will outgrow; secondly, adolescent depression being mistaken for other problem behaviours (Reynolds, 1992; Weinberg & Emslie, 1988); thirdly, the internalising, covert nature of depressive symptomatology resulting in underidentification; fourthly, the limited contact and communication by adolescents with parents, teachers and professionals; and finally, the lack of self-referral of adolescents to mental health professionals (Offer & Schonert-Reichl, 1992; Reynolds, 1994).

Depression is now considered to be the major psychiatric disease of the 20th century, affecting 8 million people in North America (Blackman, 1995). Numerous researchers have noted that adolescent depressive disorders are among the most prevalent forms of psychopathology in adolescents. A marked increase in the prevalence of adolescent depression has been found with approximately 1 out of 6 youth in psychiatric settings been diagnosed with a depressive disorder (Reynolds, 1994). In clinical populations, the prevalence of chronic depression has been reported as high as 48% of adolescents (Ryan, Puig-Antich, Ambrosini, Rabinovich, Robinson, Nelson, Iyengar, & Twomey, 1987). Fleming, Boyle, and Offord (1993) report that more than 20% of adolescents in the

general population have emotional problems and one-third of adolescents attending psychiatric clinics suffer from depression.

2.2. ADOLESCENT DEPRESSIVE SYMPTOMS

At present, three approaches to the classification of adolescent depression have been reflected in the literature: depressed mood, depressive syndromes and clinical depression (Petersen et al., 1993). Attempts have been made to clarify the concept of adolescent depression by distinguishing depression as a transient mood from depression as a disorder (Garrison et al., 1989). Depression as a syndrome can be described as a range of symptoms and indicators which are consistent with or covary with depressive mood. When symptoms are of sufficient severity, prevalence and/or duration a 'clinical level' of depression or depressive symptoms exist. A depressive disorder is a constellation of symptoms which fit into a consistent classification scheme. Adolescent depression research has primarily focused on depressive symptoms or syndromes (Reynolds, 1994). Psychiatric disorders that contain depressed mood as a symptom include major depressive disorder, dysthymic disorder, adjustment disorder with depressed mood and cyclothymic disorders (Rabinowich, 1993).

A closer look at the features of adolescent depression reveals that although there are some developmental differences, depressive symptomatology in adolescents involves many of the essential features commonly found in adult depression. The symptoms of depression can be divided into four areas: affective, cognitive, behavioural, and physical. In the affective state, diagnostic signs and risk factors are noted by dysphoric mood, fearfulness, anxiety, inadequacy, anger, guilt, confusion, tiredness, hopelessness and irritability (Weissman, Klerman, Paykel, Prukoff, & Hanson, 1974). Cognitive signs and risk factors include a negative view of the world, the self, and the future; irrational beliefs; recurrent thoughts of helplessness, hopelessness and worthlessness; recurrent thoughts of death or suicide; self-reproach, low self-esteem, indecisiveness, slow thinking; disinterest in activities, people and pleasure; confused thoughts; poor

concentration; and agitation. Behavioural factors include dependence, submissiveness, nonassertiveness, poor communication skills, tearfulness, withdrawal, neglectful appearance, and retarded motor response. Physical symptoms include low energy, weakness, fatigue, sleep disturbance, weight loss or gain, appetite disturbance, indigestion, constipation, diarrhea, nausea, muscle aches and headaches, tension, slowed psychomotor reflexes and sex-drive disturbances (American Psychiatric Association, 1987 in Jensen, 1994).

A feature of adolescent depression is that clear complaints of depression are not always evident. Adolescent depression is often masked and the symptomatology differs to some extent from adult depression. For instance, irritability and social withdrawal are more common in depressed adolescents in comparison with depressed adults (Harrington, 1994). Symptoms of adolescent depression such as hyperphagia and hypersomnia may replace the more common symptoms of loss of appetite and wakefulness. Depressive symptoms common to adolescents who may lack the cognitive ability to articulate their feelings, may manifest as boredom, restlessness and fatigue; aggressive behaviour or withdrawal from parents and friends; promiscuous sexual behaviour; bodily preoccupation; concentration difficulties; suicidal tendencies (Glaser, 1967; Hodgma & McAnamy, 1992; Toolan, 1962); or risk-taking and antisocial behaviours (Lewin & Williams, 1994). These along with denial, substance abuse, rebellion and acting out may be used to mask their depressive feelings (Blackman, 1995; Carlson & Cantwell, 1980; Solnit, 1974; Toolan, 1974; Weiner, 1970).

2.3. CO-MORBIDITY FACTORS

One of the most well-documented facts about adolescent depression is that they often co-occur with other symptoms and disorders. High rates of coexisting psychiatric problems have been found among depressed children and adolescents (Bernstein & Garfinkel, 1986; Puig-Antich, 1982; Rohde, Lewinsohn, & Seeley, 1991). Research has demonstrated strong links between adolescent depression and anxiety disorders, conduct

problems and disorder, relationship difficulties, suicide (Mufson, Moreau, Weissman, Wickramaratne, Martin, & Samoilov, 1994; Petersen et al., 1993), substance abuse (Bukstein, Glancy, & Kaminer, 1992; Stowell & Estroff, 1992), eating disorders, school dropout or difficulties in school performance (Kovacs & Goldston, 1991), antisocial and deviant behaviour (Alessi & Magen, 1988; Kandel & Davies, 1986; Puig-Antich, 1982), and personality disorders (Clarkin, Friedman, Hurt, Corn, & Aronoff, 1984; Yanchyshyn, Kutcher, & Cohen, 1986).

A considerable amount of work has been done in the area of adolescent depression and suicidal behaviour (Berman & Jobes, 1991; De Wilde, Kienhorst, Diekstra, & Wolters, 1993). According to Offer and Schonert-Reichl (1992), the suicide rate for adolescents has increased more than 200% over the last decade. Research shows that depressed mood appears to be a strong predictor of suicidal ideation, implying mortality or significant morbidity (Kandel, Raveis, & Davies, 1991; Lester & Miller, 1990) and this is of particular concern (Reynolds, 1994). Longitudinal studies suggest that major depression in children and adolescents may be a risk factor for subsequent suicide attempts and completed suicide (Kovacs, Goldston, & Gatsonis, 1993; Rao, Weissman, Martin, & Hammond, 1993) although these investigations have not reported the follow-up of these cohorts beyond adolescence. Andrews and Lewinsohn (1992) on the other hand found that approximately 42% of youngsters of a community/school sample who had a history of suicide attempt(s) did not have a history of major depression. Thus, although there appears to be an increasing relationship between suicidal behaviour and depression, no conclusive evidence has been found (Reynolds, 1994).

For some adolescents, the early onset of depression results in serious mental health problems in adulthood. Research has shown continuity between adolescent and adult depression with adolescent depression having a substantial long-term morbidity (Harrington, Fudge, Rutter, Pickles, & Hill, 1990; Kandel & Davies, 1986). Thus, the early recognition of adolescent depression will have significant implications for later morbidity and mortality. Research has also focused on at-risk groups. For example,

studies have found an increased risk for major depression among offspring of parents who have suffered from an affective disorder (Hammen, Burge, Burney, & Adrian, 1990; Warner, Weissman, Fendrich, Wickramaratne, & Moreau, 1992) or who are psychiatric or emotionally disturbed (Maag & Behrens, 1989; Maxwell, 1992) and those who came from dysfunctional homes (Moreau, Mufson, Weissman, & Klerman, 1991). The mental health of adolescents can have long-term health implications and the improvement of the mental health status of the adult population is largely dependent on the improvement of the health status of adolescents.

Research on adolescents has resulted in attempts to validate the diagnosis of adolescent major depression (Fine, Forth, Gilbert, & Haley, 1991; Strober, 1985). Considering the large numbers of adolescents diagnosed with depressive disorders, the co-morbidity of adolescent depression with other risk-taking behaviours and disorders, and the possibility of mortality of adolescents, the need for research specifically related to adolescent depression is clear (Reynolds, 1994). Although research examining the relationship between depression and other problems or disorders is inundated with methodological problems, and conclusions are complex and at times inconcise, depression in adolescence is clearly a major mental health problem which needs to be addressed.

3. INTERVENTIONS FOR ADOLESCENT DEPRESSION

With the recognition of depression and its increasing prevalence, came a need for effective interventions. According to Kazdin (1991), the development and identification of effective treatments for emotional disorders of youth are of critical importance for mental health professions. The treatment of depression in adolescents is a complex task and the success rate for treatment by mental health practitioners is unknown (Reynolds, 1994). Pharmacotherapy and psychotherapy are the two primary modalities used for the treatment of depression in adolescents, both of which have been adapted and developed from work with adults.

3.1. PHARMACOTHERAPY

The area of pharmacotherapy in adolescents is in its early stages, with few well-designed empirical studies on the efficacy of pharmacological treatments for depressed adolescents. Antidepressant medication has been used as a treatment option for depressed children and adolescents and at times used in combination with psychotherapy. According to Reynolds (1994), this is problematic given the lack of evidence about the therapeutic efficacy of pharmacotherapy for depression in youth. In comparison to adult studies on the efficacy of antidepressant medications, the few pharmacological studies with adolescents do not show similar support for their effectiveness (Moreau et al., 1991; Puig-Antich, Perel, Lupatkin, Chambers, Tabrizi, King, Goetz, Davies, & Stiller, 1987; Reynolds, 1994; Ryan, 1990). In the most severe forms of depressive disorders, medication is not helpful in repairing social functioning in mood-disordered adolescents (Rabinowich, 1993). This may be a result of methodological problems such as small sample size, diagnostic variability or the biological uniqueness of adolescents (Campbell & Spencer, 1988). However, even studies which have addressed these methodological deficiencies have failed to demonstrate statistically significant differences between antidepressant medication and placebo (Moreau et al., 1991). Garland and Weiss (1995) comment that the lack of positive responses to antidepressant treatments may be a result of the more mild, situational depressions of older adolescents not responding to antidepressants because they respond equally well to placebo. They refer to the work of Ambrosini, Bianchi, Rabinovich, and Elia (1993) who found that almost 50% of child and adolescent depression may be placebo responsive. What is clear from these studies is that considerably more work is required in the area of pharmacological treatment of depressed adolescents.

3.2. PSYCHOTHERAPY

No standardised definition of psychotherapy exist, since a range of therapeutic interventions such as individual, group, family, insight-oriented, behavioural, and

cognitive therapies must be accommodated. Kazdin (1991) nevertheless broadly defines psychotherapy as an intervention designed to decrease distress, psychological symptoms and maladaptive behaviour or to improve adaptive and prosocial functioning through the use of interpersonal sources of influence such as learning, persuasion, counselling and discussion, integrated into a specific treatment plan. The focus is on considering how individuals feel (affective), think (cognitive) and act (behaviour).

Although psychotherapy is complex when dealing with a range of psychological problems (Truant & Lohrenz, 1993) and more so when dealing with adolescents, where psychotherapy is often seen as more challenging and less fulfilling than work with adults or children (Biever, McKenzie, Wales-North, & Cortéz González, 1995), psychotherapeutic treatments have an important place in the treatment of depressive disorders in adolescents (Rabinowich, 1993). Numerous forms of psychotherapeutic treatments exist for adolescents, a large proportion of which have not been evaluated empirically. These include various forms of individual psychotherapy, group psychotherapy, cognitive-behavioural psychotherapy and numerous others (Weisz & Weiss, 1993).

According to Moreau et al. (1991) there is not one published, controlled clinical trial on the efficacy of any psychotherapy in the treatment of adolescents diagnosed as depressed according to the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R) (American Psychiatric Association, 1987) criteria. Research on both individual psychotherapy for depressed adolescents (Bemporad, 1988; Shaw, 1988) and group therapy for this age group (Azima & Dies, 1989) are rare (Fine et al., 1991). In reviewing past work, Kovacs & Lohr (1995) have noted that there is a dearth of research on psychodynamically oriented (Kazdin, Bass, Ayers, & Rodgers, 1990a) and psychoanalytic therapy (Marans, 1989), while there are numerous studies of behavioural and cognitive therapies. They alert to a study of Barnett, Docherty, and Frommelt (1991) who located merely five studies of traditional psychotherapy published since 1973, while over 100 studies of behavioural and cognitive therapies have been reviewed by Kazdin et

al. (1990a). A more comprehensive review of the literature on a range of psychotherapeutic interventions is provided in the following chapter.

4. CONCLUSION

What this chapter should make clear is the significance of adolescent mental health problems and disorders and in particular, the importance of adolescent mood disorders. Over the past decade, adolescent depressive symptomatology has been researched and the co-morbidity factors associated with mood disorders has been established. Allied to these developments has been a range of treatments for depressed adolescents. However, while therapeutic interventions exist for the alleviation of psychological problems and disorders, the question of efficacy of treatment continues to linger in the minds of researchers, funders and clinicians alike. The question 'Do treatments work?' repeatedly comes to the fore and evidence is sought on the effectiveness of treatments or programmes. The rise of the field of evaluation and more specifically 'programme evaluation' has resulted in increased attempts to address the question of efficacy. This is the subject of the following chapter.

CHAPTER 2

EVALUATION OF PSYCHOTHERAPEUTIC TREATMENTS

This chapter provides an overview of programme evaluation and its application to psychotherapeutic treatments. Difficulties encountered with the evaluation of therapeutic modalities are highlighted and recommendations for the future of psychotherapeutic evaluation research concludes the chapter.

1. AN OVERVIEW OF PROGRAMME EVALUATION

1.1. DEFINITION

At the outset it is important to be cognisant of the distinction between programme evaluation and social science research. Rossi and Freeman (1989) define programme evaluation as the application of social science research methods for assessing the conceptualisation, design, implementation and utility of social intervention and human service programmes. Programme evaluation aims to assist in improving the quality of human services, at determining whether a service is needed, whether it meets the needs of individuals, whether the service is offered as planned, and whether the service assists those in need at a reasonable cost without undesirable side effects (Posavac & Carey, 1992; Sechrest & Figueredo, 1993).

The difference between social science research and programme evaluation lies in the intent and purpose of the investigator. Programme evaluation studies are not designed primarily for testing of hypotheses with methodologically rigorous designs which contribute to general academic knowledge. Instead, programme evaluation studies aim to make value judgements, to inform decision-making, and to contribute towards solving practical problems (Thompson, 1992).

1.2. EVALUATION APPROACHES

A range of models of evaluation have been proposed by theorists and practitioners in the field of programme evaluation. Smith and Glass (1987) identified four main paradigms governing evaluators. The first is the experimental approach which considers evaluation to be synonymous with scientific research. This approach adopts the principles of the experimental design to evaluation questions, with the evaluation methods being primarily quantitative. The strength of this approach lies in its emphasis on objectivity and the generalisability of conclusions. The weakness lies in the difficulty of establishing controlled conditions in the real world. The second paradigm conceives of evaluation as part of systems management, aiding managers in their administration of programmes. Research methods tend to be surveys to determine programme goals, information needs and priorities, and monitoring of programme processes. The evaluation is formative to provide feedback to managers for improving the programme. The third paradigm, that of professional judgement, considers those with the most expertise to be the appropriate people to make judgements about the quality of a programme. Methods include direct observation, interviews and checklists. The assumption is that this review provides objective, reliable and valid judgements. The fourth paradigm is the evaluation-as-politics paradigm, which emphasises that evaluation and politics are inextricably mixed. In designing an evaluation, the evaluator obtains multiple perspectives regarding the programme (Thompson, 1992). Included in this paradigm is the responsive approach where the evaluator strives to answer programme questions from multiple perspectives. This approach employs a predominantly qualitative, naturalistic approach, which Guba and Lincoln (1985) term 'naturalistic inquiry', judged to be the best for evaluating programmes in the social and behavioural sciences (Sarnecky, 1990). The strength of the approach is its sensitivity to multiple viewpoints. The weakness is the inability to establish priorities or simplify information for decision making and that it is not possible to take all perspectives into account.

2. THE EVALUATION OF PSYCHOTHERAPY

In the area of psychological treatments, programme evaluation provided an opportunity to reflect on the numerous forms of available treatments. One of the primary reasons for the evaluation of programmes concerned cost and efficacy issues, to the extent that there was increasing pressure to shorten treatment. Planned short-term psychotherapy is reported to be the treatment of choice in the 1990s in order to ensure efficient, effective quality treatment (Hendren, 1993). Cummings (1993) however warns that the danger of this is that basic concepts common to all psychotherapy may be abandoned in the attempt to obtain quick solutions.

There has been a great deal of reflection on the approaches and methods used by evaluators in collecting evidence and making judgements about psychotherapeutic treatments. For the past four decades, clinicians and researchers have been confronted with the question 'Does psychotherapy work?'. Attempts at answering this question proved problematic as there is no single form of 'psychotherapy' (Kazdin, 1988). The phrasing of the question was therefore considered inappropriate and invalid. Basham (1986) considered the question a limiting and misleading perception of the processes of change which occurs during psychotherapy. Furthermore, the notion of whether treatment 'works' is problematic. The effects of treatment can be evaluated in several ways, with diverse measures and perspectives, for example the reduction of symptoms, improvements in adjustment, increase in self-report happiness, evaluations by relatives and friends, and improvements in physical well-being. Thus, the effectiveness of treatment is dependent on the specific measure one examines (Kazdin, 1991). The next question then is how much change on a measure indicates 'effective' treatment? For example, if an adolescent's depression decreases slightly at the end of a psychotherapeutic treatment should therapy be regarded as effective? There are no clear answers to these questions. However, despite the ambiguities in defining effectiveness and variations among techniques, major advances have been made in the evaluation of psychotherapy (Kazdin, 1990).

The simple, global question 'Does psychotherapy work', was rephrased as a question focusing on the effects of alternative treatments, specific problems and different patient samples. Paul (1967:11) suggested asking 'What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances'. Kendall and Morris (1991) have adopted the same argument, saying that methodologically sound research in child and adolescent therapy must address the specificity of treatment effects and determine what specific therapeutic programme has what effects, for which children with which behaviour disorder, and under which conditions. They assert that researchers should develop clinically relevant theoretical models regarding these interactions which can then be empirically tested. The rephrasing of the question alerts one to the need for greater specificity in evaluating treatments. However, few studies exist for these more specific questions (Kazdin, 1991).

One of the consequences of individual comparative outcome research focusing on particular treatments for specific problems led to the question "Which treatment is best?". This has been criticised for leading to exaggerated claims for success by the proponents of therapies found to be more successful. Furthermore researchers investment in a particular approach may prevent a fair representation of all the therapies being compared (Kazdin, 1983). Moreover, past research has consistently failed to identify the relative superiority of any specific treatment (Berman, Miller, & Massman, 1985) and has led to controversy about the relative effectiveness of treatments for specific clinical problems. Kazdin (1986) attributes this to the manner in which the question (Which is best?) is phrased, as well as the failure to consider special methodological and design requirements.

2.1. LITERATURE REVIEW

The beginning of the growth of literature on the evaluation of psychological treatment of children and adolescents began with the seminal work of Levitt (1957), who found that

clinically referred youth who did not receive psychotherapy performed as well as those who did. The methodological limitations of Levitt's work included confounding variables not taken into account, poor control groups and the use of unreliable or invalid measures (Hendren, 1993). Nevertheless, his work marked the beginning of significant changes in psychotherapy outcome research especially with regard to the nature and focus of the psychotherapies examined, the types of patients treated, and the complexity of the research designs (Kazdin, 1991; Kovacs & Lohr, 1995).

In comparison to the research conducted on adult populations, literature on the evaluation of therapeutic treatments for adolescents is in its early stages. In recent years, however, considerable progress has been made in evaluating treatments for children and adolescents (Kazdin, 1990), to the extent that some consider the evaluation of adolescent treatments as one of the priorities of clinical research in the last decade (Mann & Borduin, 1991). Several of the reviews and meta-analyses of psychotherapy outcome studies have unfortunately not differentiated between children and adolescents (e.g. Kazdin, 1987; Weisz, Weiss, Alicke, & Klotz, 1987). This stems partly from the fact that treatments for children and adults have been applied to adolescents and attempts have only recently been made to design psychotherapy treatments to meet the specific needs of this age group (Mann & Borduin, 1991). One of the few that have focused solely on the adolescent age group include Tramontana (1980) who reviewed 33 studies published between 1967 and 1977 on psychotherapy outcome with adolescents. Although the majority of these studies were methodologically flawed, with only five found to be methodologically sound, there appeared to be support for psychotherapy over no-therapy conditions for adolescents.

In general, individual psychotherapy outcome studies have shown inconsistency with regard to the effectiveness of psychotherapeutic treatments. Some studies have found that psychotherapy has no significant treatment effects while others have challenged this, arguing that a number of well-designed studies exist which demonstrate that treatment is more effective than no treatment for a variety of children and adolescent problems

(Kazdin, 1990). Kovacs and Lohr's (1995) review of research conducted on psychotherapy with children and adolescents over the past 35 years found that psychotherapy is better than no treatment, and that improvement in youth is similar to the treatment gains for adults.

Despite the high prevalence of depression in adolescents and its associated morbidities, and the fact that psychotherapy is widely used by clinicians to treat depressed adolescents, the literature shows little empirical research on the effectiveness of specific treatments for adolescent depressive disorders (Fine et al., 1991; Mufson et al., 1994). In order to rectify the dearth of clinical trials of psychotherapy with depressed adolescents, the Interpersonal Psychotherapy (IPT), a brief treatment specifically developed and tested for depressed adults (Klerman, Weissman, Rounsaville, & Chevron, 1984) was adapted for adolescents and has resulted in a significant decrease in depressive symptoms and improvement in functioning over the course of a 12-week treatment (Mufson et al., 1994). The limitation of this study however is the small sample size, lack of a comparison group, and failure to account for therapist variables. Furthermore, Garland and Weiss (1995) caution that the excellent treatment response in 8 weeks without placebo controls may reflect the natural remission of the disorder.

Barnett, Docherty, & Frommelt's (1991) review of 13 studies comparing individual psychotherapy with other types of treatment such as cognitive, behavioural, group or family psychotherapy found that five of the studies reported other forms of treatment superior to individual psychotherapy while 8 studies found them equivalent. None of the studies found individual psychotherapy superior to another form of treatment. According to Hendren (1993) methodological flaws has resulted in psychotherapy outcome research with adolescents not demonstrating conclusive evidence for the efficacy of individual psychotherapy.

Mann and Borduin (1991) reviewed adolescent psychotherapy outcome studies published from 1978 to 1988 and found that evaluations of individual psychotherapy with

adolescents generally reveal positive short-term outcomes. Cognitive self-instruction training and problem-solving skills training were found superior to no treatment for adolescents with internalising (e.g. depression) and externalising (e.g. delinquency) problems. However, studies comparing these treatment approaches with psychodynamic or cognitive-behavioural forms of treatment have shown inconsistent findings. Their review of studies post-1988 found that individual treatment was better than no treatment for adolescents referred for depression and other problems, while inconsistent findings were found in studies comparing individual treatment approaches with psychodynamic treatments.

Fine et al. (1991) examined the efficacy of two forms of group therapy, namely, structured social skills training and process oriented psychotherapeutic group therapy for depressed adolescents. They found both effective in treating adolescent depression, although adolescents in the psychotherapeutic group had significantly greater reductions in their depressive symptoms than the social skills training group. At the 9-months follow-up period, both groups of adolescents maintained their treatment gains. The limitations of the study include the absence of a control group, the fact that the two treatments were not sufficiently different to allow for comparisons, and that adolescents received concurrent therapy which confounds the study.

Lewinsohn, Clarke, Hops, and Andrews' (1990) study found that subjects in two different group therapy treatment groups improved significantly more on the depressive measures than the waiting-list group, although there were no significant differences between the two active treatments.

Over the past decade there has been considerable research demonstrating the efficacy of behavioural and cognitive treatments for modifying certain disorders in adolescents (Hendren, 1993). Reynolds and Coats (1986) randomly assigned thirty moderately depressed adolescents to either cognitive-behavioural treatment, relaxation training or a wait-list control condition and found that two therapies were equally effective in

reducing depressive symptomatology and were both superior to the waiting-list control. Kahn, Kehle, Jenson, & Clark (1990) examined the efficacy of cognitive-behavioural therapy, relaxation training and a self-modelling condition with a wait-list control group in a moderately depressed adolescent sample and found all three therapy conditions demonstrated significant treatment gains at posttesting and at a 4-week follow-up (Reynolds, 1994).

In recent years, an alternative to the traditional narrative review of literature has been found. It has been considered one of the most efficient and objective means of summarising the findings of various studies (Kazdin, 1990; Weisz & Weiss, 1993). This technique known as meta-analysis (Smith, Glass, & Miller, 1980; Mann, 1990) enables researchers to combine a range of studies and derive conclusions about treatments and their effectiveness (Kazdin, 1990). It allows for the quantitative aggregating of findings of independent studies, providing summary statements about the average effect of psychotherapy across studies, expressed in the form of a mean effect size (Weisz, Weiss, & Donenberg, 1992). Effect size refers to the post-treatment difference between the means of the experimental and control groups on a particular measure (Casey & Berman, 1985; Weisz et al., 1987). One of the limitations of this method is that these studies report only on crude comparisons between treatments, with little attention to other factors such as client characteristics, therapist characteristics and the impact of these (Lipsey, 1988).

Numerous meta-analyses have been conducted on treatment outcomes of children and adolescents, with particular attention to the methodological quality of studies. Casey and Berman (1985) reviewed 75 outcome studies published between 1952 and 1983 in which children (aged 12 and younger) who received psychotherapy were compared with controls or children receiving another form of treatment. They found behavioural interventions resulted in larger effect sizes than nonbehavioural interventions. The average treated child functioned better after treatment than 76% of control group children. A similar finding was reported in a meta-analysis of Weisz et al. (1987), who

demonstrated that behavioural interventions were associated with significantly larger effect sizes than nonbehavioural interventions.

Weisz et al. (1987) who reviewed 105 well-designed outcome studies published between 1952 and 1983 which focused on children aged 4-18 years, found that the average treated child functioned better than 79% of those children not treated. The benefits of the treatment however depended on age, with children benefiting more than adolescents. Shirk and Russell (1992) have argued that these results may be due to differences in the methodological quality of behavioural and nonbehavioural outcome studies. Weiss and Weisz (1995) however found little support for the hypothesis that the superiority of behavioural interventions is due to differences in the methodological quality of studies of behavioural and nonbehavioural treatments. It therefore appears that meta-analyses are resulting in mixed results about the methodological quality of certain studies (Weisz & Weiss, 1993; Weisz et al., 1992).

Kazdin et al. (1990a) surveyed 223 treatment studies published between 1970 and 1988 involving children aged 4-18 years and found that the average treated child was better off after treatment than 81% of the no-treatment group. Weisz, Donenberg, Han, and Kauneckis (1995) reported on preliminary data from a meta-analysis conducted by Weisz, Weiss, Morton, Granger, and Han (1993) on 110 studies published between 1967 and 1991 of children aged 2-18 years and found that after treatment the average treated child was functioning better than 76% of the control group children.

From the meta-analyses examined by Kazdin (1991), it was concluded that psychotherapy appears to be better than no treatment; that the magnitude of the effects are similar to outcome studies with adult samples also (Brown, 1987); that treatment differences tend to favour behavioural rather than nonbehavioural techniques; and that specific individual treatments have not been found to differ from each other.

3. METHODOLOGICAL ISSUES

3.1. METHODOLOGICAL LIMITATIONS OF PSYCHOTHERAPY STUDIES

Most of the studies included in the meta-analyses mentioned above are subject to a potentially important limitation, namely that most of the studies reviewed may have involved conditions and interventions unrepresentative of conventional clinical practice (Weisz et al., 1992). Most studies had features of what is termed *research therapy*, which differs from conventional *clinic therapy* and it is hypothesised that positive findings in psychotherapy evaluation studies have been the result of these differences. Weisz, Donenberg, Han and Kauneckis (1995) provided a range of hypotheses on the reasons why therapy in experiments (research therapy) showed larger effect sizes than therapy in clinics (clinic therapy).

The first hypothesis is that clinic cases are more seriously disturbed, come from more dysfunctional families or are more difficult to treat successfully than those recruited for research therapy. In most clinical practice patients are seriously enough disturbed to be clinic-referred, whereas the controlled experimental studies involve the recruitment of children for the treatment suggesting that some may not have been seriously disturbed. Furthermore, subjects for treatment research are often from schools and the community and are treated with behavioural or cognitive approaches while clinical practice is more likely to involve clinically referred seriously disturbed individuals treated with individual, interpersonal, psychodynamic family-based interventions (Kazdin et al., 1990a). Kazdin et al.'s (1990a) review of 223 studies found that several characteristics of the children and adolescents and methods of treatment delivery differed markedly from clinic practice. Therefore, conclusions from the treatment research to date may have questionable external validity (Hendren, 1993).

Secondly, it has been hypothesised that research therapy is more effective because it is focused mainly on the presenting problems, whereas in clinic populations therapy is

directed at a range of problems. In research therapy, samples are selected for homogeneity with children and adolescents presenting with a similar problem and with one or two focal problems, whereas patients presenting at clinics are often heterogeneous and are referred for multiple problems. This hypothesis that precise problem focus may explain the superior effects of research therapy has however not found support (Weisz et al., 1995).

Related to this is the hypothesis that research therapy is more successful because it involves more specific, focused treatment methods than clinic therapy. Children present with an array of problems and clinic therapists may use a range of therapeutic methods and may adopt an eclectic approach. Research therapists on the other hand are more likely to use a single, focused approach to therapy. Weisz et al. (1995) found support for the possibility that specific, focused treatment may have contributed to the superior outcomes of research therapy.

Fourthly, Weisz et al. (1995) propose that research therapy is more effective because therapists have special training in the methods to be used, prior to the intervention, whereas in clinical practice therapists are unlikely to have recent training in most of the techniques they use and therapy is not confined to a few techniques. However, no support was found for this hypothesis.

Fifthly, it was hypothesised that research therapy is more effective because it is more structured than clinic therapy. In research therapy studies, therapists are often guided by explicit treatment manuals outlining for example the target behaviours or symptoms and the strategies to be adopted (Lewinsohn et al., 1990; Moreau et al., 1991). These manuals facilitate the training of therapists for clinical trials, and reduces variability in treatment delivery (Kovacs & Lohr, 1995). This structure may result in procedures being tailored to the specific needs of children and adolescents. Weisz et al. (1995) found support for this notion that structured therapy is more effective than unstructured approaches and this contributes to the superior effects of research therapy studies.

Other contributing factors resulting in outcomes of research therapy being superior to clinic therapy studies include the fact that research therapy studies have involved behaviour modification and cognitive-behavioural interventions. Although the latter are often used in clinical practice (Kazdin et al., 1990a), individual psychotherapy, psychodynamically oriented therapy, family therapy and eclectic interventions are more extensively used (Kazdin, Siegel, & Bass, 1990b). According to Hibbs (1995), methodologies should be created for these more commonly used treatments.

Although Weisz et al. (1995) hypothesised that there are aspects of the clinic setting that undermines therapy effectiveness, no reliable support for the notion that clinical settings are associated with less beneficial therapy effects than nonclinical settings were found. According to Kazdin (1990), future research needs to evaluate treatments with clinic samples of adolescents in settings where treatment is usually conducted.

Another hypothesis is that the lengths of therapy in research therapy and clinic therapy contributes to different findings. Kazdin et al. (1990a) noted that outcome studies typically involve brief interventions of approximately 8-10 weeks, whereas clinicians surveyed by Kazdin et al. (1990b) reported a mean duration of 27 weeks (Weisz et al., 1995). Hibbs (1995) alerts to the fact that patients with severe psychopathologies may require more than 8-10 sessions and research needs to consider the duration and intensity of treatment. No support, however, was found for a relationship between therapy duration and therapy effect (Weisz et al., 1995).

Finally, Persons (1991) comments on the difference in assessment and intervention procedures in clinical practice of psychotherapy and in psychotherapy outcome studies. In clinical practice, treatments are individualised for each patient, with the treatment plan based on results of a detailed assessment of the patient's problems. Both the assessment and the intervention procedures are determined by the therapist's psychotherapeutic model. In outcome studies, on the other hand, assessments and treatments are

standardised and not theory-driven, with emphasis placed on diagnosis. Furthermore, outcome studies tend to separate assessment and treatment, whereas in psychotherapy, therapists consider assessment and treatment to be linked with a treatment plan determined by the results of the assessment.

Considering the above-mentioned hypotheses, it appears that the next logical step would be to conduct more research on clinic populations. However, clinic-based studies are rare primarily as a result of practical and ethical considerations which prevent random assignment and no-treatment groups. Weisz et al. (1995) conducted a search for studies involving treatment of clinic referred youth with therapy conducted by professional clinicians as part of a clinic programme. Only studies including a control group were included. Merely nine studies fit these criteria, of which seven studies were published more than 20 years ago. These findings clearly highlight the need to conduct more research in therapy as practiced in clinics. On the other hand, Weisz et al. (1995) comment that since research therapy studies have demonstrated that therapy may be effective under certain conditions, it may well be necessary to identify these conditions which may account for the superior effects of research therapy over clinic therapy. They conclude that should support for their hypotheses be demonstrated, there may be a move towards a reconsideration of how clinic treatment is conducted.

3.2. FURTHER METHODOLOGICAL DIFFICULTIES WITH PSYCHOTHERAPY RESEARCH

The evaluation of psychotherapeutic interventions presents the clinician and researcher with a range of obstacles, many of which determine the design and nature of the evaluation. Firstly, as mentioned earlier, psychotherapy treatments are difficult to define and operationalise. With 230 different forms of therapy in use for children and adolescents alone (Kazdin, 1988), a large number of small scale studies have been conducted on non-standardised and non-comparable populations (Margison & McGrath, 1989).

Secondly, the use of control groups and random assignment have been fundamental and persistent methodological problems in experimental research on psychotherapy and behaviour change (Weisz et al., 1992). Researchers believe that there is a need for research to implement random assignment (Kendall & Morris, 1991) and utilise comparison groups (Fitz-Gibbon & Morris, 1987), since without one there is difficulty in determining how convincing results are, whether they would have been as good with some other programme or whether the programme had any effect on the patients. Previous work conducted by Smith et al. (1980) and Shapiro and Shapiro (1982) which demonstrated the efficacy of a range of psychological treatments, were challenged by those who believe that placebo controls are required to show treatment effects (Prioleau, Murdock, & Brody, 1983). However, researchers such as Parloff (1986) and Basham (1986) have questioned the assumption that control groups are necessary to determine efficacy of psychological treatments. They argue that placebo control studies cannot act as unique or critical tests of whether a treatment works.

Psychotherapy outcome studies are increasingly being criticised on ethical grounds, through depriving patients treatment, and on practical grounds, when keeping patients away from other interventions (Bashman, 1986). Random assignment of clients to no-treatment control conditions is rarely possible and therefore as mentioned earlier, comparisons of treatment and control groups are seldom possible in clinic settings. Even when considering quasi-random assignment where individuals are assigned to a waiting-list control group, this group may not be truly random since adolescents with serious problems receive priority or it is not possible to withhold treatment for long periods of time merely to match treated cases (Weisz et al., 1992). Furthermore, waiting list controls have initial contact and in psychotherapy these initial contacts may contaminate controls for the initial evaluations of treatment. Patients on their initial contact may have expectations for treatment from their first contact and this may blur the specific treatment effects. To address this problem, some have argued that the use of children and

adolescents who begin treatment but fail to continue may be an acceptable control group for outcome research (Weisz & Weiss, 1989).

Further difficulties with psychotherapy research is that large samples are needed to obtain sufficient power to detect differences between treatments and generalising to clinical populations is difficult (Margison & McGrath, 1989).

Kazdin (1995) argues that the ways in which child and adolescent dysfunction, treatment techniques and variables for investigation have been conceptualised and evaluated have limited our knowledge of the impact of how it operates. Furthermore, researchers have sampled relatively few of the many techniques in use. Kazdin concludes that there is a need to gain an understanding of the processes involved in therapeutic treatments and how they lead to improvements in affect, cognition and behaviour, since this understanding can assist in determining the specific intervention strategies and procedures which result in change.

3.3. METHODOLOGICAL LIMITATIONS OF ADOLESCENT PSYCHOTHERAPY RESEARCH

Hendren (1993) notes that there are several characteristics of adolescents and children which affect outcome. Firstly, developmental issues must be considered in psychotherapy studies with youth (e.g. Barbanel, 1982; DiGiuseppe, 1981). Previously studies included age groups of 6-18, thus not taking cognizance of the developmental gap in cognitive, emotional and social abilities between these ages. It is essential to classify children and adolescents by developmental level of functioning rather than chronological age and develop appropriate treatments (Hibbs, 1995). Yet, few studies have taken developmental issues into consideration (Kovacs & Lohr, 1995).

Secondly, in comparison to adults, the family and the environment play a much more significant role in the outcome of certain disorders in youth. Kazdin (1991) notes that

adolescents are influenced by the contexts in which they live; parent and family functioning and living circumstances and these variables play a significant role in treatment outcome and must therefore be evaluated. Furthermore, adolescents often have multiple stressors (behaviour, family, biological, school) and the goal of treatment would be to intervene at these different levels (Hibbs, 1995).

The third difficulty with the evaluation of adolescent psychotherapeutic treatments concerns the co-morbidity of adolescent depression with other disorders. Adolescents may often meet criteria for more than one disorder, for example depression and anxiety and co-morbidity have important methodological implications for evaluating treatment. Although treatment is usually provided for the most prevalent dysfunction (Kazdin, 1990), co-morbid diagnoses can lead to problems in attempts to obtain homogeneous samples (Kendall & Morris, 1991). It is therefore suggested that future research subdivide samples on the basis of the presence or absence of other disorders and that methodologies be developed to adapt to clinical practice where the individual is treated holistically and clinicians attempt to address all areas of pathology and dysfunction (Hibbs, 1995).

Another methodological difficulty pertaining specifically to adolescents concerns the identification of clinical dysfunction. Kazdin (1990) notes that terms such as 'emotionally disturbed', 'impulsive', 'socially withdrawn' need to be replaced either by standard diagnostic criteria and assessment tools or by careful documentation and operationalisation of criteria, with specifications of the severity, duration and scope of dysfunction.

Although not limited to adolescent treatment research, predictor variables, such as patient and family variables, therapist and therapy variables are important to consider and have been neglected in numerous psychotherapy treatment research (Kazdin et al., 1990a). Studies on adolescent depression have been problematic in terms of design as a result of a failure to account for the importance of individual variables (Reynolds, 1994). Ideally

the following should be considered in the evaluation of therapeutic modalities: the patient and the presenting problem/pretreatment level of prosocial functioning; the therapist and his/her personal style and techniques, the passage of time (Kiesler, 1971), the psychosocial context of therapy (Kolvin, Garside, Nicol, Macmillan, Wolstenholme, & Leitch, 1981) and the goals. Adolescents' developmental level, the characteristics of the family and social context, and the processes of intervention and goals are important to consider (Callias, 1992). There is evidence to suggest that treatment response in studies of children and adolescents are affected by parental and family dysfunction (Kazdin, 1991). A positive relationship between patient and therapist has been considered essential for successful treatment and this relationship is essential to treatment outcome (Barbanel, 1982). Therapist experience and style have been shown to effect therapeutic outcome with adults, but there are limited studies to support this among adolescents (Shaffer, 1984). Personality characteristics such as maturity, verbal ability and motivation have been found to show better results (Hendren, 1993).

In conclusion, it appears that numerous methodological challenges face the researcher and clinician wishing to embark on the evaluation of psychotherapeutic treatments. While some are of the opinion that research into the efficacy of psychotherapeutic treatments needs to improve methodologically (Mann & Borduin, 1991) and that methodological flaws prevent one from drawing conclusions about efficacy (Barnett et al., 1991), others feel that significant advances have been made methodologically in psychotherapy research over the past 35 years (Kovacs & Lohr, 1995). Lipsey and Wilson (1993) comment that it is distressing that the results of psychotherapy treatment research have not shown support for psychological and other treatments. Their review of 302 treatment studies found that well-developed treatments generally have positive effects on the outcome variables and they believe that this positive finding holds despite the possible methodological problems such as weak research designs and small sample studies. They are of the opinion that psychological treatment is effective and thus argue for the focus to be placed on how treatments work or how they can be adapted to work better.

4. FUTURE RESEARCH IN THE EVALUATION OF PSYCHOTHERAPEUTIC TREATMENTS

There appears to be a move towards the combination of treatment modalities with a recognition that individual therapeutic techniques may not be effective in treating adolescents presenting with a range of problems (Kazdin, 1990). The inclusion of a diversity of therapeutic components allows for a broad-spectrum approach to the treatment of depressive symptoms. In terms of evaluation this is problematic since it may not be clear which component of the combined therapeutic intervention was critical for change. Thus, once the efficacy of combined treatments has been determined, research needs to isolate treatment components most associated with clinic change (Kazdin, 1990; Reynolds, 1994). Lipsey and Wilson (1993) are also of the opinion that future research of treatment effectiveness should be focused on which treatment variants are most effective, as well as the characteristics of patients, therapists and the settings that influence the results.

Secondly, in relation to the above, Kazdin (1990) propounds that an important indicator for treatment evaluation should be the assessment of the effects of treatment on prosocial functioning (i.e. the presence of positive adaptive behaviours such as participation in activities and social interaction). While treatments may appear effective in reducing symptoms they may vary in the extent to which they promote and develop prosocial behaviours.

Thirdly, Kazdin (1990) highlights the need for future research to incorporate measures which determine whether treatment effects are of clinical or practical significance, rather than merely of statistical significance. Examples of measures of clinical significance include the extent to which treatment returns patients to their normal levels of functioning, the degree to which improvement in patients is perceived by significant others, and the elimination of the presenting problems.

There is a growing number of authors who point out the benefits of developing strong linkages between theory, intervention design, and programme evaluation, with emphasis being placed on the use of theory in the design, evaluation and modification of programmes (Chen, 1990; Chen & Rossi, 1980; Cook, Leviton, & Shadish, 1985; Lipsey, 1990; Sechrest, West, Phillips, Redner, & Yeaton, 1979). Some have proposed models in which theory and knowledge about mental health problems guide the development of interventions (Cowen, 1982; Lorion, 1983; 1985; Lorion, Price, & Eaton, 1989; Price, 1985). In this manner, the evaluation of interventions, in turn inform knowledge about psychosocial processes. However, despite these calls for theory-based programmes and evaluations, the literature on theory-guided interventions is sparse (Sandler, West, Baca, Pillow, Gersten, Rogosch, Virdin, Beals, Reynolds, Kallgren, Tein, Kriege, Cole, & Ramirez, 1992).

Finally, there appears to be an increasing call for future researchers to collaborate with clinical practitioners. Historically, clinicians have argued that psychotherapy research is of little use to them. Weisz et al. (1992) and Thompson (1992) however disagree, commenting that there is a need for collaboration amongst researchers, practitioners and policy makers, particularly in the health promotion field and that psychotherapy research may have considerable relevance to clinicians and vice versa (Weisz et al., 1992).

5. CONCLUSION

What has been made evident from this chapter is the growing recognition of the need for evaluation practices within the psychotherapeutic domain. The review of the literature demonstrates the increasing attempts to evaluate psychotherapeutic treatments and the methodological difficulties allied to these endeavours. The chapter concludes with a summary of Kazdin's (1990) recommendations for future research involving the evaluation of psychotherapeutic treatments or programmes. Having provided some background to the significant advances made in the area of adolescent mental health and programme evaluation, and the role of the latter in determining the efficacy of

psychotherapeutic treatments, the stage has been set for the core part of the thesis, namely, the evaluation of an adolescent psychotherapeutic treatment programme.

CHAPTER 3
**AN EVALUATION OF THE PSYCHOTHERAPEUTIC MILIEU
TREATMENT PROGRAMME OF THE WILLIAM SLATER
CENTRE FOR ADOLESCENTS AND YOUNG ADULTS**

1. INTRODUCTION

Chapter 1 provided an overview of the rise of adolescent mental health issues, and in particular highlighted the significance attributed to adolescent depressive problems and disorders. A review of the literature in Chapter 2 demonstrated the attempts made at providing interventions for emotionally disturbed adolescents and at determining the efficacy of interventions. Evaluation practices have proved particularly popular and useful for the latter. However, as with all forms of research, complex methodological limitations and challenges are presented. This is particularly the case for the evaluation of psychotherapeutic modalities, and even more so for adolescent psychotherapeutic treatments. Despite the methodological and practical problems, increasing pressure is being placed on the need to determine the efficacy of psychological interventions. In South Africa, where mental health resources are limited, it could be argued that substantially more emphasis should be placed on the evaluation of existing resources, so as to ensure maximal efficacy.

2. AIMS

This thesis attempts to evaluate one of the psychotherapeutic resources in Cape Town, namely the William Slater Centre for Adolescents and Young Adults (referred to throughout the remainder of the thesis as either the William Slater Centre or merely the Centre). Logistically, a thorough evaluation of all aspects of the William Slater Centre and its therapeutic programme is beyond the scope of this thesis. Instead, an attempt is

made to conduct an evaluation which provides a fairly comprehensive overview of the Centre and its functioning.

The guidelines provided by Liberman (1983) and Ellsworth (1983) on adopting a multi-dimensional approach for evaluating the efficacy of psychiatric milieu treatment programmes, largely influenced the structure of the present evaluation. These authors suggest evaluating three aspects of a milieu therapeutic programme: (i) the structure of the programme; (ii) the process of the programme; and (iii) the outcome of the programme. This structure formed the basis for the evaluation of the William Slater Centre for Adolescents.

2.1. PROGRAMME STRUCTURE

The central question to be addressed is:

What is the structure of the William Slater Centre and its therapeutic programme and how does the Centre function organisationally?

This aim serves as a logical starting point for the evaluation of the William Slater Centre, since it is only by obtaining a description of the Centre and its programme that one can proceed to evaluate its content (i.e. the therapeutic programme). A description not only allows one to become acquainted with the context of the programme, but also enables one to determine whether the programme is functioning in an environment conducive to therapeutic treatment. In addition, the description may highlight essential features of the structure or organisational functioning which are central to the intervention programme. The significance of the latter point will become evident in later chapters.

The evaluation of the structure of the programme involves a description of the physical characteristics of the treatment programme, and the administrative components and practices. Factors such as the floor plan, organisational chart, characteristics of staff, the

proportion of funds spent on services, and the schedule of activities reflect programme structure (Lieberman, 1983).

2.2. PROGRAMME PROCESS

There are three questions pertaining to the evaluation of the process of the William Slater Centre's therapeutic programme:

- (i) *What is the profile of adolescents admitted to the therapeutic programme?*
- (ii) *What is the theory on which the programme is based?*
- (iii) *Is the therapeutic programme implemented as planned?*

The first aim pertains to providing descriptive statistics of the adolescents assessed at the William Slater Centre, focusing on variables such as demographic factors and diagnoses. Profiles of the adolescents admitted to the therapeutic programme enables one to determine the characteristics of adolescents which are deemed appropriate and necessary for admission to the Centre's therapeutic programme. According to Lipsey (1993), without clear indications of the problem that the treatment is expected to remedy and the target population, treatment effectiveness research has considerable potential for misrepresentation. It is important to specify the symptoms or indicators which identify the population for whom treatment is appropriate.

The second research question pertains to determining the treatment theory on which the treatment programme is based. Chen and Rossi (1989) and Lipsey (1990, 1993) have highlighted the importance of programme or treatment theory when conducting evaluations. Treatment theory is a set of propositions regarding what goes on in the black box, that is, the specific treatment processes. In other words, it is how a bad situation is transformed into a better one through the treatment. The present evaluation aims to determine the treatment theory as well as the extent to which the elements of theory are effectively operationalised and implemented. This would alert to whether the

programme has attempted to achieve its goals. The third research question addresses this in more detail.

The third aim forms an integral part of the evaluation. Monitoring the implementation of the Centre's programme involves providing a description of the actual state of the programme and enables one to determine whether the programme was implemented as planned. Determining whether treatment is carried out as intended has been termed 'treatment integrity' (Yeaton & Sechrest, 1981). In the present evaluation, the aim was to document the activities of the programme and compare the latter to the philosophy underlying the treatment programme. According to King, Lyons Morris, and Fitz-Gibbon (1987), assessing the implementation of a theory-based programme involves determining the extent to which activities or organisational arrangements reflect the theory. Ideally, if the theory is correct, goals should be obtainable.

One may well ask, what concerning oneself with the way in which a programme operates would benefit one in evaluating a programme? Weiss (1991) highlights one of the reasons for this, commenting that the outcome of how a programme is experienced is perhaps more useful than determining the extent to which the programme failed to achieve its goals, since these findings can assist in modifying the design of the programme. Unless sufficient detail is provided about the process of programmes, the knowledge that some unknown thing is effective is not useful. In recent years, considerably more emphasis has been placed on determining the ways in which programmes operate (Weiss, 1991). However, it is important not to disregard the importance of outcome evaluations, since merely focusing on the process and failing to determine whether the treatment works is similarly not useful. Thus, a balance between outcome and process evaluation is ideal. This leads to the final part of the thesis, namely, programme outcome.

2.3. PROGRAMME OUTCOME

The central question to be addressed is:

Is the programme effective?

The present evaluation aimed to determine the short-term outcome of the therapeutic programme, focusing on improvement of one variable, namely depression. It is important to stress that the intention is not to perform an outcome evaluation. Instead, an attempt is merely made to obtain *some* indication of the outcome of the programme.

Finally, although not directly related to the outcome of the programme, an attempt was made to obtain data on the process and outcome of the programme from the programme participants and the staff members who were integrally involved in the Centre's therapeutic programme.

Prior to discussing the methodological orientation of the present evaluation, a comment about what the study does not aim to accomplish is perhaps in order at this point. Although a thorough description of the therapeutic programme is provided, no attempt is made to determine how the different parts of the programme affect the programme recipients or result in the desired final outcome. The author is merely taking a peek into the 'black box' without attempting to make any causal linkages.

3. METHODOLOGICAL ORIENTATION

The methodological approach for the evaluation was based on the research questions outlined above, as well as on the context in which the study was conducted. Contextual factors concerned the therapeutic setting which implied that a strict experimental design was not be feasible as a result of ethical and practical constraints. Practical problems include the difficulties in deciding which characteristics of individuals to consider in

'matching' controls to experimental subjects. Ethical problems relate to the complexity of having control or placebo groups which imply the withholding of treatment from ill individuals in need of intervention.

With the overall aim of the evaluation being to conduct both a process and outcome evaluation, and considering the context of the research, the integration of qualitative and quantitative methods, were deemed appropriate. The methods utilised for the three research areas and their strengths and limitations are briefly outlined below and are referred to in the relevant chapters of the thesis.

Programme structure: Qualitative methods which lend themselves to descriptive data were considered appropriate for the description of the context and organisational functioning of the William Slater Centre and its therapeutic programme. Methods used included observations, semi-structured and informal interviews, the examination of documents, and semi-structured questionnaires.

Programme process: Qualitative methods are considered more appropriate for determining the process of treatment (Frankel, 1982). They provide a wealth of data through careful description of the programme and the process of treatment (Patton, 1987). Formal methods (systematic observation, questionnaires, interviews, documents) were selected for the monitoring of the programme until a thorough description of the events and interpretation of them was possible. Informal gathering methods (casual observations and conversations) were also used.

Programme outcome: Primarily quantitative methods were used to measure programme outcome by way of analysing self-report measures. Qualitative analyses were conducted on the open-ended, semi-structured questionnaires administered to the programme recipients and the staff at the William Slater Centre.

3.1. STRENGTHS AND LIMITATIONS OF METHODS

Observation: Researchers of psychiatric milieus have used observation and fieldwork to gain an understanding of the therapeutic nature of a treatment environment (Lieberman, 1983). The advantage of observations is that they can be highly credible when seen as an accurate description of programme characteristics. Furthermore, although observation is the least standardised of all social science methods, this method can determine the positive and negative features of programmes (Frankel, 1982). The disadvantage is that time is needed firstly, to train observers if the observation is highly prescribed and secondly, to conduct sufficient numbers of observations. Another disadvantage is that the presence of observers may alter what takes place, although some have suggested that behaviour may be little affected by observers (King et al., 1987; Webb, Campbell, Schwartz, Sechrest, & Grove, 1981).

Interviews: According to Jayawickramarajah (1992), observation combined with interviewing allows for a holistic interpretation of the programme. King et al. (1987) and Fetterman (1989) are also of the opinion that information from various sources provides evidence to verify the accuracy of observations, and interviews have the potential to place into context the observations of the evaluator. These methods can be of value in understanding effectiveness and worth of programmes. Nondirective or open-ended interview questions encourage spontaneity and allows interviewees to provide interpretations without preconceived ideas of the interviewer. Furthermore, the interviewer is provided with an indication of those issues which are of importance to the interviewee (Fetterman, 1991). Much evaluation research relies on interviews to collect information about programme participants and staff members (Weiss, 1972). The limitation of interviews is that they can be time-consuming.

Documents: Analysis of data from records yields credible information because it accumulates evidence of programme events at the time of occurrence rather than in retrospect. Records are often viewed as objective and therefore credible. However,

problems may be experienced with the quality and completeness of data. Extracting data may be time-consuming and ethical or legal constraints may prohibit examination of certain records (King et al., 1987).

Questionnaires: The strengths of questionnaires are that they can be anonymous; uniformity of information can be imposed; information on a variety of issues from a large group of people can be obtained, and respondents are able to put thought into their responses. The disadvantages include that they are not as flexible as interviews; the completion and return rates of questionnaires may be problematic; and individuals may be better able to express themselves orally (King et al., 1987).

Self-report instruments: In the present evaluation, self-report and clinician rater reports of depressive symptoms were utilised to determine the progress of patients admitted onto the programme. Further details of these self-report and clinician-rater measures are provided in Chapter 8.

4. CONCLUSION

This chapter provided an outline of the aims, objectives and research methods for the evaluation research undertaken. What should be clear is the structure of the thesis and the way in which the broad question of the evaluation of the therapeutic programme is conceptualised and approached. Thus, what remains is the core part of the thesis, namely, the evaluation of the William Slater Centre for Adolescents and Young Adults.

PROGRAMME STRUCTURE

<p style="text-align: center;">CHAPTER 4</p> <p style="text-align: center;">A DESCRIPTION OF THE WILLIAM SLATER CENTRE FOR ADOLESCENTS AND ITS THERAPEUTIC PROGRAMME</p>
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1. INTRODUCTION

According to Posavac and Carey (1992), the most basic form of programme evaluation is an examination of the programme itself. They highlight the importance of programme and context description, noting that the planning of an evaluation is enhanced by a thorough description of the context and functioning of a programme. Furthermore, an accurate description of a programme is likely to result in problem areas becoming apparent in the initial stages of the evaluation, rather than later in the evaluation process.

This chapter provides a fairly comprehensive description of the William Slater Centre and its therapeutic programme in an attempt to outline the structure of the programme. This allows the reader to become acquainted with the context of the programme and the Centre and provides an indication of its organisational functioning. Furthermore, it enables one to determine the structural features needed for the treatment programme described, and highlights problematic areas requiring attention. The aim of this chapter is to provide an overview of the therapeutic programme and its functioning within the William Slater Centre, in order to set the scene for the remainder of the evaluation. The reader is therefore, on numerous occasions, referred to later chapters of the thesis, where more detailed descriptions and analyses are conducted.

2. THE WILLIAM SLATER CENTRE FOR ADOLESCENTS

2.1. HISTORICAL EVOLUTION OF THE WILLIAM SLATER CENTRE AND THE THERAPEUTIC PROGRAMME

In 1959, Dr William Slater donated what is now known as the William Slater Centre for Adolescents, to Groote Schuur Hospital (GSH), to be administered by the Cape Provincial Administration (CPA). Dr Slater was the secretary of the CPA and also served on the advisory board of the William Slater Hospital. The hospital functioned as an alcoholic treatment centre for both in- and outpatients. In April 1991, with the integration of services within the hospital system, the William Slater Hospital ceased to operate as an alcoholic centre. On 5 April 1991, Avalon Treatment Centre in Athlone, catering chiefly for black patients and the Psychiatric Day Hospital, a psychiatric unit of Groote Schuur Hospital, known as R11, catering principally for white patients, amalgamated to form the William Slater Centre for Adolescents and Young Adults (Roth & Swartz, 1992). With the integration of services, patients from R11, and the psychiatric patients from Avalon Centre were referred to the newly established adolescent unit, the William Slater Centre. All alcohol abusers were treated at Avalon Centre. The consultant-in-charge of R11 became the consultant of the William Slater Centre. Staff of R11 and the Avalon psychiatric department set up a working committee to facilitate the integration of the two units. This committee adapted the previous milieu therapy programmes of R11 and Avalon, for the William Slater Centre, which was opened in April 1991. The William Slater Centre is a satellite unit of Groote Schuur Hospital and also forms part of the Department of Psychiatry, University of Cape Town Medical School.

2.2. THE LOCATION OF THE WILLIAM SLATER CENTRE

The William Slater Centre is situated on the corner of Park and Milner Road, Rondebosch, an upper middle class area. It is a fairly large building, resembling an old

Victorian home, surrounded by spacious lawn and gardens. The building does not show any exterior or interior characteristics that could allow for its identification as a psychiatric unit. The ground level comprises a reception area, a comfortable, lounge-like waiting room, a large fully-equipped kitchen, a dining and lounge area for the patients, and a long passage with numerous small offices situated on either side for the trainee therapists and staff. The patients' dining and lounge area is equipped with a pool table, a compact disc player, a book cabinet and comfortable, padded chairs. Bulletin boards display the programme's activities, duties of patients and other relevant information. The walls are decked with numerous farewell cards of discharged patients as well as photographs of previous camping expeditions. Bathrooms and a clinic room, equipped with basic medical equipment and medication, is also situated on the ground floor.

The first floor comprises the offices of the consultant-in-charge and two psychologists, three research rooms, two group therapy rooms with observation rooms (equipped with one-way mirrors and a sound system and a video camera in one of the rooms), a spacious tea room, three bathrooms and one vacant room. A crow's nest is situated one floor up, where two rooms and a bathroom are situated. Ancillary buildings not adjoining the main building include a large hall-like building called the Occupational Therapy room, two small rooms utilised by the gardening and cleaning staff and a garage which houses a GSH owned vehicle. There is a considerable amount of parking space around the building.

In general, the Centre is attractively decorated and furnished and has been upgraded and refurbished over the five years of its existence as an adolescent centre. Three rooms have well-polished, treated wooden floors, while a large part of the remaining building is carpeted. The Centre houses a range of fairly modern equipment such as a telephone system, fax machine, photocopier, video recorders, television sets, personal computers and printers. All the equipment is utilised with the exception of a fixed video camera situated in one of the group therapy rooms. Judging from mental health personnel

visiting the Centre, it is well-furnished and maintained for mental health hospital standards. The initial impression of the atmosphere of the Centre is that it is informal and relaxed. From the arrival of patients in the morning, between sessions and at the end of the day, a range of contemporary music is played (often at high volumes), with rare objections from staff members. Attire of both staff and patients is casual, with formal wear (especially ties and white coats) discouraged. The majority of staff members are outspoken and freely intermingle with patients. All staff members are called on their first names.

2.3. PERSONNEL

The personnel of the William Slater Centre comprises a multi-disciplinary team of mental health professionals, post-graduate trainees, voluntary facilitators, research staff, administrative staff and cleaning staff. Permanent staff include a psychiatrist who is the consultant-in-charge of the Centre, one full-time and one part-time psychologist, one social worker, and six psychiatric nurses. The majority of staff members are middle-aged (the oldest being in the early fifties) and have on average five to six years experience in working with adolescents and within therapeutic treatment programmes. With regard to qualifications, the psychiatrist holds a specialist degree in psychiatry as well as a few diplomas. The clinical psychologists hold Masters degrees in clinical psychology and the social worker holds an Honours degree in social work. All the nurses hold diplomas in psychiatric nursing.

A range of post-graduate trainees receive education, training and supervision for varying lengths of time at the Centre. Two psychiatry registrars (who are in one of their four years of training as a psychiatrist) rotate through the Centre every six months. One clinical psychology intern (in the second year of training as a clinical psychologist) rotates through the Centre every four months. At the time of the evaluation, trainees included two psychiatry registrars, one clinical psychology intern and one Masters social work intern. At varying times and for varying lengths of time, Masters social work interns, 5th

year medical students, educational psychology interns, and psychiatric nursing students may be trained at the Centre.

Research staff include three full-time Honours and Masters level psychology graduates, one part-time research psychology graduate and one voluntary observer. The administrative staff include a receptionist and a typist, while the cleaning staff include four cleaners and one gardener.

Voluntary facilitators, from commercial and other organisations (e.g. insurance companies, family planning clinics), assist with the education and recreation of patients. Sessions are facilitated weekly or fortnightly and include areas such as drama, family planning, sex education, sports, careers, life-skills and recreation.

A more detailed description of the organisational structure and functioning of staff is provided in further chapters.

3. THE THERAPEUTIC PROGRAMME OF THE WILLIAM SLATER CENTRE

3.1. HISTORY OF THE PROGRAMME

The Psychiatric Day Hospital (R11), which catered primarily for adolescents and young adults, and the Avalon Treatment Centre, treating primarily alcoholic and psychiatric patients, both functioned as day patient psychotherapeutic milieu treatment hospitals (Roth & Swartz, 1992). With the integration of services, the psychotherapeutic milieu therapy programmes already in place of R11 and the Avalon Treatment Centre, were adapted for the William Slater Centre. Initially, this programme was not designed specifically for adolescents and catered for all age groups. As the programme progressed, staff at the Centre observed that increasingly younger age groups were being referred and the programme was no longer age appropriate. This, in conjunction with the

lack of youth services, resulted in age criteria being changed to cater only for adolescents and young adults. The structure and functioning of the programme was gradually adapted to the needs of this age group and thus the therapeutic programme evolved, rather than being specifically designed. The programme was reviewed annually, and as with all new programmes, underwent several adaptations. Since 1994, however, the therapeutic programme has been fairly consistent in its functioning.

Very briefly, the present therapeutic programme is aimed at treating adolescents and young adults between the ages of 14 to 25 inclusive, presenting with any of the following psychological, emotional and/or behavioural problems: depression, anxiety, suicidal tendencies/attempts, difficulties with interpersonal relationships, adjustment problems, sexual abuse, physical abuse, eating disorders, school refusal, academic or vocational underachievement, acting out behaviour, and poor peer relationships. The two broad, interrelated goals of the programme are to achieve (i) symptom remission from psychiatric diagnoses, and (ii) optimal functioning or well-being in psychological and social domains (prosocial competence; interpersonal skills; ability to cope with stress and adversity).

3.2. THE REFERRAL AND ASSESSMENT PROCESS

Adolescents and young adults are referred to the Centre for assessments by both mental health professionals (e.g. psychologists, psychiatrists, tertiary hospitals) and non-mental health workers (e.g. school teachers, school clinics, social welfare agencies). Research conducted on the profile of referral sources to the Centre demonstrates that adolescents were referred via a number of pathways of which educationists, psychiatric services and social agencies were prominent (Berard, Sennett, & Ahmed, 1997). The referrals are screened telephonically by the psychiatrist, clinical psychologist or other clinical staff members. Those screened out telephonically include individuals with conduct disorders, major behavioural disturbances, recalcitrant substance abuse, or psychotic illnesses. Adolescents' suitability and appropriateness for the psychotherapeutic programme are

based on a full psychiatric evaluation conducted by one of three senior clinicians (psychiatrist or psychologists), and occasionally by the social worker or psychiatric nurses. Adolescents are considered suitable if they adhere to the following criteria:

- that they present with psychological, emotional and/or behavioural problems such as the ones outlined in the Centre's brochure;
- that they do not have psychotic disorders, severe psychiatric disturbances, or actively abuse substances;
- that they are of average, or above, intelligence and motivated to attend the programme. Unilateral decisions regarding suitability of adolescents for the programme are taken by clinicians with minimal consultation with other clinical staff.

At the initial assessment patients are required to complete a battery of depression and anxiety rating scales and self-reports. This is followed by an in-depth individual interview with the patient, and a discussion with the family member(s) or referral agent. On completion of the interview an initial diagnosis is made, in accordance with the DSM-III-R (American Psychiatric Association, 1987) and more recently the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (American Psychiatric Association, 1994), and decisions are taken about the suitability of the patient for the therapeutic programme. A detailed assessment form eliciting information pertaining to demographic details, depressive symptoms, parasuicide details, and substance, and sexual and physical abuse is completed at the end of each assessment and the data is placed on the Centre's database. In determining the suitability of patients for the programme, clinicians ensure that patients are motivated to attend the programme for the 12-week duration and are committed to working at altering their present state. Patients do not attend school, college or university for the duration of their stay at the Centre, and arrangements are made with the relevant school personnel for patients to adapt to school on their discharge from the Centre.

On completion of the initial assessment of patients, clinicians make a decision with regard to the suitability of patients for the Centre's programme. Three categories of suitability exist on the William Slater Centre Assessment Form, namely, a 'suitable' category, a 'suitable, but not motivated' category, and a 'suitable, pre-admission group' category. The category 'suitable but not motivated' implies that adolescents were appropriate for the programme, but not voluntarily willing to be admitted to the 12-week programme. Adolescents categorised in the 'suitable, pre-admission group' were placed on a waiting-list and in the interim offered a place on the pre-admission programme involving individual follow-up appointments with a clinician or participation in outpatient group therapy sessions until admission occurs, or as required. Individual follow-up appointments with patients may be set for further assessment and discussion, and they are encouraged to return to the Centre in the event of them reconsidering admission to the programme. Reasons for lack of motivation include, amongst others, impending examinations, or patients requiring more time to consider admission. Another option is that patients who are found to have a certain severity of depression (as determined by a rating scale and psychiatric assessment) may be asked to participate in an anti-depressant drug trial (run by one of two pharmaceutical companies). These trials last for a minimum of 4-8 weeks duration, after which the patient's position is re-assessed. Finally, adolescents in the 'unsuitable' category were not considered appropriate for the milieu treatment programme and were either referred to an appropriate agency or contact is made with the referral agent to discuss the outcome of the assessment.

The Centre has recently set up an adolescent walk-in clinic which caters for distressed adolescents who are in urgent need of assessment and intervention. This weekly clinic is administered by the research unit. Patients are assessed by the psychiatry registrars, psychology intern or Masters social work student. Thereafter, management decisions are taken in conjunction with the psychiatrist. Similar options (as discussed above) face these clinicians, with the exception that these clinic patients may be placed in outpatient group therapy sessions for a maximum period of six weeks.

3.3. PROGRAMME PARTICIPANTS

Initially, the William Slater Centre attracted predominantly white English-speaking adolescents from affluent backgrounds. In recent years, the patient population has become more diverse, including adolescents from different racial backgrounds and economic classes. The majority of patients assessed at the Centre come from the larger Cape Metropole area. A detailed profile of patients assessed at the Centre and/or admitted onto the programme is provided in the following chapter.

3.4. THE PSYCHOTHERAPEUTIC MILIEU TREATMENT PROGRAMME

The psychotherapeutic programme of the William Slater Centre is a time-limited, psychodynamic, group-oriented milieu treatment for adolescents and young adults with psychological, emotional or behavioural problems. The programme extends over a twelve week period from 09:00 to 15:00 Mondays to Fridays. This time period was decided on by the clinical staff as the maximum time needed for the programme to produce an impact.

The programme recognises the need for a focus on positive mental health rather than merely symptom remission. Thus, although the programme aims to alleviate psychiatric and psychological symptoms or disorders, emphasis is placed on the overall functioning of the adolescent in order that they may cope more effectively with the demands of their environment. For example, the programme aims at empowering adolescents to acquire interpersonal and coping skills, developing insight, improving self-esteem, and increasing psychosocial competence.

The programme's central treatment philosophy is based on what is termed 'milieu therapy' or environment therapy. Principles and techniques of milieu therapy are applied in order to establish a therapeutic environment. The underlying principle is that change is

best effected by utilising peer group pressure in a therapeutic environment. An outline of the theory and principles of milieu therapy is provided in further chapters.

Treatment is multimodal, with the highly structured programme including various forms of therapy and group activities. Therapies include group therapy, individual therapy, evocative therapy, drama therapy and family therapy. Each patient is assigned an individual therapist. Medication is dispensed as required. Group activities include life-skills and social skills training, growth games, sex education, role play, as well as recreational and leisure activities such as crafts, sports, outings and camping. All patients and selected staff members attend a five-day stay at a Nature Reserve of the Department of Nature Conservation, situated approximately 200km from Cape Town. This camping expedition forms part of an environmental awareness programme, focusing on character building, leadership, co-operation, the development of interpersonal skills and utilising the environment as a recreational resource.

The Centre functions as a day-patient unit, in order to not take young people out of their normal environment. Some are of the opinion that children and adolescents with emotional problems are best treated in the least restrictive, most normative environment that is clinically feasible (Stroul & Friedman, 1986). There is a maximum of 22 patients on the programme at any one time. The average daily census is 15-22 patients. In an average week, two to three patients are admitted and a similar number discharged. On discharge from the 12-week programme, patients are encouraged to attend weekly ongoing outpatient group therapy sessions once a week, and family sessions and/or individual follow-up sessions, if needed. Patients in need of additional therapeutic support can continue their treatment on an outpatient basis, for an additional period of varying length.

4. EDUCATION AND TRAINING

Groote Schuur Hospital and its satellite units function as training hospitals for UCT Medical School and the William Slater is one of these satellites. The Centre therefore plays an important function in the education and training of under- and postgraduate students in the mental health disciplines. Students are integrated into the therapeutic programme depending on their length of stay and level of qualification.

Psychiatry registrars, the psychology intern, and at varying times other mental health students (referred to as trainees) receive education and training in the functioning of a psychotherapeutic milieu treatment programme. This takes various forms:

- trainees are each assigned approximately six patients for individual therapy;
- trainees observe almost all the programme sessions, with teaching and supervision provided by permanent staff members;
- trainees receive a considerable amount of training and supervision in group therapy, where they participate as co-facilitators in group therapy sessions and receive individual supervision after each session. The observation of groups is considered an invaluable training experience and is a popular training practice (Dies, Coché, & Goettelmann, 1990). Furthermore, according to Yalom (1970), trainees benefit from the personal experience in a group especially when the group is observed by an experienced group therapist who is able to provide close clinical supervision.
- trainees attend supervision sessions with the psychologist and with the consultant on a weekly basis;
- informal teaching may often occur during and after sessions.

According to the literature, milieu therapy has been recognised as a powerful instrument for teaching psychotherapy, especially where trainees receive supervision from a range of staff members involved in the milieu. There is, however, a recognition of the complexity of the role of trainees. They are required to work with adolescents, fellow

trainees and a multidisciplinary staff and function as leaders of community groups and activities, individual therapists, administrative case managers, and family therapists (Youngren, 1991). A detailed description of milieu therapy, the underlying theory of the William Slater Centre's therapeutic programme, forms the subject of entire chapter later in the thesis.

As an academic training centre, emphasis is placed on the comprehensive documentation of all patients assessed and admitted to the programme. On completion of the assessment of patients, clinicians are required to complete the 'William Slater Adolescent Centre Assessment Form' and to submit a dictaphoned or written report of the assessment. Patients admitted onto the programme are assigned an individual therapist. Each individual therapist is required to clerk their patients in the first week of their stay, providing a provisional DSM-IV diagnosis. On discharge, the individual therapist is required to document the progress of the patient and provide a psychodynamic formulation, a final diagnosis and recommendations. These reports are perused and edited on the discretion of the consultant prior to being placed in the patient files. Furthermore, all medication and the daily progress of patients are documented.

5. THE RESEARCH UNIT

The William Slater Centre has a research unit, involved in conducting research on various adolescent mental health issues, such as adolescent depression, suicide, and sexual abuse. The unit is also involved in conducting research on the pharmacological treatment of adolescent depression. Findings of research are published in relevant journals and presented at both national and international conferences.

6. THE BUDGET OF THE WILLIAM SLATER CENTRE

The budget and administration of the William Slater Centre are primarily undertaken by GSH. All adolescents and young adults referred to the Centre for an assessment or who

are admitted onto the programme are charged according to a sliding scale (Table 1) which takes into account the parent or guardian's income.

Table 1: Sliding scale for initial assessment, follow-up visits, admissions and post discharge visits to the William Slater Centre

Salary margins	Cost per day
R0 - R1666	R17
R1667 - R2416	R34
R2417 - R3250	R51
R3251 - upwards	R68

Each initial assessment and all follow-up individual, family and outpatient sessions are charged according to this scale. The minimum cost of the 12-week programme per patient is R1020,00 and the maximum cost is R4080,00. All payments are made to GSH, and some patients are able to claim from medical aid funds. Refreshments such as bread, milk, margarine, sugar, tea and coffee are provided by GSH. Patients are required to contribute R30,00 per month towards spreads for bread and for stationary. In the event of disadvantaged patients not being able to afford these costs or transport costs, funding is provided from the Centre. Post-discharge individual, group or family therapy sessions are charged only twice a month regardless of the number of sessions attended. However when only one session is attended, patients are charged for one session. The five-day camping excursion is funded through community donations.

A budget is allocated for the Centre and all costs incurred are offset by GSH. All staff salaries are paid by GSH with the exception of the consultant and psychologists salaries which are jointly paid by GSH and UCT. The research unit is funded partly by UCT but largely by the private sector. The projected budget allocations for salaries for the period

April 1996 to March 1997, obtained from GSH, is provided in Appendix A. Budgets for the costs of electricity, water, telephone, etc. were not accessible.

7. CONCLUSION

What is evident from this chapter, and is important to be cognisant of for the remainder of the evaluation, is that the William Slater Centre for Adolescents and Young Adults is a relatively new satellite of Groote Schuur Hospital. Furthermore, its therapeutic programme was adapted from previous psychiatric centres, and thus underwent numerous changes over the years. Other factors worthy of note, particularly in relation to the underlying theoretical tenet of the programme, namely milieu therapy, include: the pleasant, comfortable setting described at the Centre; the qualified personnel; the limited number of patients according to the staff quota; and the range of activities which constitute the therapeutic programme. The importance of these factors will become clear in the chapter on milieu therapy (Chapter 6).

The central purpose of this chapter was to provide an overview of the structure and functioning of the William Slater Centre and its psychotherapeutic programme. It is only by providing a thorough description of a programme and its setting that one can best know which areas are worthy of further exploration and evaluation. The drawback however is that reference is made to a range of aspects of the Centre's structure and functioning, not all of which form part of the present evaluation. Thus, although a more detailed analysis of various aspects of this chapter will be alluded to in later chapters, several areas will remain unexplored (e.g. the budget; the research unit). More detailed analyses of various aspects mentioned will be alluded to in further chapters. Having provided a description of the structure of the programme, the following three chapters are concerned with the process of the programme.

PROGRAMME PROCESS

CHAPTER 5

PROFILE OF ADOLESCENTS ASSESSED AT THE WILLIAM SLATER CENTRE FOR ADOLESCENTS

1. AIM

Having outlined the structure of the William Slater Centre and its therapeutic programme, the evaluation now turns to the process of the programme. This is encompassed in three chapters, the first of which provides an indication of the profile of adolescents and young adults who underwent an assessment at the Centre over the past five years. More specifically, the intention is to determine the characteristics of patients who were admitted to, and treated in the 12-week programme (as opposed to those adolescents who were assessed but not admitted, and those who failed to complete the programme).

2. METHOD

All records of patients assessed at the Centre *and* captured¹ on the database between the period 01 April 1991 to 01 October 1996, were retrospectively analysed. The database is based on the information documented in the 'William Slater Centre Assessment Form', which is completed by the clinician at the initial assessment interview(s) of adolescents referred to the Centre.

3. RESULTS

The results presented below begin with an overview of the adolescents assessed at the Centre, noting their outcome, that is, whether they were admitted to the therapeutic

¹ Some earlier patient records were not captured on the database. This was primarily a result of patients outside the age range of 14-25 being assessed at, and at times admitted to, the Centre at the time when age limits were not strictly applied.

programme or not. Four categories of adolescents are distinguished in an attempt to differentiate between the characteristics of the adolescents admitted to the programme as opposed to those not admitted, and those unsuccessful in completing the 12-week programme. Reference is made to these categories of adolescents throughout the remainder of the chapter. Analyses of the demographic and diagnostic data concludes the chapter.

3.1. SUITABILITY

During the period April 1991 to October 1996, 988 adolescents and young adults were assessed at the Centre. On completion of the assessment interview(s) clinicians take a decision regarding the suitability of the adolescent patient for the Centre's therapeutic programme. Analysis of these decisions is summarised in Table 2.

Table 2: Decision taken at assessment interview(s) on the suitability of patients for the William Slater Centre's therapeutic programme (n=988)

	N
Suitable	484
Suitable, but not motivated	54
Suitable, preadmission programme (waitlisted)	190
Unsuitable	139
Missing data	112
Unsure of suitability	9

Of the 988 adolescents assessed, a total of 728 (73,6%) were found suitable for the programme, 190 of whom were placed on the preadmission programme and 54 were found suitable but not motivated to attend the programme. Patient records did not provide

adequate information with regard to the distinction between the 'suitable' category and the 'suitable, but not motivated' and the 'suitable, preadmission programme' categories. The 'suitable' category was commonly found in earlier patient records, where details with regard to the motivation of patients or their suitability for the preadmission programme, were not always clearly documented. Data was not available for 112 records as a result of clinicians not recording the suitability of patients for the therapeutic programme. This was particularly the case in the earlier patient records.

Judging from the large number of adolescents considered suitable for the programme, it could be assumed that adolescents are appropriately referred to the Centre. This is however not to say that these adolescents were admitted to, or successful in completing, the 12-week therapeutic programme. Table 3 summarises the outcome of patients assessed at the Centre.

3.2. OUTCOME

Table 3: Outcome of patients assessed at the William Slater Centre ($n=988$)

	N
Initial assessment only, not admitted	453
Completed the 12-week programme	320
Defaulted from the 12-week programme	72
Currently on the programme	13
Unsuitable	130

Over the past five years, a total of 320 (32,38%) adolescents completed the 12-week programme. A substantial number of adolescents (45,85%) were initially assessed at the Centre, but not admitted to the programme. Findings from Tables 2 and 3 suggest the

need for answers to questions such as: ‘How many of the adolescents found suitable for admission ($n=484$) were admitted to the programme?’ and similarly, ‘How many adolescents admitted to the preadmission programme ($n=190$) were admitted to the therapeutic programme?’. Further analyses were conducted in an attempt to differentiate between the assessment decision regarding suitability and the outcome of patients.

3.3. SUITABILITY AND OUTCOME

Table 4 presents the comparison of the decisions regarding patients’ suitability and their outcome. Patients who were on the therapeutic programme at the time of data collection constituted such a small sample size ($n=13$) that a decision was taken not to analyse this group.

Table 4: Decisions regarding suitability of patients at assessment versus the outcome of patients

	Patients not admitted (<i>n</i> =453) ¹		Programme completers (<i>n</i> =320) ²		Programme defaulters (<i>n</i> =72) ³		Patients unsuitable, not admitted (<i>n</i> =130) ⁴	
	<i>n</i>	% ⁵ % ⁶	<i>n</i>	% %	<i>n</i>	% %	<i>n</i>	% %
<i>Suitable</i>	178	39.3 36.8	261	81.6 53.9	45	62.5 9.3	0	0 0
<i>Suitable, but not motivated</i>	50	11.0 92.6	3	0.9 5.5	1	1.4 1.9	0	0 0
<i>Suitable, preadmission programme</i>	133	29.4 70.0	40	12.5 21.1	17	23.6 8.9	0	0 0
<i>Unsure of suitability</i>	9	2.0 100	0	0 0	0	0 0	0	0 0
<i>Unsuitable</i>	4	0.9 2.9	2	0.6 1.4	3	4.2 2.2	130	100 93.5
<i>Missing data</i>	79	17.4 79.8	14	4.4 14.1	6	8.3 6.1	0	0 0

¹ Patients assessed but not admitted to the Centre's 12-week programme

² Patients assessed and successful in completing the 12-week programme

³ Patients assessed, admitted, and prematurely discharged from the 12-week programme

⁴ Patients found unsuitable for the programme at assessment and not admitted

⁵ Column %

⁶ Row %

3.3.1. SUITABLE PATIENTS COMPLETING THE PROGRAMME

The findings in Table 4 demonstrate that a large proportion (81,6%) of adolescents who completed the programme were found suitable for admission to the programme at their initial assessment interview(s). This finding may suggest that clinicians are accurate in their assessment decisions and that appropriate admissions to the therapeutic programme are made. However, analysis of all the adolescents found 'suitable' at the assessment interview(s) ($n=484$) shows that only 53,9% completed the programme, while a large proportion (36,8%), were not admitted, despite being found suitable for the programme.

3.3.2. SUITABLE PATIENTS NOT ADMITTED TO THE PROGRAMME

In a similar vein, it is of significance that 39,3% of patients not admitted to the Centre were found suitable for admission at their initial assessment interview(s). Patient records do not provide comprehensive documentation of the reasons for not admitting these patients, thus making interpretations difficult. It could be hypothesised that they were either not adequately followed up by the clinician or that the patients themselves failed to meet follow-up appointments. Alternatively, these adolescents could have attended follow-up appointments, outpatient group therapy sessions, or alternative forms of treatment, which were not consistently documented by the clinicians. While some patient records briefly document follow-up appointments, no clarity exists with regard to the final management decisions of these patients.

3.3.3. DEFAULTING PATIENTS

Another finding worthy of note is that of the total number of patients who were prematurely discharged ($n=72$), a large proportion ($n=45$; 62,5%) were found suitable at their initial assessment interview(s). This finding could imply either that patients were inaccurately found suitable at assessment or that patients were not as motivated as appeared at the assessment interview(s). While one is cognisant of the fact that the assessment of adolescents is a complex task and a margin of error is inevitable, the number of adolescents defaulting from the programme ($n=72$) from the total number of adolescents admitted to the programme ($n=392$), is of concern (i.e. 18,4%). Further analysis of this group was conducted in an attempt to determine the process of premature discharge of patients.

It was hypothesised that the premature discharge of patients may be related to the length of the therapeutic programme. Thus, the time periods in which patients were prematurely discharged were analysed. Table 5 summarises these findings.

Table 5: Time periods at which patients were prematurely discharged from the 12-week programme

Week numbers of the programme	Number of patients discharged
1 - 4	27
5 - 8	21
9 - 12	17
Missing data	7

No clear trends are evident from the above table, with only a slight increase in the number of patients prematurely discharged in the first four weeks of the programme.

Qualitative analysis of these patient records revealed some of the reasons for premature discharge as:

- lack of motivation of patients to attend the programme (19);
- active substance abuse while on the programme (7);
- compliance problems with erratic attendance (4);
- disruptive behaviour (3); and
- an inability by staff to contain patients (2).

Further qualitative analysis suggests that 20 patients were prematurely discharged by staff, 25 discharged themselves and 3 were discharged after a mutual decision between themselves and the clinical staff. There was missing data for 24 patient records. Once again, no trends are evident and the large number of missing data prevent accurate conclusions. Documentation of who discharged patients, namely the staff, the patients themselves, or a mutual decision, was at times perplexing with numerous events preceding the final decision to terminate patients' stay on the programme. Furthermore, interviews with various clinical staff members indicate differences of opinion with regard to the final documentation of the decisions taken to prematurely discharge patients. These staff members highlighted records reporting patients discharging themselves, when in reality patients did not voluntarily terminate their stay. On the contrary, they argue that unilateral staff decisions led to the discharge of patients, with minimal resistance by the clinical staff team. Further discussion of these issues is provided in a later chapter.

In summary, the inaccessibility of a large number of patient records (under review by a member of staff), and certain staff members' discontent with the process of patients' premature discharge, suggests that the data on these 'defaulting' patients be interpreted with caution.

3.3.4. SUITABLE PATIENTS, BUT NOT MOTIVATED

Of the total number of adolescents found suitable for the programme but not motivated to attend ($n=54$), a large proportion ($n=50$; 92,6%) were never admitted to the programme. The Centre places emphasis on the voluntary attendance and commitment to the programme and this finding could possibly be anticipated. The analysis failed to take into account whether these adolescents were referred to, or were receiving, alternative therapeutic interventions.

3.3.5. SUITABLE PATIENTS, PREADMISSION PROGRAMME

A noteworthy finding is that of all the adolescents placed on the preadmission programme ($n=190$), 70% ($n=133$) failed to be admitted to the programme. It could be hypothesised that patients attending the preadmission programme during the waiting period may improve to such an extent that admission may no longer be necessary. Alternatively, the programme's wait-list may have contributed to patients seeking treatment elsewhere or improving during the waiting-list time period (e.g. where medication is provided). On the other hand, it could be hypothesised that these patients were not adequately followed-up after the initial assessment.

The hypothesis that the preadmission programme may be therapeutic was investigated by conducting analyses on the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) scores of 40 adolescents who were found suitable for the preadmission programme and who successfully completed the 12-week programme. The BDI scores of three of these adolescents were missing, resulting in a sample of 37 for analysis. A matched sample t-test was used to determine the significance between the means on the BDI at assessment and at week one of the programme.

Table 6: Means, standard deviations and ttest for BDI scores at assessment and at week one (n=37)

	N	Mean	Std. dev.	t value	df	p
Assessment	37	26.54	12.48	3.402	36	0.05
Week 1	37	21.35	11.69			

These results demonstrate a significant difference in the scores at assessment and at week one on the BDI. Further analyses found that 23 (62,1%) adolescents had scores of 24+ at assessment, and by Week 1, this figure had declined to 18 (48,6%) adolescents with scores of 24+. These findings lend support to the hypothesis that the preadmission programme of the Centre may be therapeutic in itself.

In an attempt to determine whether this finding was a feature of the preadmission patient group, analyses were conducted on a sample of adolescents who completed the programme but who had no record of being placed on the preadmission programme and who did not receive any antidepressant or placebo medication from the Centre. BDI scores of 139 patient records were compared. A mean of 25 was found at assessment and 23,3 at week one of the programme. The minimal difference between these means in comparison to that of the sample of adolescents on the preadmission programme, implies the possibility of the preadmission programme having a therapeutic impact on patients. This finding is however confounded by the numerous external factors which could have contributed to the improved BDI scores. Furthermore, the finding could be confounded by the lack of documentation that adolescents were in fact placed on the preadmission programme. Nevertheless, it can be argued that the preadmission programme is *one* of the factors resulting in the improvement of patients, thus providing an explanation of these adolescents' failure to be admitted to therapeutic programme.

4. DEMOGRAPHIC DATA

Having provided details with regard to the suitability of adolescents and their outcome at the Centre, the remainder of this chapter provides an overview of the demographic and diagnostic details of four categories of patients assessed at the Centre. These are presented in Tables 7 and 10. Only available data are included in these tables, with the number of missing data not documented.

Table 7: Demographic data of four categories of patients assessed at the William Slater Centre

	Patients not admitted (n=453)		Programme completers (n=320)		Programme defaulters (n=72)		Patients unsuitable, not admitted (n=130)	
	n	% ¹	n	%	n	%	n	%
<i>Age</i>	18.1 ²		18.1		17.6		17.9	
<i>Sex</i>								
Female	303	66.8	243	75.9	48	66.6	71	54.6
Male	150	33.1	77	24.1	23	31.9	56	43.1
<i>'Race'</i>								
White	243	51.6	202	63.1	31	43.0	69	53.1
Coloured	199	43.9	88	27.5	26	36.1	43	33.1
African	12	2.6	6	1.8	4	5.5	7	5.4
Asian	8	1.7	5	1.5	1	1.4	-	-
<i>Home Language</i>								
English	278	61.4	219	68.4	43	59.7	75	57.7
Afrikaans	75	16.6	53	16.5	10	13.8	38	29.2
Xhosa	7	1.5	4	1.3	2	2.7	6	4.6
Other	8	1.8	5	1.6	-	-	1	0.8

Parental Status

Married	184	40.6	135	42.2	23	31.9	60	46.2
Divorced/ separated	19	4.2	148	46.3	36	50.0	51	39.2
Widowed	37	8.2	17	5.3	4	5.5	10	7.7
Single	27	6.0	10	3.1	2	2.7	7	5.4
Foster/ Adoptive	9	2.0	9	2.8	2	2.7	-	-

Education

Secondary	265	58.5	193	60.3	51	70.8	89	68.5
Matric	110	24.3	84	26.3	14	19.4	20	15.4
Tertiary	18	4.0	19	5.9	5	6.9	3	2.3

¹ Column %

² Mean age

Age

Findings from Table 7 show no significant differences with regard to age between the four categories of adolescents.

Gender

A predominance of females is common to all four categories of adolescents, with the ratio being the greatest in the category of adolescents admitted to, and completing, the programme.

'Race'²

Analysis of the 'racial groups' shows a predominance of the White and Coloured adolescents in all the categories, with the exception of the programme defaulters, where an equal distribution of the 'White' versus 'Black' race groups, exist. The most marked differences exist in the 'programme completers' category where a large proportion of adolescents who complete the programme are from the White race group. In all four categories, the African and Asian race groups are poorly represented.

In an attempt to determine changes in the profile of racial groups over the years, analyses were conducted on the racial groups of adolescent patients assessed each year. See Table 8 and Figure 1.

Table 8: A comparison of adolescent patients' 'race groups' by year of assessment at the William Slater Centre¹

	1991	1992	1993	1994	1995	Total
<i>'Race'</i>						
White	93	102	110	100	83	488
Coloured	44	75	61	58	74	312
African	2	1	5	4	12	24
Asian	2	0	7	0	3	12
Missing	10	9	11	15	1	46
Total	151	187	194	177	173	882

¹1996 figures not included since these were incomplete at the time of data collection

² The 'racial groups' of the adolescents and young adults assessed at the William Slater Centre is of particular importance when taking into account the history of the Centre. The adolescent unit was the product of the government hospital systems effort to integrate the mental health institutions (i.e. racially integrate them). Analysis of the 'race groups' of adolescents assessed at the Centre therefore provides an indication of whether the Centre was servicing all racial groups, and thus fulfilling the intended policy of racial integration.

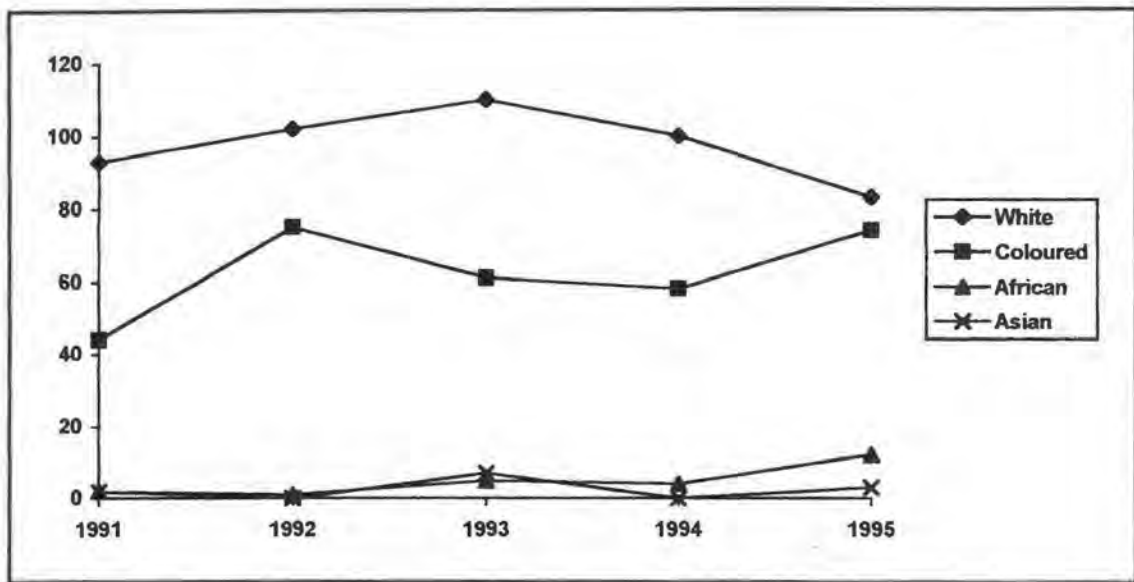


Figure 1: 'Racial groups' of adolescent patients assessed at the William Slater Centre 1991-1995

The above table and figure demonstrate a stable pattern over the five year period, with the number of White adolescents gradually decreasing in the latter years while the number of Coloured adolescent assessments increased. The number of African and Asian adolescents assessed remains very low.

Similar analyses were conducted on the adolescents admitted to the programme. See Table 9 and Figure 2.

Table 9: A comparison of adolescent patients' 'race groups' by year of admission to the William Slater Centre¹

	1991		1992		1993		1994		1995		Total
	n	% ²	n	%	n	%	n	%	n	%	n
<i>'Race'</i>											
White	36	67.9	43	69.4	47	67.0	36	63.2	29	51.7	191
Coloured	8	15.1	14	22.6	15	21.0	17	29.8	23	41.1	77
African	1	1.9	1	1.6	0	0.0	2	3.5	2	3.6	6
Asian	0	0.0	0	0.0	4	6.0	0	0.0	1	1.8	5
Missing	8	15.1	4	6.4	4	6.0	2	3.5	1	1.8	19
Total	53		62		70		57		56		298

¹ 1996 figures not included since these were incomplete at the time of data collection

² Column %

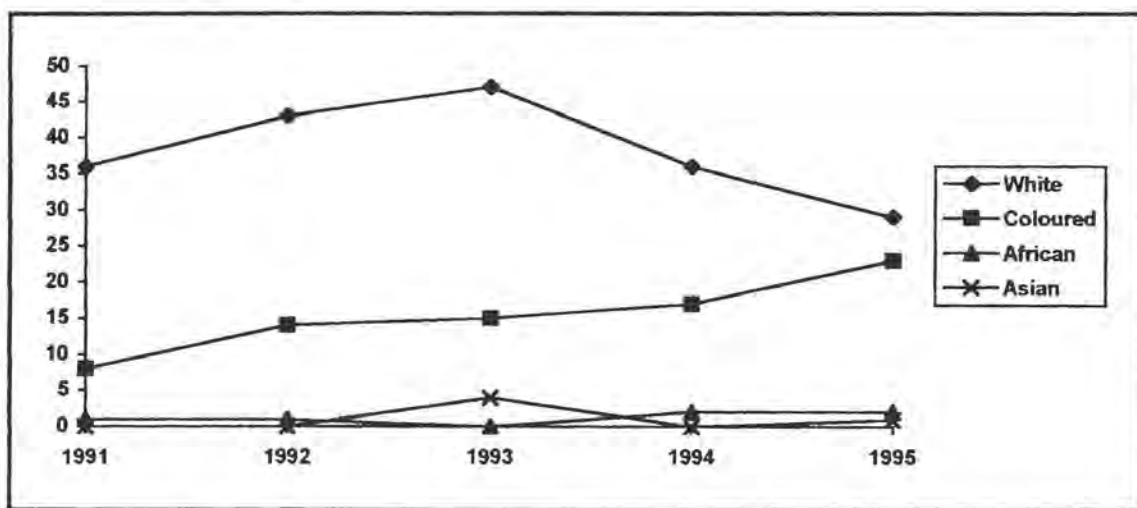


Figure 2: 'Racial groups' of adolescent patients admitted to the William Slater Centre 1991-1995

Between 1991 and 1994, there is a clear predominance of White adolescent admissions, with a decline from 1993 onwards. Coloured adolescent admissions increased gradually from year to year, with the margin between the White and Coloured adolescents decreasing by 1995. Admissions of African and Asian adolescents remain low.

Possible hypotheses for the predominance of White adolescent assessments and admissions include the following: firstly, the William Slater Centre is situated in a predominantly White, middle class area suburb and is therefore most accessible to the White adolescent population group. Secondly, in 1991, the Centre changed from a White alcoholic unit to an adolescent unit catering for all race groups. With this transition it could be expected that the predominant racial group of the previous patient population would remain with change being gradual. The increase in the number of Coloured adolescent assessment and admissions could be attributed to the Centre's Community Outreach Programme, aimed at educating social agencies, educators and child care workers on a range of adolescent issues. This programme takes the form of occasional workshops, lectures, and radio presentations. Although this programme does not make large-scale attempts at advertising the Centre, it could be argued that the outreach programme has contributed to some extent to the increased referrals from Coloured agencies.

Language

In all four categories of adolescents, there was a predominance of English as the home language, followed by Afrikaans. The minimal number of adolescents with Xhosa and other languages is a reflection of the racial breakdown, discussed above.

Parental status

No major differences were noted between the four categories of adolescents on the variable of 'parental status'. The large number of missing data (n=177; 39%) in the category of adolescents not admitted to the programme makes comparisons difficult. The

remainder of the categories appear to have a relatively equal distribution of adolescents from dysfunctional and nuclear homes.

Education

With regard to education, the majority of adolescents in all four categories were in the process of completing their secondary education.

5. DEMOGRAPHIC AND DIAGNOSTIC DATA

Further demographic and diagnostic data of the four categories of patients are presented in Table 10.

Table 10: Demographic and diagnostic data of four categories of patients assessed at the William Slater Centre

Patients not admitted (n=453)		Programme completers (n=320)		Programme defaulters (n=72)		Patients unsuitable, not admitted (n=130)	
n	% ¹ % ²	n	%	n	%	n	%
<i>Previous psychiatric contact</i>							
229	50.6	204	63.8	42	58.3	80	61.5
	41.3		36.8		7.6		14.4
<i>History of psychotropic medication</i>							
70	15.5	65	20.3	14	19.4	28	21.5
	39.5		36.7		7.9		15.8
<i>Family history of psychiatric illness</i>							
159	35.0	136	42.5	30	41.6	51	39.2
	42.3		36.2		8.0		13.6
<i>Mood disorder³</i>							
253	55.8	258	80.6	50	69.4	38	29.2
	42.2		43.1		8.3		6.3
<i>Eating disorder</i>							
43	9.5	44	13.8	4	5.5	8	6.2
	43.4		44.4		4.0		8.0
<i>Physical abuse</i>							
66	14.5	55	17.2	13	18.0	20	15.4
	42.9		35.7		8.4		13.8

Substance abuse

119	26.3	98	30.6	23	31.9	48	36.9
	41.3		34.0		8.0		16.6

Parasuicide

136	30.0	121	37.8	32	44.4	27	20.7
	43.0		38.3		10.1		8.5

¹ Column %

² Row %

³ Includes MDE, Dysthymia, Adjustment disorder with depressed mood

Previous psychiatric contact

Previous psychiatric contact refers to outpatient psychiatric or psychological assessment, outpatient and/or inpatient treatment, and psychiatric or psychological hospitalisations. More than half of the adolescents in all four categories had experienced some form of psychiatric contact prior to their assessment at the William Slater Centre. Of the total number of adolescents with a history of psychiatric contact ($n=555$), a substantial proportion (36,8%) completed the therapeutic programme. However, an even larger number (41,3%) were not admitted to the programme. This suggests that this variable does not distinguish those adolescents admitted to the Centre's therapeutic programme from those not admitted. Thus, adolescents presenting at the Centre with a history of psychiatric contact are not likely to be in a more favourable position to be admitted to the therapeutic programme.

History of psychotropic medication

Within each of the four categories, similar percentages of adolescents presented with a history of psychotropic medication at the initial assessment interview. Of the total number of adolescents presenting with a history of psychotropic medication ($n=177$), several completed the programme (36,7%), and a similar percentage of adolescents were not admitted to the programme (39,5%). Thus, similar to the above-mentioned findings,

no discrimination is possible between those adolescents not admitted and those admitted to the programme, on this variable. This implies that adolescents presenting at the Centre with a history of psychotropic medication have an almost equal chance of being admitted to the Centre's programme and not being admitted.

Family history of psychiatric illness

A familial psychiatric history was common to all four categories of adolescents. Once again, there was minimal difference between those adolescents admitted to the Centre's programme and those not admitted on the variable of a family history of psychiatric illness. What these results point to is a lack of discrepancy, on variables such as previous psychiatric contact, psychotropic medication and familial psychiatric history, between the adolescents not admitted to the Centre and those who were admitted and completed the programme.

Mood disorder

For the sake of brevity and considering the focus of the thesis, only Axis I mood disorders were analysed. Of the total number of adolescents assessed at the Centre ($n=988$), 599 (60,6%) had a diagnosis of some form of mood disorder at the initial assessment. Closer examination demonstrates that while 80,6% of adolescents who completed the programme were diagnosed with a mood disorder, a large number (69,4%) of adolescents who failed to complete the programme, and those who were not admitted to the programme (55,8%), had some form of mood disorder diagnosis at assessment. Thus, significant numbers of adolescents with diagnoses of mood disorders fail to be admitted or to complete the therapeutic programme. This is particularly highlighted when examining the total sample of adolescents diagnosed with a mood disorder ($n=599$), where an almost equal number of adolescents were admitted (43,1%) and not admitted (42,2%) to the programme. What these findings appear to indicate is that the presence of a mood disorder at the assessment interview(s) does not necessitate admission to the Centre's therapeutic programme.

Eating disorder, physical abuse, sexual abuse, substance abuse

Similar trends to the above mentioned variables are evident for those presenting with an eating disorder, a history of sexual abuse, physical abuse, and substance abuse. These variables do not predominate in any of the four categories and they do not appear to be indicators for admission to the Centre's programme. Clear differences with regard to patient characteristics appropriate for admission are not evident.

Parasuicide

The findings on this variable in many ways mirror the above-mentioned findings. Within each of the four categories defined, at least 30% of the adolescents had a history of a suicide attempt. The findings suggest that there are no indications that adolescents presenting with a history of a suicide attempt will be admitted to, and be successful in completing, the Centre's therapeutic programme.

6. CONCLUSION

This chapter provided four profiles of adolescents assessed at the William Slater Centre: (i) those assessed but not admitted to the therapeutic programme; (ii) those admitted and completing the 12-week programme; (iii) those admitted but unsuccessful in completing the programme for the 12-week duration; and (iv) those found unsuitable for the programme at the assessment interview(s). Although detailed analyses are provided on each of these four categories, the extent to which the profile of the adolescents admitted to the therapeutic programme differs from the profile of adolescents not admitted, is noteworthy. The most significant finding in this regard is the lack of differentiation between those adolescents completing the programme and those not admitted to the programme, on several of the variables analysed.

It could be hypothesised that, given the minimal differentiation between adolescents admitted and not admitted, those not admitted to the therapeutic programme may well have qualified for, and possibly benefited from, admission to the Centre. This leads one

to question the reasons for certain adolescents being admitted to the programme while their counterparts (with similar demographic and diagnostic histories) are unsuccessful in being admitted. Analyses suggest that factors such as the motivation of adolescents to participate in the programme, and adolescents participation in the preadmission programme, are some of the reasons for adolescents not being admitted to the therapeutic programme, despite their suitability. This in turn highlights the need for further analysis and possible evaluation of the preadmission programme, especially if the latter is providing a short-term, cost-effective intervention.

Having provided an indication of the characteristics of adolescents admitted to and successfully completing the therapeutic programme, the remaining two chapters on the process of the programme focus on a detailed description of the therapeutic programme itself. The following chapter provides an outline of the central tenet underlying the treatment modality on which the William Slater Centre's programme is based, namely milieu therapy. It is only by gaining a thorough understanding of this therapy that the Centre's programme and the findings of this thesis can best be understood.

CHAPTER 6

A DESCRIPTION AND CRITIQUE OF MILIEU THERAPY

1. INTRODUCTION

The aim of this chapter is to provide a thorough description of the central treatment philosophy on which the William Slater Centre's programme is based, namely, milieu therapy. The chapter begins with a description of the principles of milieu therapy, followed by a historical overview of the concept, and concludes with a critique of this therapeutic modality. The review of the literature on milieu therapy not only sets the stage for the chapter on the monitoring of the Centre's programme, but also provides a basis to determine the match between milieu therapy as proposed and as implemented. Furthermore, this chapter forms an integral part of the concluding chapter on the critique of the Centre's therapeutic programme.

2. DEFINITION OF MILIEU THERAPY

Milieu therapy, 'milieu' being a French word meaning environment or setting (Saifnia, 1988), refers to the philosophical context and organisational structure of the environment in which treatment takes place (Tucker, 1983). This form of therapy conceives of the total environment, including all relationships within the environment, as having therapeutic potential (Jansen, 1980; Scherer, 1992). Milieu therapy involves the manipulation of patients' environment in order that it may be conducive to treatment (Fourie, 1994). Since considerable emphasis is placed on the environment in which treatment occurs, milieu therapy can best be described as a treatment context rather than as a specific technique or method. The term 'milieu therapy' has been used interchangeably with 'therapeutic milieu' and 'therapeutic community', despite attempts to differentiate between them (Tucker, 1983)³

³ This thesis similarly uses these terms interchangeably.

3. PRINCIPLES OF MILIEU THERAPY

Four principles of milieu therapy have been proposed by Rapoport (1960): democratisation, permissiveness, reality confrontation, and communalism. These overlapping and interdependent principles are briefly discussed below and referred to in later chapters.

Democratisation: The principle of democratisation implies that staff and patients' opinions are of equal importance and that both have a say in the conduct of their work and treatment. Joint patient-staff decision making replaces the authoritarian control commonly found in traditional hierarchical structures (Oldham & Russakoff, 1987).

Permissiveness: The principle of permissiveness implies the toleration of deviant, disturbed behaviour in order that the behaviour can be examined. It refers to the ability of patients to relate to one another in a trusting manner without being judgmental. Permissiveness exists when patients feel confident and comfortable in revealing real-life problems in an open fashion.

Reality confrontation: The principle of reality confrontation, closely linked to permissiveness, implies that when patients reveal unacceptable behaviours, their conduct is reflected back to them in the hope that they will accept the interpretation and modify their behaviour. Confrontation is most effective when patients are able to feel supported and be criticised by their peers (Youngren, 1991). This principle applies equally to staff, whose performance is open to criticism.

Communalism: Communalism refers to the sharing of duties, facilities as well as thoughts and feelings. For example, patients and staff may take tea and lunch breaks together; staff do not wear uniforms; and all staff are called by their first names. This 'communal living' of staff and patients is considered therapeutic, with some arguing that

informal and spontaneous encounters of patients and staff are often more rewarding therapeutically than formal groups (Morrice, 1979).

More recently, Gunderson (1983) identified five elements which affect the functioning of a therapeutic milieu: structure, involvement, containment, support and validation.

Structure: Structure refers to the organisation of time, space and activity of each patient's environment. Examples of structure include ensuring that each patient receives an individualised orientation; ensuring that rules or codes of conduct are established and consequences for functional and dysfunctional behaviour are applied; and ensuring a consistent daily schedule (Gunderson, 1983; Scherer, 1992). Structure may be threatened when there is a lack of staff commitment to patients; pessimism on the part of staff about interventions not assisting patients; or inadequate numbers of staff members. Features of the setting such as colour, lighting, furniture and spatial layout form an important part of the therapeutic milieu, as well as practicalities such as food, warmth, comfort, safety, decoration and games. A well-structured, well-run, safe, secure and stimulating environment ensures structure (Donnellan, 1986).

Involvement: Involvement, similar to the principle of reality confrontation, occurs when the environment is conducive to patient interaction. Examples of involvement include patients accepting feedback from staff and peers and providing constructive feedback to fellow patients. A central assumption of involvement is that patients are active participants in the healing process.

Containment: Examples of containment strategies include frequent monitoring by nurses; suicide precautions; and policies restricting patients' freedom. An important containment function of a therapeutic milieu is safety. Failure on the part of nurses to provide appropriate containment in the milieu is detrimental to patients. The ideal is when patients themselves enforce containment through 'peer pressure'.

Support: Support involves the active efforts of staff to promote a sense of well-being and self-esteem in patients. Mechanisms to develop support include group recreational opportunities; community meetings; and individual postdischarge follow-up. Ideally, nurses create opportunities in which patients can interact and build supportive relationships (LeCuyer, 1992).

Validation: Validation is a process that affirms patients' individuality (Gunderson, 1983) and requires focusing on the personal attributes of patients when planning treatment (LeCuyer, 1992). An overly structured programme, which makes little attempt to modify the structure to meet the needs of particular patients, may prevent an individualised approach to patient treatment (Walker, 1994).

Milieu therapy programmes are based on the rationale that staff and patients contribute towards the creation of a therapeutic environment, in which participation in an open, democratic group setting enables patients to gain insight into themselves and learn appropriate behaviours, which can be transferred to the outside world (Abroms, 1969; Lewis & Selzer, 1972; Rapoport, 1960; Tucker, 1983). Within the milieu, patients take responsibility for themselves, and participate in their own treatment and in that of fellow patients (Badaines & Ginzburg, 1979).

Therapeutic communities, as developed by Jones (1962), have the following characteristics:

- it is small with no more than 100 patients, with everyone able to know each other;
- regular community meetings are held with all staff and patients attending;
- the underlying hypothesis is psychodynamic - i.e. that individuals' difficulties are mostly in relations with others and these can be examined, discussed and understood;
- occurrences in the unit are discussed in the community group meetings and attempts are made to understand them;
- emphasis is placed on improving communications with everyone free to communicate;

- the authority pyramid is flattened, in contrast to traditional wards;
- patients are taught new ways of coping with difficulties;
- patients and staff examine their roles in order to achieve more effective and helpful ways of functioning (Clark, 1965).

4. HISTORY OF MILIEU THERAPY

Milieu treatment can be traced as far back as the 1700s with Pinel finding that asylum inmates were less violent when free to move around. During the nineteenth and early twentieth century, these ideas were nearly lost with the rise of the medical model and Freudian theory (LeCuyer, 1992). The concept of therapeutic communities was an innovation of the 1940s, the term being coined by Thomas Main in 1946. It marked the beginning of a dramatic move towards the more humane treatment of psychiatric patients. This concept was revolutionary at a time when psychiatric hospitals were essentially repressive and human rights were violated.

The 1950s and 1960s saw a revolt against the abuse of power, with the introduction of the therapeutic community style of hospitals (Main, 1946). The best known early milieu approach was that of Maxwell Jones (1953), whose primary aim was the improvement of patients' social functioning instead of the treatment or containment of psychiatric illness (Bell & Ryan, 1985). The therapeutic community concept marked the liberalisation of mental hospitals with the reintroduction of mutual care and open communication between staff and patients (Shoenberg, 1980).

Since World War II the therapeutic community had varying popularity. In 1953, the WHO demonstrated support for the concept, reporting that it was one of the most important types of treatment which psychiatric hospitals could provide. This significantly contributed to the spread of this approach (Clark, 1965). The landmark study of Stanton and Schwartz (1954), suggested a possible link between certain psychosocial characteristics of a psychiatric ward and patients' response to treatment. However,

despite these and other work in the area, the idea of the therapeutic community was not actively put into practice in the 1950s (Manning, 1976a).

The 1960s, marked by the rise of pharmacological methods of treatment, was a period fraught with difficulties in the implementation of milieu therapy concepts. Numerous papers reported on the failure of the method (Crabtree & Cox, 1972; Stotland & Kobler, 1965; Wilensky & Hertz, 1966) and this approach gradually began to fade from prominence, with only six of these units in existence in England in 1966 (Clark, 1977).

The 1970s saw a new era for the proponents of therapeutic communities with the Association of Therapeutic Communities being formed, meetings and conferences being held, and most importantly research being published. However, the majority of research papers failed to satisfactorily prove the efficacy of therapeutic communities. Spadoni and Smith (1969) described the failure of an entire milieu unit treating schizophrenic patients, despite the appropriate environment and dedicated staff. Other research found behavioural changes not persisting after patients' discharge, and different patients responding positively to different kinds of settings (Ellsworth, Maroney, Klett, Gordon, & Gunn, 1971). According to Clark (1977), there was no concrete evidence to suggest that the application of milieu therapy concepts had enhanced treatment effectiveness. In fact, some studies demonstrated the converse, that milieu programmes may be harmful for some patients (Van Putten, 1973). While numerous descriptions of therapeutic communities existed, few attempts were made to assess what was achieved. Few controlled studies existed and there was increasing concern about the efficacy of milieu therapy concepts and practices (Ellsworth et al., 1971). The end of the 1970's saw a strong move back to the traditional medical concepts with a focus on drug treatment (Myers & Clark, 1972).

5. THE DECLINE OF MILIEU THERAPY

Milieu therapy or therapeutic communities came under harsh criticism (Lerner & Roskos, 1979), being labeled faddish, cultish, rigid, dogmatic, militant, uncritical, nontherapeutic, and recklessly permissive (Fischer & Weinstein, 1971; Zeitlyn, 1969). Numerous factors resulted in its downfall, only some of which are discussed below.

Proponents of milieu therapy began with the assumption that this approach could be universally applied across the field of psychiatric treatment. Research however demonstrated that this concept was not conducive to all forms of mental illness (Frank & Gunderson, 1984; Moos, 1974). Milieu therapy, which was originally devised for the treatment of psychopathic personalities (Manning, 1979b), was adapted for the needs of various patient populations (Jansen, 1980). Thus, numerous modifications of milieu therapy existed (Ellsworth et al., 1971; Lewis & Selzer, 1972) and interpretations of the concept varied (Wilmer, 1981). This in turn resulted in research on the efficacy of therapeutic communities producing inconsistent findings since studies differed in the patient samples; treatment programme characteristics; concurrent use of other therapeutic modalities; and nature of staff and patient interaction (Ellsworth, 1983; Karasu, Plutchik, Conte, Siegel, & Hertzman, 1977; Lehman, Strauss, Ritzler, Kokes, Harder, & Gift, 1982). According to Gunderson (1983) and Almond (1983), milieu therapy programmes influence patients favourably or negatively depending on these factors.

A commonly cited reason for the failure of the implementation of milieu therapy concepts was the personal limitations of staff. Morrice (1979) commented on the charismatic type of leadership, clearly present in many therapeutic communities, which resulted in a closely guarded set of relationships within the milieu. A consequence of this was that staff resented criticism from 'outsiders' and distrusted criticism from those within the programme. This lack of self-evaluation and open communication led to progress being stunted and milieu programmes disintegrating. Another staff-related

criticism was the lack of knowledge and understanding of milieu therapy by staff members. Fourie (1994) highlights the need for clarity of staff's own philosophical viewpoints and the institutions philosophical beliefs with regard to milieu therapy in order to prevent different and conflicting ideas of the treatment programme.

Although milieu therapy was valuable in preventing institutionalism, it was criticised for being more of an ideology than a defined method of treatment (Van Putten, 1973). As an ideology it resulted in overconcern with conceptual aspects, and innovative policies and procedures. As a result, one of the major tasks of milieu therapy, namely, to diagnose individual patients' needs and to plan, think and reflect on an individualised treatment approach, was overlooked (Lewis & Selzer, 1972; Wing & Brown, 1970).

Milieu therapeutic principles and values were both criticised and misused (Clark, 1977). Morrice (1979) found that certain ideas and assumptions about therapeutic communities were inaccurate or misleading when put into practice. For example, difficulties were encountered in communicating, sharing and taking responsibility, with not all patients responding positively to an emphasis on patient responsibility (Ellsworth et al., 1971). Furthermore, values and norms were not always clearly established and goals were at times vague. The principle of democratisation was particularly criticised as being merely ideological (Morrice, 1979; Scherer, 1992). Democracy became confused with equality, where some individuals believed that everyone had a right to comment on everything. The situation therefore arose where patients and lay therapists (with no training) assumed responsibility equal to that of trained staff. Obvious problems with this (e.g. delayed decisions, general inefficiency), resulted in staff abandoning the ideals of democracy and permissiveness and resorting to asserting their power (Rosie, Azim, Piper, & Joyce, 1995). Another criticism of the principle of democratisation was that it was relative, with different levels of the democratisation appropriate to different situations. For example, it was found that the ideal of a democratic community does not apply to adolescents since the ultimate authority lies with staff members (Steinberg, 1983). Similarly, the principle of permissiveness, criticised as being oppositional to the principle of reality confrontation, was found particularly difficult with adolescents, who were

inclined to test-out limits and act out, and at times prematurely terminate treatment (Morrice, 1979).

Related to these principles is the criticism of the intensity of environmental stimulation. Van Putten (1973) argued that the therapeutic community contained too much environmental stimulation (e.g. loud music, an inability to distinguish staff from patients, forced group interaction) and suggested that the emphasis on group interaction in particular be critically reviewed.

It has been hypothesised that therapeutic communities had limited success as a result of the failure to adapt and implement it in general psychiatric hospitals (Karasu et al., 1977). This in turn was a consequence of its high running costs. Milieu therapy required above average resources per patient, increased numbers of higher quality staff and suitable facilities. However, since medical staff were primarily trained within the medical model, they clearly lacked experience and expertise in milieu therapy (Whiteley, 1979). This, together with the expensive nature of this treatment modality, partly resulted in its failure. Suggestions were therefore made to determine the forms of mental disturbance that maximally profit from milieu therapy (Van Putten, 1973).

One of the most important (and possibly most detrimental) difficulties of milieu therapy was the failure of its proponents to evaluate and research milieu treatment programmes (Scherer, 1992). Kennard (1979) argues that although the question 'Do therapeutic communities work?' is not possible to answer, research cannot merely be disregarded or neglected; instead, a balance is required between what is practical to ask and what is meaningful to ask. As an innovation, the role of research is crucial as a source of legitimation that the method is effective. However, with the innovation of milieu therapeutic practices the assumption was made that the major idea worked. Proponents of therapeutic communities made few attempts to research the efficacy of milieu therapy. This was primarily a result of internal self-satisfaction that the basic idea had been

sufficiently developed, and external pressure to provide a regular service (Manning, 1979b).

6. MILIEU THERAPY AT PRESENT

In recent years, there appears to have been renewed interest in milieu therapy (Zimmerman, 1994). By the 1980s researchers began to argue that milieu therapy is a viable treatment modality (Gutheil, 1985) and that there was clear evidence that for some patients, intensive milieu treatment could be therapeutic (Oldham & Russakoff, 1987). More recently, researchers and clinicians have similarly demonstrated the effectiveness of milieu therapy for the treatment of certain types of patients (Perris, 1992; Reeves, 1993). This resurgence has been accompanied by the realisation that a future for effective milieu therapy exists on condition that there is a move away from uncritically holding on to its ideological principles. Instead, proponents of milieu therapy have recognised the need to adapt milieu principles for different types of patients, and more importantly, to evaluate the milieu programmes (Herz, 1981; LeCuyer, 1992; Morrice, 1979).

This chapter provided an historical account of the rise and fall, and in recent years, the resurgence of milieu therapy. There is certainly no doubt that the concept of milieu therapy has made a major contribution to the field of mental health, providing a new, more humane perspective on the treatment of psychiatric patients. However, the extent to which future milieu treatment programmes will remedy the shortcomings of this treatment modality and demonstrate its efficacy is unknown. The reader is urged to consider the factors outlined in this chapter (particularly the reasons for the decline of milieu therapy), in reading the following two chapters, as well as the concluding discussion on the critique of the Centre's milieu programme.

CHAPTER 7
MONITORING THE IMPLEMENTATION OF THE
PSYCHOTHERAPEUTIC MILIEU TREATMENT PROGRAMME
OF THE WILLIAM SLATER CENTRE

1. INTRODUCTION

This chapter, the third on evaluating the process of the programme, is in many ways the core of the thesis. Having provided a summary of the theoretical framework underlying the therapeutic programme at the William Slater Centre for Adolescents, this chapter turns to examining the internal processes and functioning of the programme, in other words, how the programme operates. This involves providing a description of the actual state of the programme in order to determine whether the programme is implemented as planned. Yeaton and Sechrest (1981) termed this process of determining whether treatment is carried out as intended, as 'treatment integrity'.

Monitoring the implementation of a programme, or treatment integrity, involves an in-depth examination of how the programme operates in practice, focusing on the population it serves and the functioning of it. The primary purpose is to determine the extent to which the programme is operating as planned. As discussed in an earlier chapter, one may question how concerning oneself with the way in which a programme operates may benefit an evaluation. Several researchers and authors have commented on the advantages of this aspect of evaluation. Fitzgerald and Illback (1993), for example, comment that information on the process of a programme can lead to identifying problem areas and highlighting aspects of the programme that are effectively implemented. Weiss (1991) is of the opinion that determining how a programme is experienced is more useful than determining the extent to which the programme failed to achieve its goals, since these findings can assist in modifying the design of the programme. Another important aspect of treatment integrity is that unless sufficient detail is provided about the process

of programmes, the knowledge that some unknown thing is effective is not useful. Monitoring the implementation of a programme therefore ensures that measured programme outcome effects can be attributed to an intervention that has been implemented as planned (Manning, 1979a). Lack of clear data on treatment integrity therefore makes outcome effects difficult to evaluate (Kazdin, 1990; Staff & Fein, 1994).

Monitoring the implementation of programmes is an important but neglected topic (Hamburg, 1991), with few evaluation studies providing a description of the process of a programme when actually delivered (King et al., 1987; Staff & Fein, 1994). Approximately one half of outcome research on child and adolescent psychotherapy make some effort at ensuring treatment integrity (Kazdin et al., 1990b), although only about one-fifth of the studies actually monitor or assess treatment integrity.

2. AIM

The aim of this chapter is to provide an in-depth description of the William Slater Centre's therapeutic programme, in an attempt to determine whether it is implemented as planned, namely, according to milieu therapeutic principles, and according to the structured weekly time table. (See Appendix B).

3. METHOD

As mentioned in an earlier chapter, qualitative methods are best suited for the careful description of programmes and the process of treatment (Patton, 1987). According to Clark (1977), the only way to learn about therapeutic communities is to work in one. Monitoring of the Centre's programme involved casual and systematic observations and informal conversations and semi-structured interviews with staff. The author took on the role of a non-participant observer, and at times a participant observer, over five consecutive weeks. The majority of sessions were observed in an observation room

equipped with a one-way mirror. Observations were recorded immediately at the time of the events with no predetermined format.

4. RESULTS

Results are presented differently, depending on the nature of the session observed. For example: detailed information is provided where individual patients are the focus of the session, whereas summaries are provided for sessions involving a range of group activities. Furthermore, since the observation took place over a 5-week period, during which the same weekly time-table was observed, a substantial amount of repetition occurred in observation notes. As a result, observations representative of certain sessions are provided, with differences noted. This section is structured in accordance with the Centre's weekly time-table.

MONDAY

PRESENTATION / PATIENT FEEDBACK 8.15 - 9.00 am

The 'Presentation and Patient Feedback' sessions most often began promptly at 8.15 am in what was termed the 'Brown Room', a fairly spacious room with wooden floors, and comfortable arm chairs. Existing windows provided generous natural light. The chairs were positioned in a large semi-circle all facing an overhead projector. The room was equipped with a one-way mirror, the curtains of which were open.

Although all clinical staff members were expected to be present for this session, none of the sessions observed were attended by the full complement of clinical staff. On average, ten staff members and students were present with varying numbers of staff members each week either not being present, or coming late and observing the session from the

observation room. Presentations were conducted by the postgraduate trainees (i.e. the psychology intern, psychiatry registrars, and at times the Masters social work student). The trainees were allocated approximately seven patients for individual therapy. On admission, the trainees clerked their individual therapy patients and presented these patients' histories at the 'Presentation' session. One patient was presented at each 'Presentation' session.

The presentation was a lengthy and detailed account of the patient, lasting approximately 45 to 50 minutes. Although presentations differed depending on the personal style of trainees, the content of the presentation was fairly constant, with a thorough account of patients' history and presenting problems. In general, the following areas were covered: demographic information; reasons for referral to the Centre; presenting complaints; previous diagnoses; stressful life events (acute and enduring); psychiatric history (noting parasuicides); family psychiatric history; a genogram with details of the relationship of the patient to other family members and pathology in the family; personal history including birth, childhood, schooling, hobbies, habits, substances, relationships, religion, psychosexual history; medical history; personality; mental state examination; intelligence test results (if available); psychodynamic formulation; diagnoses (DSM-IV diagnoses Axis I to V); treatment, management and prognosis. Diagnoses on the five axes were defined as follows (according to the DSM-IV): Axis I comprised clinical disorders (e.g. Major Depressive Episode, Alcohol Abuse) as well as other conditions that may be a focus of clinical attention (e.g. academic problem); Axis II comprised personality disorders and/or traits (e.g. Histrionic personality disorder, Narcissistic personality traits); Axis III comprised the general medical condition of the patient (e.g. epilepsy); Axis IV comprised psychosocial and environmental problems (e.g. negative life events, inadequate social support); and Axis V comprised the Global Assessment of Functioning (GAF) (i.e. the level of psychological, social and academic functioning at present and over the past year).

In comparison to other sessions, the format of the 'Presentation' session was more formal. This was mainly a result of the trainees presenting the patient details without much discussion or comments amongst staff members. Only rarely were there interjections asking for clarification. On completion of the presentation, a few staff members asked questions and provided comments and suggestions, especially with regard to their observations of the patient in the milieu. Time was largely spent on the diagnoses and management of the patient (e.g. the need for family therapy, collateral information from parents, guardians or the school to corroborate patient information; intelligence test; or medication). Specific problem areas with regard to the patient's functioning and performance were discussed. Staff participation in these sessions varied from week to week. In most instances one influential staff member led the discussion. Differences of opinion with regard to diagnoses and management of a patient were cautiously discussed amongst staff, with one dominant staff member making the final decisions, with rare objections from the clinical staff team. Although some staff members commented on their viewpoints, no substantial discussions or debates were entered into, with comments by staff merely acknowledged at times, but in most instances 'lost'. Discussions therefore revolved around the affirmation of the comments made by the one influential member of staff.

In most instances the sessions ended a few minutes prior to 9am, with a brief discussion of the following patient to be presented and changes to the timetable for the week (if any). One of the nurses finalised which staff members would be facilitating the various sessions for the week. As a result of time constraints, these decisions were taken fairly swiftly and the 'Patient Feedback' part of the session rarely occurred. The sessions ended with all the staff members proceeding to the Occupational Therapy (OT) room, for the following session.

Only one of the five 'Presentation' sessions observed differed in that there were no new admissions and therefore no patients to present. Instead a 'Ward Round' session was held. Details of this session is provided later in the chapter.

INTRODUCTIONS AND BUSINESS 9.00 - 9.15 am

The OT room had natural light, cream coloured vertical blinds, an old piano in one corner and stacks of white plastic chairs scattered around the room. The chairs were arranged in a large circle by staff and patients and the seating occurred in no particular order. All clinical staff, research staff and patients were present for this session, which was led by the psychiatrist and in his absence, the social worker. The session began with one of the staff members requesting that one of the 'older' patients (i.e. patients who were at the middle or end of their stay at the Centre) provide the introductory remarks. The session was introduced by one patient requesting that each person introduce themselves, mentioning their age and the week number of their stay at the Centre. 'Business' was defined as an opportunity for patients to request to be excused from certain sessions in the event of them having appointments or alternative commitments. The session began with patients stating their name, age, and the week of their stay, and staff mentioning their name and professional status. In general, this name 'go-round' occurred fairly quickly. Throughout the session late-coming patients introduced themselves at the end of the 'go-round'.

The 'Business' part of the session was utilised by both patients and staff. Patients requested time off from the programme, but were encouraged not to schedule appointments during the times of the programme. Changes in the programme for the week were discussed with patients (e.g. changes as a result of a public holiday), as well as pressing issues in the community (e.g. stealing in the Centre; patients coming late in the morning and not informing staff). In general, patients were dealt with firmly, with long periods of silence until situations were satisfactorily resolved. In general, the feeling in this session was one of placidness with some patients drifting in late and moods of patients varying depending on their weekend. This session ended with the nurses determining which patients were absent. In the weeks where no new patients were admitted, the session involved only 'Business'.

WEEKEND FEEDBACK / WEEK PLANNING 9.15 - 9.30 am

This session followed immediately after the 'Introductions and Business' session. All staff with the exception of two nurses (and at times the nursing and/or medical students) departed from the OT room. Depending on the number of new patients and items of 'Business' to discuss, the 'Weekend Feedback and Week Planning' session occurred at varying times. A small circle was formed and one of the 'older' members of the patient community introduced the session to the new patients. The session involved patients providing a brief account of their weekend; a discussion of whether their weekend goal(s) (which they set on the Friday of the previous week in the 'Weekend Planning' session) were met; and finally planning a goal for the week ahead. Some patients provided lengthy accounts of their weekend, while others were so brief that staff requested more detail. In general, patients appeared lethargic and dispirited, some being unable to recall their weekend goal set the previous week while others were at a loss for a goal for the week ahead. In all these instances, the nurses questioned patients and forced them to think about the goals they set; why they set these goals; why they failed to achieve their goals; and encouraged and guided them with regard to future goals. Patients reluctant to participate were confronted and encouraged. Examples of goals set by patients include: to talk about their relationship with their parents, to discuss the separation of their parents, difficulties they have in talking in sessions, and talking about why they were at the Centre. When very general goals were set (e.g. 'My goal is to speak about myself'), nurses requested that patients be specific in their goals. At times patients verbally 'attacked' fellow patients who were not clear in their speech and/or who were repetitive in the goals they set.

Nurses often informed patients to plan their 12-week stay, since failure to do so might result in them regretting not utilising the Centre adequately. After one session a nurse commented to the author that when patients had a clear idea of their needs and goals, these sessions were considerably easier and occurred in a shorter period of time than when patients were not motivated and when little thought went into their stay. Much encouragement was then needed on the part of the facilitators.

The sessions observed with experienced nursing staff, working within the milieu for approximately three years, contrasted significantly from those facilitated by the less experienced nurses who were at the Centre for a year or less. For example: inexperienced nurses were unconvincing in reprimanding or demanding patients' attention, resulting in some patients conversing throughout the session. Furthermore, these sessions ended 15 minutes earlier than normal, with inexperienced staff not questioning patients as much as the experienced nurses. This was particularly the case where two relatively inexperienced nurses facilitated the session.

GROUP WORKING DRAMA 9.30 - 11.00 am

Prior to the 'Group Working Drama' sessions, one or at times two nurses from the 'Weekend Feedback and Week Planning' session briefed the drama therapist about important developments with regard to the patients, and discussed plans for the 'Group Working Drama' session. Time constraints (especially since the previous session often ended later than stipulated), implied that the drama therapist, who came prepared for the session, often had to adapt her plans depending on the feedback from the nursing staff. Exercises were suggested by the drama therapist, with the nurses commenting on the appropriateness of them for the patient community.

The Group Working Drama sessions occurred in the OT room, which was not equipped with a one-way mirror. Observation therefore occurred from a remote corner of the room. These sessions occurred approximately 15 minutes later than schedule each week. One of the 'older' patients introduced the session as a range of group activities aimed at teaching one to work as a group. The facilitators added that the session involved the teaching of oral and non-verbal communication skills, listening skills, observation skills, cultural sensitivity and assertiveness. The drama therapist acquainted herself with the new patients and introduced the author, explaining her role in the following five sessions. The sessions were facilitated by the drama therapist who introduced various group

exercises. *Some* of the exercises employed in the five Group Working Drama sessions observed are briefly outlined below.

- Patients were required to associate names of an animal starting with the same letter as their name. The animal with whom patients associated their names was of significance.
- One patient was required to touch five different parts of the room (e.g. the ceiling, the floor, the side walls, etc.). Once the patient demonstrated the sequence, the remaining patients followed the sequence. The patient completing the task last became the leader and was required to touch another five objects in the room. This exercise physically warmed up patients and allowed them to function with their bodies, acting as a bridge to bring patients into 'working mode'. From this exercise it was possible to determine those who were motivated and eager to work from those who were lethargic.
- Patients were asked to walk around casually and to stop when told to do so by the facilitator. At this point patients were required to talk to the person opposite or nearest to them about any three objects or activities which they enjoyed. They continued to do this for a period of time after which a circle was formed with one patient placed in the middle of the circle. The group was asked to recall what the persons responses were to the topic discussed. After each patient had an opportunity to be in the middle of the circle, the exercise was terminated. Several patients who were not participating were reprimanded and asked to leave if not willing to contribute to the session.
- Patients formed groups of three or four and were asked to verbally and non-verbally enact a cinema production for a maximum of one minute. The remaining patients were required to guess the title of the production enacted. This activity allowed all patients to participate and several found it enjoyable.

- Patients were paired and sat facing each other on mattresses. They were asked to tell each other a story about something which happened to them in the past week or month. They had to retell their stories non-verbally, using only their hands and no facial expressions. Patients found this difficult at first but were encouraged to attempt it. Thereafter they were asked to re-tell the story only using their eyes. Some were unable to do this but once again were encouraged to try. On completion of this task, patients reflected on the exercise commenting that stories became shorter, less interesting and more difficult to relate. They noted that emotions were expressed through their eyes and their hands demonstrated actions.
- Patients followed a leader and stopped immediately when the leader called out 'STOP'. Patients then held the position they were in. Any movement, laughter or change in facial expression resulted in patients no longer participating in the exercise. The leader attempted to invoke responses in individuals able to hold a statue-like position. This continued until there are only a few patients left to follow the leader.

Patients were purposefully assigned a 'high-status' and 'low-status' position by one of the nurses and placed into pairs, with opposing status positions. Each patient's status role was specifically selected by the nurse who was cognisant of the type of status positions which they would have difficulties with. Once the nurse clarified that patients understood the terms 'high-status' and 'low-status', five minute role-plays were conducted by each pair of patients. The nurse decided on the scenario and without any preparation, pairs of patients had to enact a scene with the remaining patients and staff observing. Examples of scenarios included a passive, subservient domestic worker and a dominating, demanding madame; a beggar and a rich madame; a demanding employer and a passive employee; a domineering wife and a passive husband.

At first patients were reluctant to participate, becoming very playful. Staff however firmly encouraged patients, asking them to concentrate on their roles. When a considerable amount of resistance to participate was demonstrated, the nurses remained silent and patients eventually continued with their role plays. Several patients resisted the exercise and had difficulties in their roles. On completion of the role plays patients reflected on the roles they enacted, with the facilitators encouraging patients to think of factors which made their role difficult. Some explanations included that they did not like being told what to do; they enjoyed the position of power; and they found it infuriating being in an inferior position. Other patients expressed their enjoyment in being in certain positions (e.g. the high-status position) which they are not accustomed to. The exercise ended with staff commending patients on their participation in the role plays.

In one of the Group Working Drama sessions, one patient made a request to play a game with two other patients, with the remaining patient community looking on. The facilitators enquired about the length of the game and then granted permission to the patient. The game however resulted in discomfort for some patients and was interrupted as soon as staff became aware of the patient's motives. The facilitators discussed the reasons for the discontinuation of the game and informed the patient of her need to become aware of individuals' privacy, informed consent, and respect for others.

The sessions usually ended with patients and the facilitators forming a circle and discussing and summarising the various exercises. The sessions concluded with a decision about which patient would be involved in the Wednesday drama session. The majority of sessions ended at 11 am.

The only deviation from the norm observed in these sessions was that in the absence of the drama therapist, the sessions were facilitated by two nurses, one experienced and one inexperienced. No significant differences were noted in the facilitation of these sessions.

DRAMA FEEDBACK 11.00 - 11.10 am

The 'Drama Feedback' session occurred immediately after the 'Group Working Drama' session for approximately 10 to 15 minutes. Although all clinical staff were expected to attend these sessions, the attendance at all the sessions observed was very poor. Informal discussions with the drama therapist confirmed this observation. It is unknown whether this was a result of this session not being featured on the Centre's timetable. The drama therapist and the psychiatric nurse who co-facilitated the session communicated their observations and the underlying themes and content of the session to other staff members, with the focus being on the performance of specific patients and the general mood of the group. During one feedback session the drama therapist commented on the very loud, rowdy music playing during their tea break, noting that it was possibly indicative of their mood after the session. The sessions usually ended with a brief discussion of the activities which were particularly successful and those which were not.

In one feedback session, the drama therapist discussed one patient's initiation of the game which resulted in discomfort in the group. The drama therapist regretted that she did not enquire about the content of the game, prior to granting permission to the patient. The nurse co-facilitating the session however commented that the game resulted in the patient benefiting in that she learnt about boundaries and respecting the privacy of others. Staff members commented on the behaviour of this particular patient in the milieu as well as her family. The facilitators highlighted numerous patients who had difficulties participating and concentrating, and who were particularly disruptive. Staff members hypothesised about the underlying resistance of patients to activities.

TEA 11.00 - 11.30 am

The tea and lunch breaks began with high volume contemporary rock or pop music being turned on, almost always audible to the entire Centre. During these breaks, pairs of patients took turns to ensure that refreshments were provided for the patient community and that dishes were washed. Patients played pool, smoked, conversed with each other, slept or read during these times.

The tea break on a Friday differed in that the new patients to be admitted the following week had a brief orientation to the Centre during this time. The patients were introduced to two of the 'older' patients who orientated them to the patient community, to the staff and the building. They left at the end of the tea break.

GROUP THERAPY⁴ 11.30 - 12.30 pm

Group therapy sessions occurred each week on Mondays, Wednesdays, Thursdays and Fridays in either the Brown Room or in what was termed the 'Blue Room'. All clinical staff, with the exception of the psychiatrist and the administrative psychiatric nurse, were involved in the facilitation of group therapy sessions. Two facilitators were assigned to each group of patients. Facilitators rotated according to a time-table, agreed on by the majority of staff members. Attempts were made to allow trainees approximately four to six continuous weeks in facilitating one group of patients. These trainees, as well as inexperienced staff members, acted as co-facilitators with an experienced member of staff as the facilitator. Every week one supervisor was allocated to each group. Staff members were appointed as supervisors depending on their experience, but in most instances depending on the availability of staff. Thus, in reality all staff (excluding the trainees) adopted the role of a supervisor, which entailed observing the group therapy session, assisting the facilitators via the intercom telephone, and providing individual supervision at the end of the group therapy sessions.

Newly admitted patients were randomly assigned to one of two groups for the group therapy sessions⁵, depending on the discharge of patients from these groups. One group of patients were selected for the duration of the observation. This group comprised 6 patients (5 females and 1 male), two facilitators, one female, experienced nurse and one

⁴ The group therapy sessions were based on the principles and approach of Yalom (1975). No attempt was made to determine whether the group therapy sessions adhered to these principles.

⁵ There are advantages and disadvantages to homogeneous groups comprising adolescents with different problems and groups focusing on one diagnostic syndrome as a primary focus (Beeferman & Orvaschel, 1994).

male psychiatry registrar. New patients entered the group therapy sessions on the Thursday of their first week, as a result of staff conducting various admission procedures and other activities with them during the Monday and Wednesday group therapy sessions.

The group therapy sessions varied considerably from day to day, depending on factors such as new patients entering the group, patients leaving the group during their discharge week, new facilitators entering or leaving the group, and crises with certain patients (e.g. attempted suicide). Brief discussions of three group therapy sessions observed are provided.

- Patients and staff were seated in a circle with facilitators situated roughly opposite each other. Empty chairs were left within the circle for absent patients. The session began 10 minutes late, resulting in the facilitators questioning patients about their late arrival. Staff in the observation room explored the metacommunication (i.e. what was said behind the spoken work) and commented that patients' resistance to therapy and commitment to the programme was important to focus on. Staff discussed occurrences which took place during the tea break as well as patients' behaviour in previous sessions. The processes within the group were discussed and 'here and now' issues were considered essential to focus on. Some staff members were of the opinion that the group facilitators should have assumed less responsibility within the group therapy session, even if it implied long periods of silence. It was felt that the silence would force group participants to initiate discussion. This led to a general discussion on patients' resistance to therapy and a decision was taken that all staff should no longer play a dominant role, and that it should be the patients' prerogative to attend sessions or not. During the course of the group therapy session the supervisor used the intercom phone to inform the group facilitator firstly, to attend to the current problems and secondly, to not be as dominant in the group, thus forcing the group members to participate. The facilitator then rephrased these comments and informed patients of the observations made from the observation room.

- Group therapy sessions involving the entry of new patients took on a different form. The session began with patients introducing the session and the rules of group therapy, for example, no physical violence, no premature exit of the group, the role of the one-way mirror and the observers, and the kinds of issues dealt with in the sessions. Patients were warned that trust was a requisite to talking about themselves. The facilitators explained their role in the group, namely to direct patients in the issues brought to the session, to encourage them to identify with fellow-patients, to provide support, and to encourage them to utilise the sessions. They acknowledged that at times it would be hurtful and difficult to discuss certain issues and that this would be respected and support would be provided. On completion of this introduction, one patient spoke about a relationship and sexual identity problem which she was experiencing. Staff in the observation room discussed the family history of this patient in an attempt to understand her comments.
- One group therapy session began at 12.20 pm and ended at 12.30 pm as a result of a lengthy community meeting. Details of this meeting is provided later in the chapter. The group therapy session was not extended in order to maintain structure, consistency and containment.

The number of staff and students in the observation room varied considerably from day to day. In most instances, the psychologists, social worker and psychiatric nurses provided commentary about the session, noting positive and negative aspects of the facilitation, drawing attention to patients' responses and nonverbal communication, and linking previous sessions and events to what was occurring in the group therapy session.

One of the group therapy sessions observed had no supervisor in the observation room. This particular group session required communication between the facilitators and the supervisor and a situation arose where the trainees were left in a predicament, unsure about whether they could use the intercom phone to communicate with the facilitators.

GROUP FEEDBACK 12.30 - 12.45 pm

Staff, students and group facilitators from both group therapy sessions and observation rooms were present for the feedback sessions. One representative facilitator from each group summarised the content of the group, noting the basic themes and areas of concern. At times other staff members commented on the group processes, or drew on occurrences of other sessions. The content of feedback sessions varied with mere summaries being provided at times, while at other times, group processes and positive and negative aspects of the facilitation were discussed in more detail. The objective of these sessions was to inform all clinical staff of the outcome of both group therapy sessions.

In the one group session observed, where intervention was required but only trainee staff were present, feedback was given to the trainees that they should have used the intercom telephone to communicate with the facilitators. No comment was made about the reasons for the absence of a supervisor in the observation room.

The group feedback sessions were followed by individual supervision sessions for the facilitators of the group therapy sessions. The supervisors of each group met with the group facilitators and provided feedback about their facilitation, noting the areas where they could have improved, which comments or techniques may have been preferable, the positive and negative aspects of their facilitation and general comments about the group. Individual supervision took various forms, depending on the supervisor.

Concurrent with the staff feedback sessions, were patient feedback sessions, where representatives from each group provided a commentary of the group content to all the patients. These sessions were not observed.

ADMISSION OF NEW PATIENTS

Patients in their first week on the programme did not attend group therapy on a Monday and Wednesday, evocative therapy on a Tuesday and drama therapy on a Wednesday. Instead the psychiatric nurses completed a range of admission procedures with them.

These include, amongst others: patients signing an indemnity form; being informed about the rules of the Centre; having a full physical examination by one of the psychiatry registrars; completing collages and the Johari's window exercise; being assigned an individual therapist; and discussing finances.

PATIENT MEETING 1.30 - 2.00 pm

The patient meetings began with the Ward Representative, one of the 'older' patients designated to this role, congregating all the patients in the lounge area. This meeting allowed patients to take responsibility for resolving issues without the presence of staff members. The Ward Representative chaired the meeting and began by discussing whether patients had any compliments or complaints. Once these were discussed and noted by the Ward Representative, decisions were taken about the election of representatives for various tasks for the coming week. Duties and its therapeutic benefits were outlined on a large sheet of paper on the bulletin wall outside the patients' recreational area. At the patient meeting patients were assigned duties which changed every week or every second week. Decisions to allocate duties to patients was done in a haphazard manner, with some patients volunteering for certain tasks while others had tasks assigned.

SEX EDUCATION / CRAFTS 2.00 - 3.00 pm

The 'Sex education' session occurred fortnightly and was facilitated by a young woman from the Planned Parenthood Association. All patients (excluding some who had individual therapy or family therapy sessions scheduled during this time) attended these sessions. Patients were seated in a large circle in the Brown Room. In general the atmosphere was relaxed with patients in a fairly inactive mood after the lunch break. The facilitator prepared a topic for discussion for each session. The theme for one of the sessions observed was on preventing sexual intercourse. Patients and students were divided into small groups to discuss ways in which to prevent sex. After the small group discussion, patients discussed the main points arising from their group with the larger group, with comments written on a flip chart by the facilitator. There was a considerable

amount of laughter amongst the patients with some explicit examples given by some and others asking curious questions. In general it appeared to be an enjoyable, light-hearted but informative and educative session.

The topic of abstinence from sexual intercourse was discussed in a second session. A 30-minute video on sexual intercourse was shown, with patients watching and listening attentively. The video used comic, line-drawn figures to demonstrate how a male and female gave preference to other methods of sexual activity instead of sexual intercourse. The consequences of sexual intercourse were discussed, focusing on both the emotional and physical aspects. Precautionary measures were outlined in detail. In general, the video was educative and although the comic figures were at times humorous it appeared successful in portraying the message of alternatives to sexual intercourse. Although few comments were made after the video, many of which were of a humorous nature, the patients were attentive throughout the session and requested more videos in the future. At times staff members were present in the session or in the observation room, while at other times no staff members were present.

Every fortnight there was a craft session, facilitated by one of the psychiatric nurses, in which patients participated in a range of creative activities, such as painting, t-shirt dying, etc. During the craft sessions observed, patients were involved in painting recreational furniture (e.g. outside benches).

WARD ROUND 2.00 - 4.00 pm

This session, depicted on the time-table as 9.30-11.00 am, occurred in the afternoon. The majority of staff members were present at the Ward Round sessions in which trainees provided a detailed account of the progress and management of each of their individual therapy patients. Examples of management decisions included patients requiring intelligence tests, family therapy sessions, outpatient and/or individual therapy post-discharge sessions. Patients who did show improvement while on the programme were considered for anti-depressant medication. The session was dictated by one staff member

who was critical of trainees who failed to adequately follow-up patients from week to week. This staff member was also fairly authoritarian with regard to the management of patients. This was evident from the minimal discussion around alternative management strategies and the apparent resistance to opposing viewpoints.

One of the Ward Round sessions observed differed in that the one dominant staff member was absent as well as two other staff members. While the session took on the same format with the trainees presenting the progress of their patients, this occurred fairly briskly. When patients were not adequately followed up (e.g. where a family session was not held, as discussed in a previous Ward Round session), few attempts were made to determine the reasons for this. Only one staff member at times clarified and questioned the trainees with regard to the management of patients. What was clearly evident though was the considerable amount of participation by all members of staff, several of whom drew on specific incidents which occurred within the milieu. This was different to the sessions observed with the full complement of staff.

SUPERVISION WITH THE PSYCHIATRIST (CONSULTANT)

The supervision sessions with the psychiatrist did not occur at the time allocated on the Centre's time-table. Instead, the session took place on Wednesday mornings. These sessions were attended by the trainees and involved the psychiatrist discussing the history and diagnoses of the patients to be presented in the 'Presentation' sessions. These sessions were not observed; instead trainees were interviewed and asked to complete a semi-structured questionnaire in order to determine the aim and functioning of these sessions. This will be discussed in the following chapter.

TUESDAY

EVOCATIVE THERAPY PLANNING 8.15 - 9.00 am

All staff were expected to attend this session, with the exception of psychiatry registrars who had lectures during this time. All the sessions observed were poorly attended, with nurses being the only staff members consistently attending. The aim of the session was to determine the activities for the Growth Games and Evocative Therapy sessions and to allocate facilitators and co-facilitators to these sessions. The allocation of a supervisor applied particularly to the Evocative Therapy sessions. Nurses proposed various exercises for the Evocative Therapy sessions, providing reasons for their choices, while others questioned the appropriateness of it.

A description of four of these sessions observed is outlined below.

In the first session observed, one staff member suggested an exercise requiring trust, but several staff members objected, commenting that containment work was required and that there was insufficient trust in the patient community for this exercise. This resulted in the conclusion that a cohesion-building exercise would be preferable and the 'Island exercise' was suggested. This was discussed and approved. Staff then generally discussed the patient community, commenting on their resistance to talking and their difficulty in accepting feedback from staff. These issues were related to the early discharge of two patients the previous week, who left as a result of abusing substances while on the programme. In light of this discussion, staff took a decision to opt for the 'Role reversal exercise' instead of the 'Island exercise'. The rules of the exercise were discussed (e.g. all staff were to vacate their offices, not to take telephone calls and to adopt the role of patients). The session ended with a brief discussion about the activities for the Growth Games session and the allocation of staff members to the Evocative

Therapy session. Decisions about the types of games took into consideration the types of issues appropriate for the patient community each week.

The second 'Evocative Therapy Planning' session observed began with a discussion of two patients entering areas such as the gardeners' and domestic workers' rooms. Staff discussed the behaviour of one of these patients, and commented on the need to teach the patient about setting limits and boundaries. One of the nurses reported that a patient contacted her telephonically as a result of family difficulties. After some discussion about this patient a decision was taken to inform the patient's individual therapist of the possible usefulness of family therapy for this patient. Decisions were finally taken with regard to the Evocative Therapy session. Staff discussed the 'Goals and obstacles exercise', in light of the fact that several patients were unsure of their goals and needed to give some thought to goal setting and the obstacles facing their goals. Two of the more experienced nurses physically demonstrated the exercise. The 'Ragdoll exercise', which dealt with boundaries, was considered appropriate for the Growth Games session.

The third session observed comprised three nurses and two nursing students. One of the staff members was not present as a result of staff-related problems. Suggestions for the Evocative Therapy session included the exercise 'The animal I am, the animal I want to be' since patients were having difficulties revealing the 'other side' of themselves. In this exercise patients were required to draw an animal which best depicted themselves followed by a drawing of an animal which they would like to be. This exercise was agreed on by all the nurses. A decision was taken to do the 'Portrait exercise' in the Growth Games session in which patients are required to place themselves in a 'portrait' of the Centre.

In the fourth session observed, a decision was taken to do the 'family clay modelling exercise', where patients would be able to discuss parts of themselves and their home environment. One of the nurses made the necessary preparations for the session, ensuring that there was sufficient clay, boards, and paper and pencils for written feedback. The

Growth Games exercises were then discussed. The 'Twenty questions exercise' was decided on, where everyone was required to non-verbally act out another person and other patients had to guess who the person is. The session ended with a discussion of the patient who would be involved in the following day's Drama Therapy session. Staff expressed shock at the patient mentioned and asked whether another patient could not be involved in the session instead. It was mentioned that a family session was scheduled for this patient and it would not be appropriate for her to simultaneously have an individual Drama therapy session. No conclusion was reached on this issue.

GROWTH GAMES 9.00 - 10.00 am

Two nurses always facilitated these sessions and the majority of patients were present. Only rarely were there staff observing these sessions. The majority of sessions began promptly at 9am, with an introductory statement about the purpose of the session, although this was at times vague, with little clarification provided by the facilitators. Patients introduced the session as one in which they played games, grew emotionally, learned to trust each other, got in touch with their feelings and obtained feedback from others. The types of games played during this session are outlined below.

- Patients were seated in a large circle. One patient's chair was removed from the circle and one patient stood in the middle of the room. The patient called out that all those who were wearing a particular article of clothing or colour had to move from their seat to someone else's seat which was vacant. Each time this occurred one patient was left without a seat and the game continued in this manner. Patients actively participated and seemed to enjoy the exercise.
- The 'upset fruit basket' exercise was similar to the game described above. Everyone was seated in a circle with one chair removed and a patient standing in the middle of the circle. Each patient was assigned a fruit name, namely, apple, pear, banana, peach. When the patient in the middle shouted the name of any of the fruits, all those who were labeled with the fruit moved to another patients vacant seat. When the

person shouted 'upset fruit basket' everyone moved. All patients actively participated.

- Patients were seated in a circle and one patient began to whisper a message to the person next to him/her who then whispered what was heard to the next person and so on. No repetition or questioning of the message was allowed. At the end of the exercise the nurse commented on the purpose of the exercise, namely to listen attentively and to note the ease in which stories could be fabricated.
- Patients were placed in pairs and the 'Ragdoll exercise' was explained to them. One patient was a ragdoll and the other was the owner of the ragdoll. Patients were allowed to do whatever they wished with their ragdoll. At the end of the exercise they were asked to place the doll in any position they wished and to look at the position the ragdoll was in. Roles were reversed and the same instructions were given. Some patients handled their ragdoll very harshly, while others were gentle. Two patients positioned their ragdoll with their hands in mid-air. On completion of the exercise the nurse asked patients what it felt like being the ragdoll and the owner.
- The 'portrait exercise' involved patients positioning themselves in a 'portrait' of the Centre. Patients placed themselves at various levels, some seated on the floor, others standing on chairs, some with their back towards others and some far away from others. On completion of the portrait, patients were told to note their body language and their position in relation to others. Nurses questioned patients on their positions, for example those that placed themselves away from others were asked if they felt removed or distant from the patient community, and if so, the reasons why.
- Each patient selected a name of another patient from a box. Patients were required to ask upto 20 questions in order to guess the names of the patient selected. Preference was given to questions relating to the personality and characteristics of the person (e.g. asking if the person is aggressive, friendly, sensitive, active in sessions,

withdrawn, lonely, etc.). Only 'yes', 'no', or 'sometimes' responses were allowed. Patients actively participated. On completion of this exercise, patients drew another name and this time verbally and nonverbally enacted the patient selected.

EVOCATIVE THERAPY 10.45 - 12.15 pm

All patients attended this session with the exception of patients in their first week of the programme, who were involved in collages and other activities with one of the nurses. New patients were introduced to the session. Evocative therapy was described as the use of different mediums to identify issues and express emotions, for example fantasy trips, drawing, poetry and discussions of these⁶. These sessions were often observed by a range of staff members, with one supervisor allocated to the session. Evocative therapy took the form of projective art exercises, the aim being to create a setting where unconscious material can surface allowing group exploration.

A lengthy description of three evocative therapy sessions are provided below.

- The first session included the new patients as a result of the decision to discuss the 'Role Reversal exercise', which everyone would be involved in. The session was facilitated by two psychologists, two nurses and the social worker, with one nurse observing the session. Facilitators discussed the resistance of patients towards staff and the 'Role reversal exercise' was a way in which staff and patients could be made aware of each others' roles and of the experience of the programme. Facilitators asked patients to comment on whether this exercise would be beneficial to them. They responded with a range of questions, demonstrating enthusiasm and excitement. There was a considerable amount of laughter as patients began imitating certain staff members. The staff's programme for the week was placed on the wall and sessions which patients were unaware of (e.g. Evocative Therapy Planning, Group Feedback)

⁶ Some disturbed patients are unable to communicate their thoughts and feelings verbally. To overcome this, nonverbal therapeutic strategies are utilised in a group format. These can be viewed as a language which has closer contact with one's feelings, hence patients are able to express themselves in a symbolic way (Perris, 1992).

were explained. The facilitators emphasised that although the exercise would be humorous and enjoyable, it was essential that it was taken seriously in order to learn from it. The rules of the exercise were then discussed. Patients and staff were expected to dress appropriately. Staff offices were available for use, with the exception of filing cabinet materials, telephones, and files, which patients were requested to respect. All staff were informed to use only the patient areas and not their offices. Staff left patients to plan the day on Friday. Patients requested that staff in the observation room leave.

- The second session involved the exercise 'The animal I am, the animal I want to be'. Patients were asked to think of an animal that best resembled themselves, taking note of the characteristics of the animal. Emphasis was placed on the fact that artistic skill was not being tested. On completion of this, patients were required to think of an animal which they would like to be in the future, once again taking into consideration the characteristics of the animal. Patients quietly reflected on their choice of animal and several of them put a considerable amount of thought into their drawings, using a range of different coloured crayons and paying attention to detail. One patient took particularly long and this was observed by the facilitators and commented on in the observation room.

On completion of the drawings, patients volunteered to discuss their pictures with the group. One patient, who was usually withdrawn and quiet in sessions, volunteered and placed her picture in the middle of the room on the floor. The patient drew a picture of a dog tied with a chain, surrounded by a fence. Some of the questions and comments that ensued from this drawing were as follows:

Facilitator⁷: Why did you draw a dog, and why did you chain the dog?

E⁸: It is a vicious dog, when angry he bites.

Facilitator: How does the dog feel when tied up in an enclosed space?

E: The dog fears that it might hurt others.

F: I don't understand what you really saying. Explain it to us.

[E. clarifies that this is who she is]

Facilitator: A vicious dog? I've never seen you like that - that part of you.

J⁹: I understand the fence. It is about being scared that others will see the other side of oneself.

E: Become out of control

Facilitator: How do you understand how that happens?

[E. had difficulty responding to this question and the question was directed to other patients.]

Facilitator: How do people understand why anger goes out of control?

[Patients are unable to respond.]

E: Sometimes anger goes to where it doesn't belong.

Facilitator: Any ideas of where anger comes from, what it's about?

E: Parents.

Facilitator: Why your parents?

[E. is unable to answer this question.]

⁷ Facilitator: One of three facilitators

⁸ E: The patient whose drawing was discussed

⁹ J, M, E, C: Other patients commenting during the session

Facilitator: Often it is difficult to show those feelings of anger and it becomes easier to take it out on others.

J: Do you feel bad when you take your anger out on others?

Facilitator: It is important for everyone to know to put their anger where it belongs. Think why you are angry with people.

Facilitator: This is a similar situation to what happens between you (Jane) and your father.

Facilitator: It is difficult to know what to do with your anger.

J: Some can keep it in, some can't.

M: I keep my anger in and explode later on.

Facilitator: How do others feel?

E: I wouldn't like people to take anger out on me.

M: Why must we talk about this?

Facilitator: Because it is a problem for E. and others. Let us look for different ways of dealing with anger.

E: It helps to talk about anger.

Staff commented that the majority of patients were insensitive to E. who has taken a risk to disclose, but had not received adequate support and feedback, with only a few patients actively participating.

E. was then asked to present the picture of the animal which she would like to be. A picture of a bird was drawn.

Facilitator: Why did you choose a bird?

E: Feel free, do your own thing, don't want to worry about anything.

- C: But a bird also has its boundaries; freedom has its boundaries. If you do your own thing, then there will be chaos. Even if you are free you must still have limits and know when to stop.
- Facilitator: Are you saying you must have responsibility?
- Facilitator: Is it a young bird that needs to be taken care of?
- E: Yes.
- Facilitator: Sometimes it is nice to have someone to look after you. Is this a part of yourself that wants to be looked after.
- E: No, the bird doesn't want its parents; it wants to go its own way.
- Facilitator: But the bird must come down to feed, it cannot keep on flying. Realities need to be looked at.

Other patients asked how E. was feeling, but she had difficulty responding. The staff commended E. for being prepared to look at herself and for sharing her drawing with the group.

Two other patients who volunteered to discuss their pictures were asked similar types of questions, although less time was spent on these patients. The session ended with staff thanking those who discussed their pictures. Patients were asked to return their pictures with their names on it to the staff members. Sheets of paper and pencils were handed to patients for written feedback on the session.

- There were no staff observing the session for the first hour of the third session observed. The 'family clay modelling exercise' involved patients being instructed to construct a clay model of themselves in relation to important others in their lives, including all those who played significant roles in their lives (e.g. parents, guardians, friends). Symbols could be utilised to depict certain individuals. Patients each took pieces of clay to soften and boards were handed out. It was emphasised that no

talking, giggling or signing to each other was allowed. The majority of patients were engrossed with their models, with only a few patients looking around at others.

One patient volunteered to begin discussing her clay model, describing her position in relation to others in the family. The facilitators noted the way in which the patient moulded herself and her family, noting the various positions of each member of the family. The patient was questioned on the ties and distances the patient experienced with various family members. A range of questions relating to the model were posed to the patient in an attempt to help her identify patterns and become aware of the underlying dysfunctional cognitions. Facilitators noted that she omitted significant individuals in her life and the patient was asked whether she had understood the reasons for this. One of the nurses asked her to place herself where she would like to be. The remainder of the patients became restless and fidgety, while attention was focused solely on one patient.

The next patient presented her family clay model and patients and staff once again asked questions related to the position of each family member. For example, the patient placed her father, depicted as a very small ball of clay, in one corner of the board, removed from the other clay pieces. The patient was asked to alter the model according to what she wished it could be. The patient then proceeded to remove significant individuals from her model. One of the staff members in the observation room commented that a family session with the patient and her family would be useful in order to determine the family situation. The facilitators commended the patient on discussing her model with the group, but reminded her that in reality the family members removed needed to be dealt with and could not merely be removed. At this point, one of the patients enquired about when the session ends. Another two patients' clay models were discussed before the session ended. The facilitators thanked those who discussed their models and asked patients not to dismantle their models but to take them to their individual therapy sessions. The models were left in

the room for discussion with the remainder of the clinical staff on Wednesday morning's Evocative Feedback session.

LIFE SKILLS 2.00 - 3.00 pm

All patients (excluding those who were in individual therapy or family therapy) attended the Life skills session, facilitated by two of the nursing staff. Most of the sessions began slightly after 2pm. Staff observing the session varied from a few staff members to none at times. The session was introduced by one of the 'older' patients as one in which they learned social skills to deal with the outside world. The facilitators added that the aim was to learn skills to be able to communicate in a social setting, for example learning to assert oneself. During the course of several of these sessions, the facilitator stopped the session, commenting that patients were not attentive, with some talking to each other and others falling asleep. Two of the sessions observed took the form of a lecture with little participation by the patients. In general patients were lethargic and appeared tired and bored. One of the trainees enquired from a staff member in the observation room whether patients could be scheduled for individual therapy during the Life Skills session. It was suggested that this be arranged with the facilitators of the session since some sessions were particularly relevant to certain patients and should not be missed.

In another session, management of anger was discussed. Although patients were more active in this session observed, contributing with examples of their own behaviour, it once again took the form of a lecture by the facilitators with insufficient participation by the patients. A role play was planned for the end of the session but did not materialise as a result of time constraints. One of the staff members observing the session commented that a role play may have been preferable near the beginning of the session so that practical ways of dealing with anger could be demonstrated and simultaneously ensuring patient involvement.

WEDNESDAY

PRESENTATION / EVOCATIVE THERAPY FEEDBACK 8.15 - 9.00 am

During the 5-week observation period, no presentations occurred during this session as a result of a minimal number of new patients being admitted. Instead, the session was used to provide feedback to clinical staff of the previous day's Evocative Therapy session. In general, this session was well attended by clinical staff. Facilitators summarised the session and commented on each patient who contributed, as well as those who did not actively participate or who appeared to have had difficulties with the session. It was noted that patients became restless and appeared to lose concentration in these sessions. Discussion of certain patients led to decisions such as arranging family sessions or intelligence tests. One feedback session led to the decision to schedule a session on anger management for the Life Skills session, since patients appeared to have difficulties expressing and managing their anger.

The feedback session on the clay modelling exercise involved all the models being placed in the centre on the floor, with staff seated around it. The facilitators gave an account of each patient's model, explaining the various members. The written feedback of patients were read aloud, several of which were brief and uninformative. The session ended with a discussion of the collages of two newly admitted patients. Aspects such as the colour, content and position of the pictures were noted. The comment was made that no staff were present in the observation room with the exception of the author for the previous day's evocative therapy session. However, no attempt was made to determine the reasons for the absence of the supervisor.

INDIVIDUAL WORKING DRAMA 9.00 - 11.00 am

The 'Individual Working Drama' session was preceded by a briefing between two psychiatric nurses and the drama therapist for approximately 10 to 15 minutes. The drama therapist was provided with a brief account of the individual patients' history, presenting problems and progress in the milieu. The main problem areas of the patient, (e.g. problems with acceptance; unable to assert herself; difficulty talking and accessing emotions) were highlighted, with specific incidents drawn on where necessary. For example, nurses recalled an incident where one patient allowed two other patients to continuously physically hurt her in order to be accepted by them. Nurses felt the need for the session of this patient to be conducted in the patient's home language, Afrikaans, to allow for easier expression of feelings. It was noted that the patient had previously demonstrated resistance to speaking Afrikaans at the Centre. With the given information, the drama therapist thought of an exercise appropriate for the patient. There was limited time available for this briefing.

As a result of the pre-session briefing, all the drama sessions observed began approximately 15 minutes late, with staff apologising to patients for the delay. The drama therapist, with the support of the nurse, facilitated the session. The session began with introductory remarks to the new patients. The session was described as one in which an individual patient was focused on throughout the session, although all patients participated, by being involved in the enactment of a scene. Patients emphasised the need to respect each other by providing feedback, not laughing, being quiet and supportive, and assisting in the role plays. The drama therapist defined the session as one focusing on an individual's personal therapeutic process, with the participation and assistance of the group. This provided an opportunity to engage spontaneously with and reflect upon different aspects of the self and relationships.

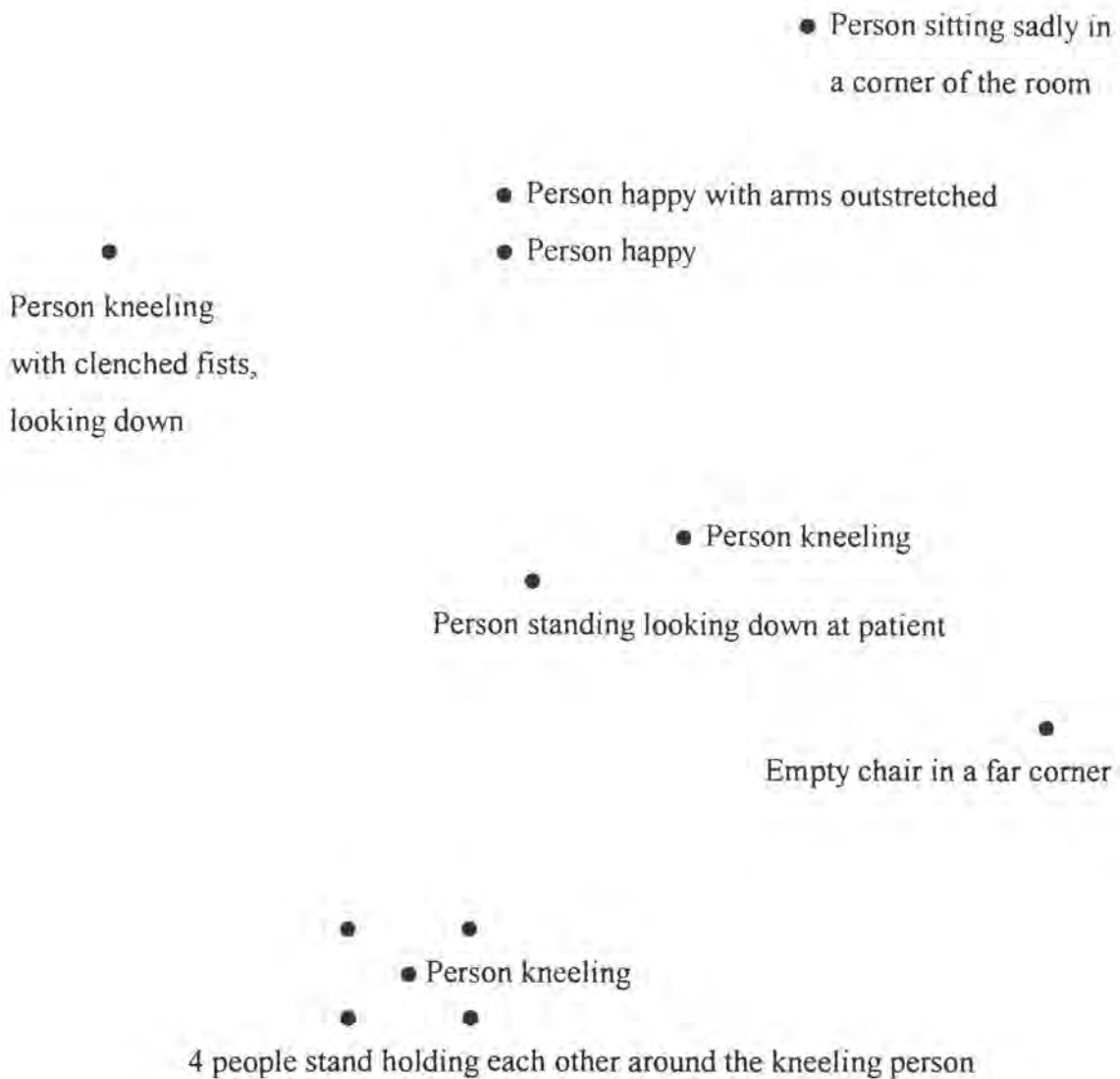
After the introduction, patients were asked to volunteer for the coming two Individual Working Drama sessions. The drama therapist urged those patients in their eighth week onwards to volunteer on condition that they were willing and prepared to participate. On

confirmation of two patients for the coming weeks, the session began with a warm-up exercise, the aim being to increase the level of readiness of the group members to become involved in the session. This was followed by the action stage which took up most of the session. This stage differed from session to session, depending on the nature of the patients' problems. The basic structure of these sessions were as follows: An individual patient, known as the protagonist, volunteered to identify and explore the psychosocial dimensions of his/her conflicts through the portrayal of a situation which demonstrated his/her past, present or anticipated future life situation. Thus, each psychodramatic scene was an individual's own creation, spontaneously enacted. The protagonist was the focus of the session. The auxiliaries were the remaining patients who facilitated the protagonist's conflict situation by portraying necessary roles that served the needs of the protagonist. The action space was the area where the enactment took place, where the protagonist had complete control over the space. With the assistance of the auxiliaries and the drama therapist, the protagonist worked through his/her problems. The session ended with patients sharing similar experiences with the protagonist and discussing patients whose own difficulties were evoked by the session.¹⁰

Detailed accounts of the action stage is provided for two of the four sessions observed.

The first session observed was facilitated by the drama therapist and an inexperienced nurse. Twelve patients were present for the session. The protagonist was asked to think of important relationships in her life and to create a 'sculpture' which depicted these relationships, utilising the patients as 'clay'. The protagonist was reminded that the entire room space was available and that the bodily posture, proximity of 'clay' figures, and facial expressions of the 'clay figures' were important. The protagonist proceeded to place patients in various positions. The majority of patients took the exercise seriously, actively participating and remaining quiet as the protagonist placed them in positions. The scene was depicted as follows:

¹⁰ The reader is referred to Kipper (1992) for a detailed discussion on the structure and process of psychodrama.



On completion of the sculpture, each of the ‘clay figures’ commented on their feelings in the role they were placed in. Thereafter patients were asked to provide their interpretations of the sculpture, regardless of whether it was accurate. Patients responded drawing on their knowledge of the protagonist’s history and disclosures in the milieu. Others provided general comments, for example, ‘looks as if she is suffocated’, ‘under pressure’, ‘as if there is a darkness over her’, ‘unable to break loose’, ‘hiding her anger’. Each part of the sculpture was examined, focusing on the facial expression and positions, with various interpretations provided. One patient for example commented that the empty chair symbolised a feeling of emptiness and that life was not worth living.

The protagonist was asked to respond to the comments made by patients and proceeded to discuss what her sculpture depicted, with patients and the facilitators asking numerous questions and comments, many of them in-depth, sensitive and emotional in nature. The majority of patients were attentive although two patients appeared to be falling asleep. A negative scenario was depicted and the drama therapist questioned the protagonist about the ways in which her situation could be changed, focusing on the future aspect of the sculpture. Alternatives were discussed and possible solutions were enacted. Towards the latter part of the session patients became very restless and did not appear to be concentrating, with little feedback given to the protagonist. The session drew to a close with everyone forming a circle and commenting on the session and the difficulties they had in giving feedback. Patients were reprimanded for not respecting the protagonist. The session ended with patients writing feedback on the session.

In the second session observed, the Afrikaans speaking patient mentioned earlier, was asked to set up a scene depicting the various masks which she wears. The drama therapist insisted that the session be conducted in Afrikaans, but the patient immediately resisted. The session however was conducted in Afrikaans with the patient continuously replying in English. Similar to the first session observed, a scene was set up in which patients were placed in certain roles, taking note of the position, posture, and facial expressions. A very similar procedure to the one described above was followed. Towards the end of the session, a role play was set up by the nurse, who was aware of the protagonist's difficulties in asserting herself. The nurse asked one patient seated opposite the protagonist to merely say the word 'Yes' continuously while the protagonist was asked to respond by saying 'No' continuously. The protagonist had enormous difficulty with this exercise. Staff and patients encouraged her, emphasising that her responses had to be said loud and forcefully. The patient refused to continue, saying that it was an impossible task, and walked away. Another patient was then asked to take her role and to role play the same situation, demonstrating with both verbal and nonverbal behaviour how to be assertive and say 'No'. Patients then recalled their experience of the

protagonist's difficulty in saying 'No' to them. The facilitators encouraged her to examine the reasons for her difficulties in asserting herself.

Situations were continuously role played by the protagonist until she gradually became more assertive and was able to say 'No'. The drama therapist encouraged the protagonist to find ways of asserting herself and to begin with accepting herself. The session ended with everyone forming a circle and discussing their experience of the session. The facilitators urged patients to insist that the protagonist asserts herself. Patients then proceeded with their written feedback.

DRAMA FEEDBACK 11.00 - 11.10 am

Attendance at the drama feedback sessions varied, but in general was poorly attended, although all staff members were expected to attend. The drama facilitators briefly summarised the session, providing feedback on the protagonist's difficulties and the participation of patients. The clinical staff provided related comments about patients, drawing on the content of previous sessions. At times the feedback sessions took the form of a discussion rather than a mere report on the session. In one feedback session the drama therapist reported difficulty in working with an inexperienced nurse, commenting that since she was unaware of all aspects of the protagonist and other patient's histories, the support of an experienced staff member was crucial.

In another feedback session the drama therapist appeared despondent, commenting on the protagonist's inability to function emotionally and within a drama medium. Clinical staff however reassured her that knowing the limitations of the protagonist assists in their management of the patient. Thus the session was diagnostic in that it showed the extent of the protagonist's dependent personality style.

Although a considerable amount of feedback was provided within the ten minutes allotted, a large amount of material was not discussed. These drama feedback sessions

were followed by more in-depth, informal feedback and discussions between the two facilitators, lasting approximately 30 minutes.

EMERGENCY COMMUNITY MEETING 9.15 am

One of the Wednesday mornings saw a dramatic change in the therapeutic programme with an emergency community meeting held at 9.15 am. The majority of clinical staff and patients were present. The meeting was led by the social worker who informed the community of the reason for the meeting, namely that two patients were reported to have been smoking cannabis the day before and were sent home that morning to think about their commitment to the programme. They would be returning the following day to inform the community of their decision, either to commit to the programme or to leave. All patients were extremely quiet and attentive. Staff commented that what occurred with these two patients was a reflection of the patient community in general, namely, that patients were not committed to the programme, that they were insensitive to each other in sessions, and that they mistrusted each other. There was a period of silence which was broken by one of the staff members requesting comments from the patients. Patients however were reluctant to respond. Much later, a discussion ensued amongst the patients, with some agreeing that there was a lack of trust. Silence persisted once again, followed by a staff member asking whether the silence implied that they were in agreement that the programme was not being taken seriously. The meeting eventually ended with staff leaving patients to make decisions regarding their commitment to the programme or whether they wished to be discharged. It was noted that attendance at the programme was a voluntary decision and although they could benefit from the programme, the choice was ultimately theirs. The meeting ended at 9.45 am.

The afternoon sessions varied from week to week. Once a month a nursing sister from a Family Planning Clinic facilitated a session in which she consulted individually with patients. These consultations were confidential and voluntary for patients.

THURSDAY

STAFF GROUP 8.15 - 9.00 am

The staff group was a weekly group session facilitated by an external clinical psychologist from Groote Schuur Hospital. Observation of the session was not possible from the observation room and therefore occurred in the session. The majority of staff members were present for these sessions which almost always began five minutes late. The facilitator began the group by introducing herself and welcoming new trainee staff to the group. At the first observation session, the facilitator confirmed with the staff that permission was granted for the author to be present and enquired whether the author's presence would interfere with the process. No objections were made.

The observation of three staff group sessions are described below.

The staff were seated in a large circle. The facilitator asked one of the staff members to introduce the session to the new trainees. Staff however resisted and there was silence for approximately ten minutes. Several of the staff gazed down at the floor and the silence persisted for another ten minutes. One of the staff members questioned the staff's resistance to talking and commented that she was unaware of the purpose of the staff group. One of the nurses immediately reacted commenting that it was unacceptable that permanent staff who have been at the Centre for a period of time were unsure of the purpose of the group. She discussed her unwillingness to talk, as a result of the considerable amount of responsibility she had in the milieu. She expressed concern about the patient community which was disintegrating and felt that this was related to the lack of staff cohesiveness. Two other nurses supported these comments, noting the high absentee rates which never occurred in the past and the fact that the nurses were carrying

a considerable amount of responsibility running the milieu. It was noted that the staff as a team were not showing an interest in the programme.

Some staff members commented that they were reluctant to contribute to the discussion since this issue had been dealt with ad nauseam and there was no real solution to the problem. Others felt that the group was not productive or useful, noting how confidentiality was not upheld in the past. This was posed as one of the reasons for the resistance to talking in the group. Silence prevailed again for a period of time. The session ended with the facilitator apologising to the new psychology intern and to author that the purpose of the group was not defined and that this may occur in future sessions.

The second staff group observed began in silence. The facilitator asked whether staff wished to continue the discussion from the previous week. Some staff members felt that nothing more needed to be said and silence prevailed once again. One of the nurses then commented that nothing has changed and that the situation had in fact become worse with one of the nurses being absent due to illness. This nurse commented on her inability to cope, facilitating numerous sessions everyday. Other staff members commented that the situation should not continue and perhaps the programme should be adapted. One of the more senior staff members however reacted saying that this was not the solution and that a meeting should be held to determine the problems and possible solutions. Another staff member agreed that the programme should not be altered. Instead, the staff problem should be addressed. The suggestion was once again made that the programme be adapted, taking into consideration the number of staff members available. One of the experienced nurses noted how in the past, the programme was run efficiently with the same, and at times fewer, staff members and that was a result of cohesiveness of the staff team, where support and assistance were present.

The psychologists and the psychiatrist commented on their responsibilities to UCT and GSH, which resulted in them being unable to devote more time to the milieu. Some staff members commented that they were unaware that staff had responsibilities and

commitments outside the milieu programme. It was mentioned that it was important to voice this in order for others not to have undue expectations of them. Some staff members expressed the need to know when staff were available, what their workload was, and most importantly what their priorities were: the therapeutic milieu or other responsibilities.

The session ended with the facilitator summarising the session, stating that it appeared that the dynamic was one of the nursing staff versus non-nursing staff, a phenomenon common to staff groups at other centres. The same applied to the lack of clarity of staff members' responsibilities towards GSH and UCT. One of the staff members commented on the considerable amount of time and effort expended on administrative work in order to ensure that the Centre remained an adolescent unit at a time when psychiatric services were being reduced. Another staff member however reacted to this statement saying that the discussion did not concern administrative work; instead there were staff problems which needed to be resolved. The session ended with the facilitator suggesting that these matters be dealt with at the following staff group session.

The third staff group included all the clinical staff with the exception of the psychologists. The social work student was introduced to the session by the social worker who described the group as a place where (i) staff obtained support; (ii) where they were able to discuss interpersonal problems which could not be dealt with on an individual basis; and (iii) where personal problems could be discussed, especially where it affected their work performance. He however added that in practice, staff do not always feel comfortable to talk in the group as a result of lack of trust. He added that there are often periods of silence and at times there are no pressing issues to discuss in which case the group may end early. The facilitator emphasised that the group was for the benefit of the staff and they were able to utilise it as they wished. One of the psychiatry registrars thanked the staff for their support during the week in which one of his patients took an overdose and was seriously ill. There was a considerable amount of participation by all staff members in this session with no-one dominating the discussion.

No staff groups were held for two weeks as a result of the external facilitator being on leave. Some of the staff members commented to the author after the staff group sessions that the sessions observed were not a true reflection of the conflicts and dynamics amongst the staff members.

RELATIONSHIPS 9.00 - 10.15am

Two of the 'Relationships' sessions observed are described below.

The first session comprised all the patients, one psychiatry registrar and the psychiatrist who facilitated the session. The session was observed by several staff members in the observation room. After the session was introduced to the new patients as one in which relationship issues are discussed, there was a long period of silence. One of the new patients then initiated a discussion on the important components of a relationship. The facilitator asked numerous questions with few patients providing comments. The issue of trust in relationships was the topic of discussion and the facilitator took this opportunity to ask two of the patients who were caught smoking cannabis at the Centre, for their comments. One of the patients responded saying that he was unable to trust himself and therefore unable to trust anyone around him. Two other patients discussed their experiences of lack of trust and this led to a discussion on responsibility. Staff in the observation room discussed the importance of the session, commenting that the key issue in the patient community was trust between patients and trust between the patient community and the staff. The positive aspects of the facilitation such as the manner in which the facilitator directly confronted patients was highlighted. Non-verbal communication was noted as well as the inappropriateness or unusualness of new patients talking in their first week at the Centre.

The theme of the second session observed was on responsibility and boundaries. The facilitator did most of the talking, with some participation by patients. Patients discussed the difficulties they have when finding themselves in situations where they feel obliged to

have sexual intercourse. Some patients felt that these situations could be avoided by discussing it with their partner and the facilitator linked this conversation to the topic of responsibility. Staff in the observation room commented that several of the patients did not have a clear notion of their boundaries and could possibly find themselves in situations ripe for abuse. Patients later discussed television programmes and the facilitator attempted to redirect the discussion to the theme of responsibility. One patient commented that the Centre does not assist her since it is more painful being at the Centre discussing their life situations. The facilitator alerted the patient to the fact that it is often difficult and painful to talk about sensitive issues, but that this could result in situations improving. Staff in the observation room commented that had the facilitator observed the previous day's 'Individual Working Drama' session or attended the 'Drama feedback' session, in which this patient was the protagonist, he might have been in a position to understand her comments and more importantly to highlight the changes which occurred within her since she expressed several painful feelings. The session ended at 10.15 am with the facilitator emphasising the importance of taking responsibility.

During the weeks when the psychiatrist was on leave, one of the psychologists and nurses facilitated the session. Observation was however not possible as a result of the sound system which was faulty.

COMMUNITY MEETING 10.30 - 11.00 am

The first community meeting observed was attended by all patients and clinical staff. The meeting took place promptly at 10.30am in the patients' lounge area. Chairs were situated along the sides of the room, forming a square-like shape. The community meeting was a general feedback and 'clearing house' for problems from both patients and staff. The patient acting as the Ward Representative led the meeting. She related the patients' lists of complaints and compliments, discussed at the Patient meeting earlier on in the week. Complaints included the fact that patients were not present at all sessions; that patients were smoking cannabis at the Centre; that some patients were not doing their duties; and that patients were insensitive during feedback sessions after group

therapy, showing little interest and smoking and eating in these sessions. Staff dealt with the complaint of substance abuse by confronting the accused patients. These patients were asked to make a decision about their commitment to the programme which implied signing a contract to not abuse substances while on the programme, or to leave the Centre. Two patients opted to leave and left immediately. These events together with the remaining complaints of patients resulted in staff leaving patients to decide on their commitment to the programme.

The second community meeting observed once again began with patients complaining and complimenting patients and staff, with a discussion on the most pressing complaints. Complaints included patients not upholding their duties adequately, for example not washing the dishes, and not cleaning the lounge area; staff being late for sessions; verbally abusive language used in sessions; and some patients not contributing money towards the sandwich fillings. Each complaint was discussed with staff members relating some of the complaints to their observations in the milieu. The complaint of patients not contributing to sandwiches resulted in patients arguing that they gave preference to bringing their own food. Staff however informed patients of the need to function as a community, thus requiring participation and contributions from everyone. Complaints from staff included patients coming late for sessions; patients entering areas, such as the gardener's room; and feedback after sessions being inadequate. Compliments included representatives performing their roles well; one patient asserting herself and saying 'No' to her peers; and patients talking in group therapy sessions.

This was followed by the Ward Representative reading the duties of patients for the coming week. Staff often questioned patients on the reasons for them being assigned with a particular duty. Patients were unaware that the tasks were therapeutic and that they were required to select tasks or be given tasks depending on their particular lack of skills. The duties of patients were often discussed and reallocated.

Community meetings were also utilised to discuss significant events (e.g. the outcome of a patient's suicide attempt). Each community meeting was of sufficient duration to permit adequate and meaningful discussion of issues. Although all community meetings did not have clear conclusions about all the matters discussed, patients were left with decisions to take or a mere awareness of certain issues. Emphasis was placed on bringing issues to closure before moving on to other topics.

EMERGENCY COMMUNITY MEETING 9.15 am

On one of the Thursdays a change in the programme was observed with a community meeting held at 9.15 am to determine whether the two patients who were smoking cannabis the previous day had made a decision about their commitment to the programme. The meeting began with the two patients discussing their commitment to the programme and their motivation for wanting to continue with the programme. Positive feedback was given by staff to the patients for their commitment. A decision was then taken to continue the meeting to incorporate the general community meeting and to adjust the programme. The remainder of the meeting took the format of the community meeting discussed above.

FUN DRAMA 2.00 - 3.00 pm

The Fun Drama session was facilitated by one nurse. All patients attended the session with the exception of those involved in individual or family therapy. Fun or recreational drama, based on educational drama, allows for relaxation, for the development of the adolescents' creativity, spontaneity and interpersonal skills. Mattresses were scattered around the room with patients lying on them. The relaxation exercise took approximately thirty minutes, with patients falling asleep for the remaining part of the session. All patients appeared to participate in the exercise with the exception of two patients who were restless throughout the session. At the end of the session, patients were reminded to utilise the exercise when necessary.

The second Fun Drama session was facilitated by a psychiatric nursing student and supervised by a nurse. All patients were present with two members of staff observing the session. The session involved patients listening to an audio recording of stories of Clarissa Pinkola Estes (1992). Although patients appeared to be concentrating on the content of the recording, several became restless approximately twenty minutes later. In the observation room staff commented that the content of the recording may be too high-powered for the patients with numerous psychological terms referred to (e.g. psyche, archetypes). Patients gradually became more restless. The session ended with a brief discussion of the stories and definitions of the psychological terms. Patients were lethargic in responding to questions and failed to make any comments.

ADMINISTRATIVE MEETING 2.00 - 3.00 pm

All the administrative meetings observed occurred slightly later than usual. The meeting was led by the psychiatrist and attended by the nurses, social worker and psychologist. The psychiatrist prepared an agenda for the meeting and took the minutes. Each staff member had a copy of the agenda and minutes of the previous week's meeting. The meeting began with a review of the previous weeks minutes and a discussion of the agenda items.

The first administrative meeting began with one staff member questioning the relaxation exercises in the Fun Drama session. The comment was made that the patients should not be allowed to fall asleep and that the session should last for a maximum of half an hour. The session began with the psychiatrist reporting on the administrative and budgetary meetings held with GSH. This was followed by a discussion of the future planning of the programme, resulting from the mornings staff group session. The shortage of staff in the milieu, and the lack of staff unity and cohesiveness was discussed and the need to review the programme was highlighted.

One of the senior staff members questioned whether all patients required individual therapy or whether some required more family therapy. Staff appeared to have had very

different views of the definition and function of individual therapy. One staff member was of the opinion that individual therapy involved case management, where the individual therapist (i.e. the trainees) were responsible for their patients and participated in clerking the patient, becoming acquainted with the patient and discharging the patient. This staff member was adamant that individual therapy should remain part of the programme, with family therapy increased where necessary. Others had different perceptions of individual therapy, with one staff member in particular commenting on the difficulties which trainees would encounter with individual therapy. This was strongly opposed by a staff member who felt that trainees should learn to work with adolescents in individual therapy. It was further added that trainees expressed confusion about their role within the therapeutic team. Staff's perceptions of individual therapy were debated.

One of the staff members related the lack of clarity with regard to individual therapy to the numerous family sessions which were not scheduled. This staff member felt that family sessions were not materialising as a result of the indecisiveness of staff and trainees about scheduling these sessions. One staff member felt the need for more family therapy sessions instead of individual therapy, commenting that family therapy is more beneficial and that trainees were unable to adequately provide individual therapy to adolescent patients. This was once again opposed by a staff member who insisted that trainees should be given the opportunity to do individual therapy. This issue was left unresolved as the discussion moved to the need for more staff members for the programme. There was active participation by all staff members on most of the issues.

No administrative meetings were held while the psychiatrist was on leave.

FAREWELL 3.30 - 4.00 pm

A farewell party was held for patients in the final week of their stay on the programme. Prior to the farewell, the older patients took responsibility for making farewell cards for the patients who were being discharged and the latter patients prepared a farewell card for the patients and staff of the Centre. The number of patients discharged each week

varied, with an average of 2-3. The majority of staff and patients attended the farewell which occurred in the patient's recreational area. Patients alternated in bringing refreshments. The farewell began with the patients to be discharged reading their card to the patient and staff community and representatives of the patient community reading their card to the patients to be discharged. The farewell ended with everyone singing 'For they are jolly good fellows...', followed by the music being turned on and refreshments being eaten. Farewell rituals differed depending on the patient community and the patients themselves. For example, some farewells had considerably more refreshments than others, while some patients had a braai instead of the traditional farewell.

FRIDAY

WEEKEND PLANNING 9.00 - 9.30 am

The Weekend Planning session occurred at 9.00 am and not at 12.30 pm as depicted on the time-table. This session was facilitated by two nurses, with one staff member observing the session. The session was introduced to the new patients as one in which each patient discussed their week's goal and whether they achieved their goal; and their plans and goals for the weekend. Both patients and staff questioned patients about why goals set for the week were not achieved. Patients were encouraged to assist those who had difficulties in setting goals or in helping those to understand why goals were not achieved. When goals were too general in nature, facilitators questioned patients about the way in which they would accomplish their goals. Staff often linked the behaviour and progress of patients in other sessions to the goals they set or the difficulties they had in achieving their goals. Those patients who were successful in achieving their goals and who made considerable progress were complimented. The session ended with the nurse

reminding patients of the emergency telephone number at GSH and of the nurse on call for the weekend, which was placed on their notice board.

CAREERS 9.30 - 10.15 am

The careers session was facilitated by two external volunteers from 'Career Options'. Patients were divided into two groups, each group having one facilitator. One of the two groups were observed. The group comprised five patients, one medical student, and the facilitator, all seated in a circle. The facilitator began the session asking each patient about their current employment or the course which they were studying. The session took the form of a lecture, with few comments from patients. The facilitator discussed the importance of personality factors, abilities, as well as qualifications. Patients enquired about the difference between colleges and schools and between technikon and university qualifications. The advantages and disadvantages of both were discussed. In general, questions varied considerably and were asked very haphazardly.

ROLE PLAY 9.30 - 10.15 am

The 'Role Play' session was not documented on the time-table. This session alternated with the Careers session. The session was introduced to the new patients as one in which difficult relationships with people were dealt with through enacting a situation. Role plays simulate or create real life situations which allows one to explore more effective methods of communication and problem solving. The facilitator distinguished between social skills (as dealt with in Life Skills) and the role play session which emphasised individual relationship skills. Patients volunteered to be involved in the session and in every session observed patients were eager to be involved in the role play.

One of the patients who volunteered for the role play (referred to as the protagonist from here on) set up a scene in which her family was verbally abusive to her. Patients were selected to enact the various family members in the scene. These patients were informed of the way in which they should act and the roles which they were adopting. The role

play was set up in the middle of the room with the remainder of the patients seated on the outskirts of the room.

The role play began with the protagonist requesting to talk to her mother and her mother reacting in a verbally abusive manner, with the remainder of the family supporting the mother. At times patients had difficulty enacting their roles, with some of them laughing. The facilitators encouraged patients to concentrate and to remain in their roles. As the role play progressed, the nurses paused at various points to assist the protagonist, demonstrating ways in which she could improve the way she related to her family members. The role play was re-enacted approximately five times until the ideal situation or behaviour of the protagonist was achieved. Patients were encouraged to comment on the behaviour of the protagonist at the end of each role play. For example, patients told the protagonist to control her anger, and to not be verbally abusive when her family was rude to her. Throughout the role plays the focus remained on the protagonist with attempts made to alter her behaviour. At one point the protagonist withdrew from the role play, being unable to deal with her 'mother' and becoming tearful. The nurse encouraged her to continue, kneeling by her side and taking on her role and in this way demonstrating one of the ways in which she could deal with the situation. The session concluded with a general discussion about the role plays. One of the fairly new patients became tearful and walked out of the session, soon followed by one of the facilitators. It appeared that patients were disturbed by the role play, several becoming very withdrawn and tearful. The session ended with facilitators encouraging patients to discuss the effects of the session and their relation to it, in group therapy and individual therapy.

INDIVIDUAL THERAPY

Individual therapy sessions were scheduled at least once a week, with some patients receiving more than two sessions a week. The psychiatry registrars, psychology intern, (and at times the Masters Social Work student) were involved in individual therapy, with each one being assigned approximately six individual patients. Occasionally other staff members were involved in individual therapy. Interviews with therapists suggested that

they adopted an eclectic approach, with their style and theoretical framework adapted to the individual needs of the patient. Individual therapy sessions were not observed.

FAMILY THERAPY

Family therapy sessions were held at times decided on by the patient's individual therapist, the facilitator (either the social worker or psychologists) and the family members of the patient. The majority of sessions were held in the afternoons with occasional ones in the mornings. The sessions lasted for approximately one hour. The sessions most often comprised the patient, one or both parents, the individual therapist and an experienced staff member. On completion of the family therapy sessions, the facilitators and staff members who observed the session met to discuss the most important themes and features of the session. Positive and negative aspects of the facilitation were noted as well as nonverbal communication of the participants. Facilitators discussed particular difficulties which they experienced with the session and commented on their general feelings about the family.

5. DISCUSSION

At the outset, it is important that the detailed monitoring of the William Slater Centre's programme be viewed within the context in which it occurred. Staff have cautioned the author of the cyclical nature of the programme and alerted to the fact that what was observed was dependent on, amongst other factors, the type of patient community (e.g. predominantly personality disordered, specific age or gender groups, patients with leadership qualities or lack thereof); the nature of organisational problems (e.g. lack of staff); and the type of trainees (e.g. their previous experience, competence, level of qualification). Thus, the monitoring of the programme reflects only one period of time in the life of the programme and by no means implies that these findings are a precise reflection of the functioning of the milieu programme throughout the year.

The second important factor to note is that the following discussion does not do justice to the wealth of data obtained. While analysis of each session described and the impact of these sessions on individual patients could contribute to an in-depth understanding of the functioning of the milieu programme, this would detract considerably from the aim of the thesis (i.e. to merely 'peek' into the black box). Instead, an attempt is made to highlight the most significant factors evident from the monitoring of the programme, drawing heavily on the principles of milieu therapy. The reader is referred to the previous chapter for the definitions of these principles.

Perhaps the most striking overall finding is that, with a few exceptions, the therapeutic programme operated as planned, that is, according to its devised schedule. The exceptions were mere changes in times of sessions and emergency meetings which required adaptations of the programme. The majority of sessions took place at the times stipulated, were facilitated by the Centre's staff, and were implemented according to the programme's schedule. Thus, it can be stated that the time-table of the Centre is a true reflection of the structure of the milieu programme. The extent to which each of the sessions were implemented as planned is not possible to ascertain since no written documentation exists indicating the aims, structure and functioning of each session. What can however be determined is the extent to which the Centre's programme is based on milieu therapy principles. This will largely be guided by referring to the principles of milieu therapy as proposed by Gunderson (1983), Jones (1962) and Rapoport (1960). The shortcomings of these principles, as outlined in the previous chapter, will be taken into account.

According to the definition of milieu therapy (Jansen, 1980; Scherer, 1992; Tucker, 1983), the Centre *does* function as a milieu programme. This is evident from the emphasis placed on the treatment context rather than on a specific therapeutic modality. This is exemplified by the efforts taken by the staff at the Centre to ensure an environment conducive to milieu therapy. Chapter 4, which provides a description of the Centre and the therapeutic programme, lends support to this finding. However, while the

therapeutic programme on the surface appears to be a milieu treatment programme, closer examination of the Centre's adherence to the milieu therapeutic principles suggests otherwise.

Possibly the most important milieu principle minimised at the Centre was the principle of *democratisation*. Contrary to this principle, staff and patients comments and opinions were not equally valued and patients did not participate in decisions regarding the programme or their treatment. However, as argued by Steinberg (1983), the ideal of a democratic community is relative and does not apply to programmes with adolescent populations since the ultimate authority lies with staff members. The failure therefore of the Centre's programme to heed this principle could be attributed to its impracticality with an adolescent population.

What is perhaps less likely to forego is the lack of democratisation among the staff. The presence of a dominant leader and a somewhat cautious staff team affirmed an authoritarian style of functioning, with minimal open communication in the multi-disciplinary team. This was particularly the case for the non-therapeutic sessions (e.g. Presentations, Ward Rounds, Administrative Meetings), which were headed by the leader of the Centre. These sessions formed an integral part of the therapeutic programme where significant decisions regarding patients' diagnoses and management were made. Not only did the authoritarian style of decision-making and functioning in the Centre contravene the principle of democratisation, but also the notion of the *flattened authority pyramid*, where all staff have equal influence and power.

Possibly the only indication of some form of democratisation was in the absence of the leader, in the more therapeutic sessions, for example the Evocative Therapy Planning session, as well as in the observation rooms. Here, differences of opinion were discussed and communication and interaction amongst staff appeared more relaxed and open. However, it was noted that the total absence of the leader from *all* the sessions, resulted in patients' management and progress at the Centre not being stringently monitored,

although it was considerably less directive. Thus, it appears that the leader ensures efficiency and structure in the milieu programme, though at the expense of democratisation. Although Rosie et al. (1995) highlight that problems such as disordered management, delayed decisions and general inefficiency historically resulted in staff abandoning the ideal of democracy and resorting to the assertion of power, this argument does not hold for the Centre's milieu programme since an authoritarian style of functioning was present from the inception of the Centre.

The ultimate application of the principle of democracy was evident in the allocation of supervisors to sessions such as Group Therapy and Evocative Therapy, where all permanent clinical staff were in a position to supervise each other regardless of their experience or training. Rosie et al. (1995) however warn of the danger of this, where democracy is confused with equality and staff at different levels of training and/or experience assume equal status.

What certainly cannot be disputed is that free, open communication was lacking in the Centre's programme, and that the principle of democratisation was minimised. The extent to which this was inevitable, given the evidence of its ideological and impractical nature, is a possibility, that is, with the patient community. However, the absence of democracy among the clinical staff team is perhaps a failure on the part of the individuals themselves rather than a consequence of the principle.

The second principle found lacking in the Centre's milieu programme was that of *permissiveness*. Although the Centre strongly upheld the patient-staff community meetings, where practical problems were discussed at length until closure was reached, deviant, disturbing behaviours, were not always adequately explored or understood. Although the staff made concerted efforts to deal with problems and reacted promptly by scheduling emergency community meetings in order to discuss important incidents, the lack of democracy (and at times the unilateral decision-making), implied minimal cognitive understanding of patient's deviant behaviour. As a result, these patients were

severely dealt with, and at times prematurely discharged from the programme. Morrice (1979) similarly commented on the difficulties of permissiveness with adolescents who are inclined to test-out limits and act out, and at times prematurely terminate treatment. Related to this principle was the principle of *reality confrontation*, which was evident at the Centre to some extent. Patients who revealed unacceptable behaviour were confronted and their conduct was reflected back to them. However, as commented above, patients who revealed very unacceptable behaviours, were firmly dealt with.

The absence of thoughtful, in-depth debates and discussions about patients was noted not only with patients presenting with deviant behaviours, but also with the management of patients in general. According to Jones (1962), a milieu programme's underlying hypothesis is psychodynamic, implying that patients' difficulties are primarily in relations with others and that these can be examined, discussed and understood. The Centre's therapeutic programme however appears to attribute little time and energy to the examination and understanding of patient's problems. Instead, emphasis is placed on diagnoses, and management decisions are made in light of the diagnostic decisions with minimal consideration or discussion of psychodynamic factors. Jones (1962) adds that patients and staff examine their roles in order to achieve more effective and helpful ways of functioning. This too appears lacking at the Centre, where little reflective thinking occurs. A minimal number of staff members expressed their concern of the impact of their functioning on the patient community, with few attempts made, if any, in resolving these issues.

The concepts of *communalism* and shared responsibility were clearly apparent and upheld at the Centre. Communal living was evident from staff at times taking tea or lunch breaks with patients, staff not wearing uniforms and being called by their first names. Furthermore, the practical application of communal sharing was emphasised in Community Meetings, where patients were encouraged to function as a community. The findings of the monitoring of the Centre's programme indicate the importance attributed to patient responsibility and the principle of *involvement*, where attempts were made to

ensure that the environment was conducive to patient interaction. The decision of staff to be less active in sessions in order to enable patients to take responsibility, as well as patients being reprimanded for not providing adequate feedback to fellow-patients, demonstrate the Centre's commitment to patients participating in their own and others treatment. When the therapeutic environment was not conducive to patient interaction (at the time of the monitoring of the programme), staff demonstrated an awareness of this and made attempts to remedy it (e.g. Role Reversal exercise).

The characteristic of *structure* was evident in the Centre's milieu programme by providing newly admitted patients with an individualised orientation for the first week; ensuring that rules were established; and providing a consistent daily schedule. Furthermore, the environmental features of the Centre such as the spatial layout, furniture, as well as the provision of food, warmth, comfort, and recreation were adequately catered for. These are all crucial for the effective functioning of milieu treatment programmes. Numerous factors however also suggest the absence of structure at the Centre. Firstly, related to the importance of adequate facilities is the experience of staff members trained in milieu therapeutic principles. The Centre had no form of in-service training for either inexperienced or experienced clinical staff. This resulted in staff being trained experientially, which was particularly problematic in a programme dependent on staff experienced or trained in milieu therapy. In addition, no literature or clear documentation of milieu therapeutic principles and the proposed application of these principles to the Centre's therapeutic programme exist. Thus, it appears that staff implement the programme as it has historically evolved, with few debating the correlation of the programme to milieu therapeutic principles. More importantly, no attempts are made to provide any form of training of milieu therapeutic principles and practices at the Centre.

Secondly, the absence of the full complement of clinical staff at important sessions (e.g. Evocative Therapy Planning, Presentations, Drama feedback), suggests the lack of some staff members' commitment to the programme. This lack of commitment together with

the inadequate number of staff members at the Centre, is contrary to securing structure in a milieu programme. Fourthly, the debate amongst staff about appropriate and effective interventions for patients, as evident in the Staff Group and Administrative Meetings, may have contributed to a lack of structure. The latter is of particular concern.

As mentioned in an earlier chapter, lack of knowledge and understanding of milieu therapy by staff members is a commonly cited reason for the downfall of milieu programmes. The compatibility of staff's own viewpoints and the institutions with regard to milieu therapy is essential, since differences may result in conflicting ideas of the milieu programme (Fourie, 1994). This is particularly relevant to the Centre's programme, where staff expressed differences of opinion with regard to the important components of the milieu programme. In addition, viewpoints on the role of trainees and the responsibilities of each member of staff differed. Staff however made few attempts to discuss these differences to the point of closure. The dynamics of the clinical staff team was highlighted in the Staff Group sessions, where staff commented on the lack of cohesiveness in the clinical team; their inefficient functioning as a team; and the lack of support amongst them. These factors are of critical importance in light of the impact of these staff dynamics on patients. Shapiro and Carr (1987) highlight that it is commonly assumed in psychotherapeutic units that patients mirror staff issues. Thus the extent to which these staff issues impact on patients is of concern. From what was observed it is clearly evident that while emphasis is placed on the resolution of patient's problems, the organisational problems are largely left unresolved. Issues are not adequately dealt with and no attempt is made to reach closure, despite several issues recurring. According to Foskett (1986) however, this is a feature of staff group sessions, where emphasis is not placed on achieving goals.

Thus, the Centre appears to be in a predicament where staff hold diverging views on the practice of milieu therapy, and the Staff Group and Administrative Meetings fail to function as forums for clarification and resolution of staff differences. In addition,

several other factors, for example, the lack of democratisation and the absence of the flattened authority pyramid, appear to hamper this process.

Validation, which requires the affirmation of patients' individuality and individual treatment planning was lacking in the Centre's programme. This was primarily a result of the overly structured programme, which made no attempts to modify the structure to meet the needs of particular patients. This prevented an individualised approach to patient treatment. Several staff members' resistance to individual therapy and to restructuring of the programme, is perhaps a reflection of the lack of validation in the Centre. Although several of the therapeutic sessions were planned taking into account the patient community and certain individual patients, the activities and exercises appeared predetermined and structured, with few innovative ideas.

Several events suggest that *containment* and *support* was evident in the Centre's milieu programme. For example, nurses determined which patients had not arrived at the Centre at the first session of each day; patients were required to sign contracts in the event of them contravening certain rules (e.g. substance abuse, suicide precautions); and patients were required to request permission to be absent from sessions. The manner in which fellow patients reprimanded patients was an indication of containment. Support was provided via the group recreational activities and the community meetings. The programme was structured to ensure a balance between therapeutic sessions and recreational activities, although these were also considered therapeutic. What was lacking at times was the explanation of the aim or purpose of the group activities.

While numerous other observations about the Centre's programme can be highlighted, some general comments are worthy of note. Firstly, it was observed that the programme had a feeling of continuity to it. This was primarily a result of the considerable amount of communication amongst the staff members about patients, prior to, during and after sessions. Staff often related outcomes of sessions and events of patients, or of the patient

community in general, in the observation rooms and in feedback sessions. This is an indication of the total environment being considered as having a therapeutic purpose.

The second observation was the importance of the Centre as a training unit. The observation rooms provided trainees with the opportunity of discussing the processes and content of sessions under the supervision of an experienced member of staff.

Thirdly, it was noted that several of the sessions scheduled in the afternoons were problematic in that patients rarely participated and appeared distracted and restless. This was partly a result of the format of the sessions. Other sessions such as Evocative Therapy and Individual Working Drama were similarly problematic in that they were too long, resulting in several patients losing concentration and interest.

6. CONCLUSION

What this chapter aimed to accomplish was to provide an indication of the everyday functioning of the William Slater Centre's milieu therapeutic programme. It can be concluded that the Centre's programme adheres to several of the milieu principles. Those not adhered to are possibly a reflection of the patient and staff communities at the time of the monitoring of the programme. Furthermore, some of the principles have been noted in the literature as problematic. However, the extent to which principles such as democratisation and permissiveness are neglected at the Centre, is of concern particularly because of the failure of the staff to address these issues. It could be hypothesised that these are central principles which are possibly the key to the effective functioning of the therapeutic milieu programme. The findings of this chapter are further explored in Chapter 9 in which an alternative perspective on some of the issues are provided.

PROGRAMME OUTCOME

CHAPTER 8

DEPRESSION RATING SCALES AS A MEASURE OF ADOLESCENT DEPRESSION

I. INTRODUCTION

Having provided a description of the structure and process of the William Slater Centre and its therapeutic programme, the final part of the thesis is devoted to obtaining *some* indication of programme outcome. As mentioned earlier in the thesis, a proper outcome evaluation is not the intention; instead, an attempt is made to determine merely one measure of outcome of the programme. While previous chapters have largely dealt with observations of the dynamics of the William Slater Centre's programme, little mention has been made of those integrally involved in the therapeutic programme, namely the staff and patients' perspectives. As this thesis draws to a close, it would certainly not be complete without some indication of the progress of patients admitted to the Centre's therapeutic programme.

There has been increasing concern about depressive disorders among the youth (Harrington, 1994). With this recognition came attempts to measure adolescent depression by way of adopting adult depression rating scales, the most commonly used being the Beck Depression Inventory (BDI) (Beck et al., 1961), and the Hamilton Depression Rating Scale (HDRS) (Hamilton, 1960). These two scales have been researched and validated for the adolescent population (Robbins, Alessi, Colfer, & Yanchyshyn, 1985; Strober, Green, & Carlson, 1981). Since child and adolescent depression is often masked and the symptomatology differs from adult depression, specific child and adolescent depression rating scales were developed, such as the Reynolds Adolescent Depression Scale (Reynolds, 1986) and the Weinberg Screening Affective Scale (Weinberg & Emslie, 1988). The literature indicates a tendency for adolescents to be considered valid reporters of internal states such as feelings associated

with depression, thus the accepted use of self-report measures for adolescent depression (Kendall & Morris, 1991). Furthermore, depression rating scales can be viewed as objective and credible when ratings are obtained at stipulated time periods rather than in retrospect. Self-report rating scales, in particular, impose uniformity on the information obtained (King et al., 1987).

2. AIM

Since 1991, the research unit of the William Slater Centre administered amongst others, the Beck Depression Inventory, the Hamilton Depression Rating Scale, and the Montgomery-Åsberg Depression Rating Scale (MADRS) (Montgomery & Åsberg, 1979) to patients assessed and admitted to the Centre. A retrospective analysis of these rating scale scores was conducted in an attempt to obtain a measure of treatment outcome for depressive symptomatology of adolescent patients completing the 12-week programme.

3. MEASURES

Beck Depression Inventory. The BDI is a widely-used, well-studied clinical and research measure of depressive symptoms, used for both adult and adolescent populations (Ambrosini, Metz, Bianchi, Rabinovich, & Undie, 1991; Barrera & Garrison-Jones, 1988; Emslie, 1990; Robbins et al., 1985; Strober et al., 1981; Teri, 1982). In recent years, the BDI has become one of the most widely accepted instruments for the assessment of depression in mental health patients (Piotrowski, Sherry, & Keller, 1985). It has been utilised in studies based on large-scale screenings of community or school-based samples as well as in clinical settings with adolescents (Archer, Maruish, Imhof, & Piotrowski, 1991) and on normal populations (Steer, Beck, & Garrison, 1985).

The Beck Depression Inventory comprises 21 questions with four choices of answers. The total BDI score (the sum of the individual items) ranges from 0 to 63. Cutoff scores used in previous studies on adolescent populations are as follows: 0 to 9 non-depressed;

10 to 15 mild depression; 16 to 23 moderate depression; 24+ severe depression. A total BDI score of 16+, which has been validated to be a cutoff score for major depressive disorder in adolescents (Strober et al., 1981), was used for the present study. According to Tarnopolsky, Hand, McLean, Roberts, & Wiggins (1979), instruments should be re-validated in different settings or when used in different populations. Research conducted at the William Slater Centre found the BDI and HDRS to be useful measures of depressive symptoms in their psychiatric adolescent population (Berard & Ahmed, 1996).

Hamilton Depression Rating Scale. The HDRS is the most widely used clinician-rater scale in psychiatry (Beaumont, 1994) and has been proven reliable and valid with adolescent populations (Robbins et al., 1985). The HDRS is designed to assess the severity of depression. Although the original inventory comprised 23 items, the 17-item version of the scale has been most widely used (Beaumont, 1994). Items of the HDRS are scored from 0 to 4 or from 0 to 2. The total score (the sum of the individual items) ranges from 0 to 64. No standardised interview questions or cutoff scores exist. Cutoff scores utilised in clinical trials have ranged between 15 or greater and 18 or greater. Suggested ranges are 0-7 no depression; 8-15 mild depression; 16+ major depression. A cutoff score of 16+ was used for the present study.

Montgomery-Åsberg Depression Rating Scale (MADRS) (Montgomery & Åsberg, 1979); The MADRS was designed for adults and no literature was found on its validation on the adolescent population. It is a clinician-rater scale comprising 10 items, which are all core symptoms of depressive illness, although a few characteristic symptoms are not included (Montgomery & Åsberg, 1979). It is a brief and easy scale which can be administered by trained nurses, psychologists and psychiatrists (Montgomery, Jörnstedt, Thoren, Träskman, McAuley, Montgomery, & Shaw, 1978). Items of the MADRS are scored from 0-6. The total score (sum of individual items) ranges from 0-60. Scores of 0-10 imply no depression; 11-16 mild depression, 17-25 moderate depression; and 26+ severe depression. Research has shown no consistency with regard to cut-off scores of the MADRS. In general a range of 15 to 25 has been used (Nierenberg, Feighner,

Rudolph, Cole, & Sullivan, 1994; Rouillon, Markabi, Febvre, Phillips, & Vaillant, 1994; Tignol, 1993), while others have used 29 and 30 as criteria for depression (Perez & Ashford, 1990; Rahman, Akhtar, Savla, Sharma, Kellett, & Ashford, 1991). A cut-off score of 16+ was utilised in the present study.

4. METHOD

An adaptation of the single-group, interrupted time-series design was used. Ideally, this design comprises a *series* of measures before, during and after the programme, thereby enabling one to determine whether measures taken after the programme are a continuation of earlier patterns or whether they mark a decisive change (Weiss, 1972). At the Centre, a series of measures were taken at four intervals for each patient admitted to the programme. These occurred firstly, before the onset of the programme just prior to the initial assessment interview; secondly, during patients' first week on the programme; thirdly, at patients' sixth week of the programme; and fourthly, at discharge of patients' from the programme at week twelve¹¹. Thus, only one measure was available prior to the onset of the programme and no measures were analysed post-treatment¹². Ideally, at least one measure prior to the onset of the programme and measures approximately six months post-treatment, would have been preferable. The time lapse between the initial assessment and admission to the programme ranged from two weeks to three months.

Three research assistants¹³, who were not involved in the treatment programme, independently administered the HDRS at assessment and at week numbers one, six and twelve of patients' stay on the programme. Two clinicians provided research assistants with informal training with regard to the administration and scoring of the HDRS. The clinician conducting the initial assessment administered the MADRS. Scores for the

¹¹ Occasionally rating scales were administered in the penultimate week of patients' stay on the programme.

¹² Although depression self-report measures were mailed to discharged patients at various intervals, this data did not form part of this thesis. The attrition rate of rating scales mailed to discharged patients resulted in such a small sample size that a decision was taken to analyse this data elsewhere.

¹³ At any one time, one of two research assistants, with a minimum qualification of an Honours level degree in Psychology, administered the HDRS.

remaining three time periods were obtained from the clinical psychologist, psychiatrist, or at times the nurses or psychiatry registrars, the latter three being integrally involved in the therapeutic programme.

Subjects

A retrospective analysis of all patients with records on either the BDI, HDRS and MADRS, during the period December 1991 to February 1996, was conducted. Initially, a total of 681 files were examined, several of which had missing scores for the three rating scales. This was a consequence of different time periods in which the rating scales were initiated and inconsistent administration of the scales. As a result, analyses were conducted on samples with the maximum number of complete records of rating scales for the four time periods. The reader is referred to Chapter 5 for a profile of these adolescents [under the heading 'Programme completers ($n=320$)'].

5. RESULTS

5.1. MEANS AND STANDARD DEVIATIONS OF RATING SCALES

Table 11 shows the means and standard deviations of the three measures, while time-series graphs (Figure 3, 4 and 5) represent this table graphically. It is important to note that the three samples of adolescents are not mutually exclusive since the only criterion was the completeness of patient records for each rating scale.

Table 11: Means and standard deviations (SD) of the BDI, HDRS and MADRS at four time periods

	ASSESSMENT		WEEK 1		WEEK 6		WEEK 12	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
BDI (<i>n</i> =189)	25.1	12.3	22.4	12.2	20.4	12.4	12.5	10.8
HDRS ¹⁴ (<i>n</i> =252)	-	-	23.6	9.9	21.3	9.8	15.0	8.8
MADRS (<i>n</i> =39)	25.1	10.8	19.7	6.5	17.6	8.4	13.6	7.7

5.2. COMPARISON OF BDI SCORES AT FOUR TIME PERIODS

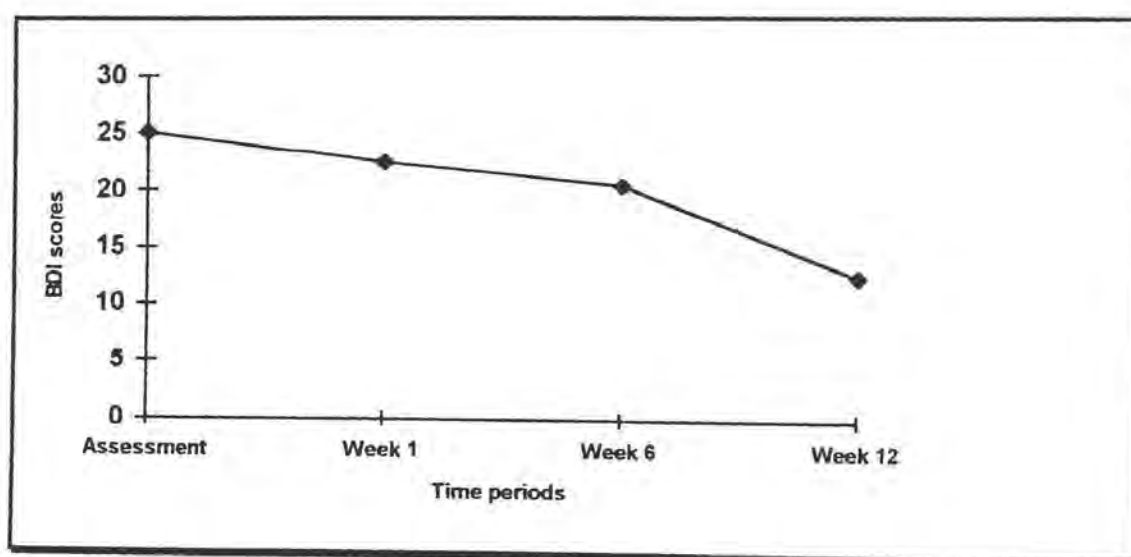


Figure 3: Time-series graph for the BDI at four time periods (*n*=189)

¹⁴ Since merely 39 patient records were available with HDRS scores at the four time periods, the assessment scores were omitted, resulting in a sample size of 252.

A repeated measure, one-way analysis of variance (ANOVA) was conducted on the BDI scores. The results are depicted in Table 12 below.

Table 12: Repeated measure, one-way ANOVA, fixed effects

Source	df	MS ¹	df Error	MS Error	F
Within groups	3	5536.3	564	65.78474	84.15788

¹Mean Squares

Critical value at $p < 0.00$

The ANOVA indicates that there is significance for the main effect factor of time ($F = 3.564$; $p < 0.00$). This implies that patients' scores on the BDI significantly improved over the course of the 12-week period. The variability of scores also decreased

Figure 3 indicates that patients fluctuated between the moderate to severe range of BDI cutoff scores during the waiting period. By the sixth week of treatment, patients' BDI scores remained in the moderate depression range. It is only in the very latter part of the treatment programme that the mean scores fell below the cutoff score of major depression. At discharge from the treatment programme, patients fell within the mild depression range.

5.2.1. FURTHER ANALYSIS OF THE BDI SCORES

Given these high mean BDI scores, a further analysis was conducted on patients who scored within the severe depression range (i.e. 24+) at any of the four time periods. Of the sample of 189, 105 patients scored 24+ at the initial assessment. By discharge the number of patients within the severe depression range declined to 22, demonstrating a phenomenal improvement in patients from the time of assessment. (See Table 13).

Table 13: Number of patients with BDI scores of 24+

ASSESSMENT	WEEK 1	WEEK 6	WEEK 12
105	76	60	22

In view of the significant improvement in scores of these patients, analyses were conducted on the BDI scores of the sample of adolescents assessed at the Centre but not admitted to the programme. A total of 296 BDI assessment scores were analysed, resulting in a mean of 22,64. Of this sample ($n=296$), 207 (69,9%) adolescents had scores of 16+, and further analysis of these adolescents found 136 (45,9%) scores of 24+. It is a noteworthy finding that such a large proportion of adolescents (45,9%) who presented with severe depression were not admitted to the William Slater Centre's programme. This cohort of adolescents has been alluded to in earlier chapters where it was suggested that any one of a number of hypotheses could be applicable to these adolescents (e.g. that they participated in an anti-depressant drug trial; were admitted to the preadmission programme; were unmotivated to attend the programme; were referred elsewhere). What this finding clearly points to is confirmation of earlier findings of the lack of distinction between those adolescents admitted to the programme and those who fail to be admitted. In addition, it highlights the limitation of the present study of not analysing the management decisions and outcome of this cohort of adolescents not admitted to the Centre.

5.3. COMPARISON OF HDRS SCORES AT THREE TIME PERIODS

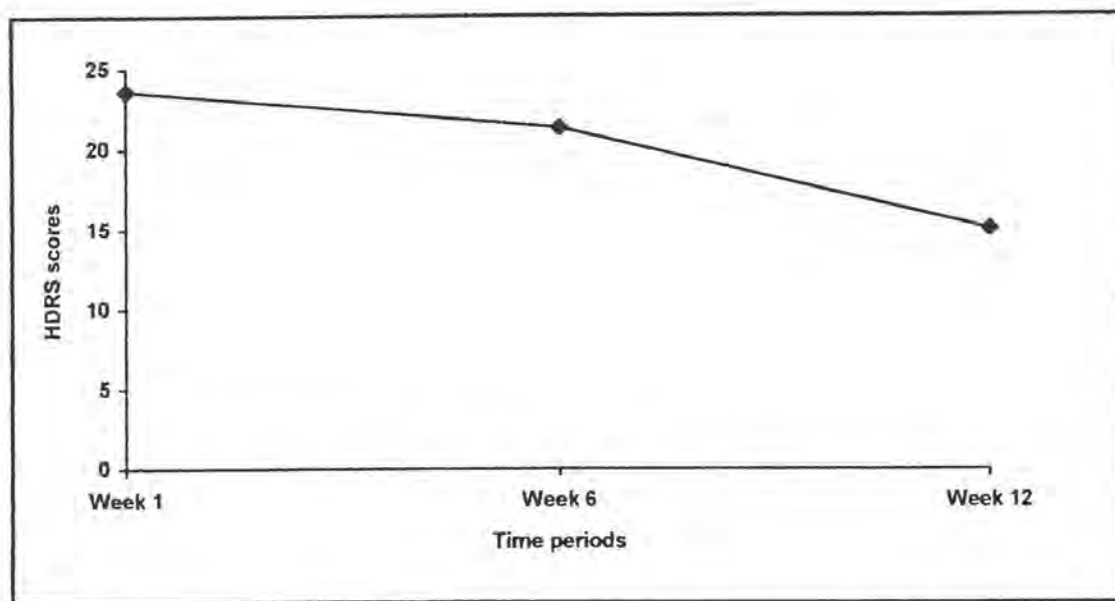


Figure 4: Time-series graph for the HDRS at three time periods ($n=252$)

A repeated measure, one-way analyses of variance (ANOVA) was conducted on the HDRS scores. The results are depicted in Table 14 below.

Table 14: Repeated measure, one-way ANOVA, fixed effects

Source	df	MS ¹	df Error	MS Error	F
Within groups	2	4949.04	502	30.90684	160.1279

¹Mean Squares

Critical value at $p < 0.00$

The ANOVA indicates that there is significance for the main effect factor of time ($F = 2.502$; $p < 0.000$). This implies that patients' scores on the HDRS significantly improved over the course of the 12-week period.

Figure 4 demonstrates that adolescent patients remained in the major depressive range for most of the programme, declining to the mild depression range at discharge. This finding is similar to the BDI scores, where on average, adolescents rated themselves as mildly depressed at discharge.

5.3.1. FURTHER ANALYSIS OF THE HDRS SCORES

The above-mentioned finding may suggest that non-clinicians ratings are equivalent to, or as accurate as, adolescents' self-reports. This however cannot be assumed from the above finding since *different* cohorts of patients were analysed. An attempt was therefore made to test the hypothesis that non-clinicians were accurate in their ratings of adolescents. The accuracy of nonclinicians' ratings was determined by conducting analyses on all the available BDI and HDRS assessment scores of the *same* cohort of patients ($n=104$), using a paired two-sample ttest.

Table 15: Means and paired two-sample t-test for HDRS and BDI scores ($n=104$)

	N	Mean	Std dev.	t value	df	p
BDI	104	24.105	11.8	9.765	103	0.05
HDRS	104	15.894	7.3			

These results demonstrate a significant difference in the self-report BDI scores and the non-clinician rater scores on the same cohort of patients. This discrepancy suggests that non-clinicians are not accurate in their ratings of adolescent depression. It appears that non-clinicians under-rate depression in comparison to the adolescents' self-reports. It is however important to note that these comparisons were based on scores taken at the initial assessment of adolescent patients at the Centre. Thus, what is perhaps necessary is

a further analysis on the scores of the BDI and HDRS of adolescents *admitted* to the programme.

Analyses were conducted on a cohort of 220 adolescents who completed the Centre's therapeutic programme. The BDI and HDRS scores of these adolescents taken at three time periods were compared. (See Figure 5).

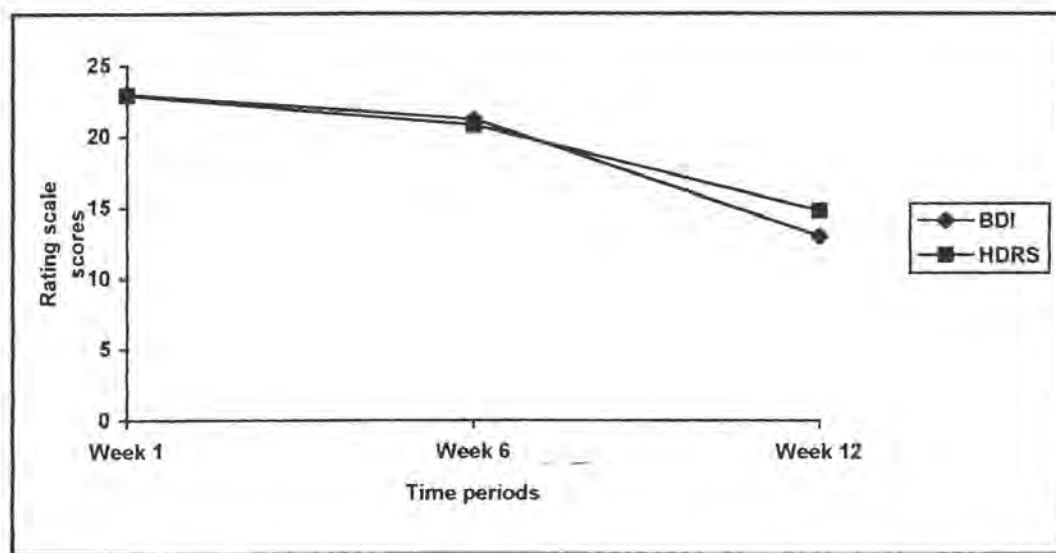


Figure 5: Comparison of ratings of the BDI and HDRS of the same cohort of patients ($n=220$)

Contrary to the earlier finding on the discrepancy between the BDI and HDRS *assessment* scores, the above graph indicates accuracy between non-clinicians' ratings and patients' self-reports on scores of adolescents *admitted* to the programme. Thus, while one analysis suggests discrepancy, the latter suggests agreement between raters. A number of hypotheses could be advanced for this anomaly. Firstly, it could be hypothesised that the discrepancy between non-clinician and patients' ratings at the assessment interview was a result of non-clinician raters lack of training with regard to the HDRS. It is likely that the non-clinicians may not have acquired or mastered skills required for the detection of adolescent depressive symptoms.

A second hypothesis is that the accuracy of the two rating scales of those adolescent patients admitted to the Centre could be attributed to the fact that patients become more verbal and candid about their internal states when on the therapeutic programme. The nature of the milieu treatment programme implies that patients are in a therapeutic environment which deals with emotional issues, and this may result in adolescents becoming more accustomed to responding to questions pertaining to their depressive state.

A third hypothesis, related to the above, is that non-clinicians have varying contact with patients and their therapists and this could contribute to more clarity with regard to patients' depressive symptomatology. Thus, non-clinicians scoring the HDRS may have clues and knowledge of patients' difficulties, their progress on the programme, or significant events which may have affected the adolescent patients (e.g. a suicide attempt, death of a parent, etc.). It is likely that this proximity of non-clinicians to patients could account for the accuracy of scores of patients on the programme.

Finally, the extent to which the HDRS was administered blindly (i.e. without reference to the BDI scores) is not known. It could be hypothesised that knowledge of the BDI score(s) may account for the accurate findings depicted above.

6.3. COMPARISON OF MADRS SCORES AT FOUR TIME PERIODS

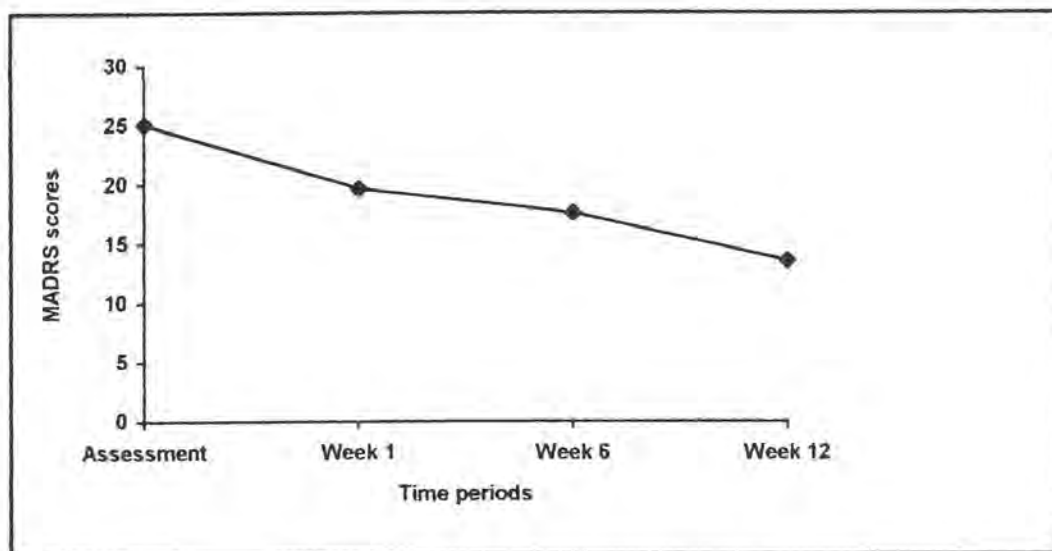


Figure 6: Time-series graph for the MADRS at four time periods ($n=39$)

Analysis of the MADRS as depicted in Figure 6 demonstrates improvement in depressive scores throughout the therapeutic programme. A repeated measure, one-way analysis of variance (ANOVA) was conducted on the MADRS scores. The results are depicted in Table 16 below.

Table 16: Repeated measure, one-way ANOVA, fixed effects

Source	df	MS ¹	df Error	MS Error	F
Within groups	3	886.33	114	52.947	16.739

¹Mean Squares

Critical value at $p<0.000$

The ANOVA indicates that there is significance for the main effect factor of time ($F = 3.114$; $p<0.000$). This implies that patients' scores on the MADRS significantly

improved over the course of the 12-week period. As with the BDI and HDRS, improvement is evident towards the latter part of the programme with patients falling in the mild depression range at discharge. The most significant improvement appears to be between the assessment and Week 1 phase, which is the period when adolescents are placed on a waiting list and may attend the preadmission programme. This lends support to the hypothesis in an earlier chapter on the therapeutic effects of the preadmission programme.

6.4. SUMMARY

In summary, the three rating scales all demonstrate scores of severe or major depression at assessment, with mild depressive scores at discharge. The most significant improvements as recorded by these scales, occur in the latter part of the programme with the exception of the MADRS which in addition shows improvement in the waiting period. This sample size was however considerably smaller than the BDI and HDRS samples, and the scale is not validated for adolescent depression.

7. DISCUSSION

What can clearly be stated from the findings of this chapter is that there is significant improvement in the depressive symptomatology of adolescent patients completing the Centre's therapeutic programme. In addition, these findings are consistent across three perspectives, namely the patient, the clinician and the non-clinician. That two of the three measures used are validated for adolescent depression adds strength to these findings. The phenomenal improvement in depressive scores is very promising and demonstrates that the therapeutic programme has a positive impact on adolescents presenting with major or severe depression. It is however important to note that what cannot be assumed is that the therapeutic treatment programme was responsible for the alleviation of adolescent depressive symptoms. The absence of a control group in this study clearly cautions against this conclusion.

It is important at this point to take a slight detour to comment on the association between depression rating scales and the diagnosis of depression, since this association needs to be considered in relation to the interpretations made for the present chapter's findings. According to Emslie, Weinberg, Rush, Adams, and Rintelmann (1990), self-report instruments do not take into account the presence of a cluster of symptoms needed to make a diagnosis of depression. Reynolds (1994) on the other hand highlights research which demonstrates a strong association between high levels of depressive symptomatology based on self-report instruments and clinical interview measures, and formal diagnoses of mood disorders. He argues that depression measured by self-reports provides an estimate of severity in adolescent depression on condition that the measures have empirically established cutoff scores. However, not all scores above a cutoff score meet criteria for a diagnosis of depression. It is possible for individuals with a depressive disorder to score below the cutoff because of the potential for symptom variability (Stewart, McGrath, & Quitkin, 1992). What these research findings highlight is that the scores of depression rating scales should not be equated with a formal diagnosis of depression. The outcome of the analysis on the rating scale scores in the present chapter therefore provides an indication of the severity of depression and depressive symptomatology rather than a formal diagnosis of a mood disorder.

In addition to the lack of a control group mentioned earlier, there are numerous confounding variables which prevent conclusive findings with regard to the role of the therapeutic programme in the alleviation of adolescent depressive symptomatology. An exhaustive account of the possible confounders is a complex undertaking and therefore will not form part of this thesis. Instead, the approach taken is to briefly comment on the threats to internal validity¹⁵ (Campbell & Stanley, 1963), a significant disadvantage of the time-series design.

¹⁵ Threats to internal validity refers to eliminating explanations of change not due to the programme in an attempt to demonstrate that the programme caused the changes.

Some of the threats to internal validity include maturation, testing, instrument decay, regression and history (Neale & Liebert, 1980; Weiss, 1972).

Maturation: Improvements in depressive symptoms may have occurred solely as a result of the passage of time between the various administrations of the rating scales or as a result of the length of the programme, and not as a result of the programme itself. Determining how much of the change was due to maturation requires testing other groups of adolescents or testing over a greater number of time periods (Posavac & Carey, 1992), both of which were beyond the scope of this thesis. Related to this is the natural course of adolescent depressive episodes, which Lewinsohn, Clarke, Seeley, and Rohde (1994) report as a mean duration of 8 weeks in a nonreferred sample. Thus, the significance of the improvement of depressive scores may be a reflection of the natural course of the disease.

Testing: Administration of the same rating scales at the four time periods may have differed simply as a function of patients' increased familiarity with the scales. Thus, improvement in depressive scores, particularly in the latter part of the programme, could be a result of patients' familiarity with the rating scales. Furthermore, patients' boredom with the rating scales, which was noted by the non-clinician raters in their administration of the scales at Week 12, may have contributed to the improved scores.

Instrument decay: It is possible that clinician and non-clinician raters could have become less diligent in the administration of the rating scales and in particular, in the recording of some of the depressive symptoms. At times non-clinician raters administered the HDRS to numerous adolescent patients within one week and at times within the space of two days. Thus, the inadequate administration of rating scales could have contributed to the improvements in rating scale scores.

Regression to the mean: Regression implies that extreme scores in a particular distribution will tend to move towards the mean of the distribution as a result of repeated

testing. The implication for the present chapter's findings is that significant depressive scores are likely to be less significant at the next administration of the rating scales. Thus patients who were most depressed at the initial assessment were inclined to be less depressed at the end of the 12-week programme. However, this does not imply that they were at a healthy level of functioning at discharge. In fact they could still have been more depressed than the general adolescent population. The fact that the mean rating scale scores fell in the mild depression range at discharge of patients possibly lends support for this hypothesis.

History: It is likely that events, not related to the programme, which occurred between the administration of the rating scales, could have affected patients and thus resulted in improved depression scores. For example, stressful home environments could have improved, a particular stressor may have been eliminated or the intensity of the stressor reduced, or adolescents may have taken medication. Problems related to history can be remedied by testing additional groups at additional time periods, being sensitive to unexpected events and changes. However, as mentioned earlier, this was not practical for the present thesis.

Numerous other factors could have contributed to the significant improvement in depressive scores. Firstly, it could be hypothesised that the nature of the day-patient programme which requires the removal of adolescents from stressful environments such as school or home, could in itself contribute to the alleviation of depressive symptoms. Secondly, the role of anti-depressant medication in the treatment of adolescent depression is fairly inconclusive and therefore the extent to which the therapeutic programme and/or the medication contributed to improvement in depressive symptomatology is unknown. Thirdly, patients who completed the 12-week programme chose to complete it and their improvement, as measured by the rating scales, may not represent the effect of the programme on everyone the programme was designed for¹⁶.

¹⁶ Campbell and Stanley (1963) refer to this as *selection*.

This is particularly noteworthy in light of the large number of adolescents prematurely discharged from the Centre and those who fail to be admitted to the programme.

One of the limitations of these findings is that only the short-term outcome of patients was determined and no attempt was made at determining the progress of patients post-discharge. According to Lewis, Lewis, Shanok, Klatskin, and Osborne (1980) adolescents' condition at discharge is not a useful indicator of future success. Instead, follow-up assessment is central to outcome evaluation and is important for determining whether gains evident at discharge are maintained posttreatment. Kazdin (1990) comments that conclusions about the effectiveness of treatment may vary greatly depending on when assessments are conducted and this is of particular importance with depressive illness which has a protracted course with a high tendency for recurrence.

Related to the above is the fact that in studying treatment results, the alleviation of symptoms alone does not reflect a cure, and what is of equal (or greater) significance is the ability of individuals to develop a meaningful life in the community (Blackman, Eustace, & Chowdhury, 1991). Thus, while depression rating scales demonstrate improvement in depressive symptoms and severity of depression, it does not provide an indication of the overall functioning or general psychosocial adaptive functioning of the adolescent. The latter is of particular importance to the present thesis given that one of the primary aims of the William Slater Centre is the improvement of the overall functioning of adolescents.

The results from this chapter are very promising, demonstrating that adolescents presenting for the Centre's milieu treatment programme significantly improve by the end of the 12-week period. It is however essential that these positive findings be interpreted in light of the above-mentioned threats to internal validity. It is in this kind of situation, where obvious and hidden confounders are multiple and complex in their relationship, that qualitative data becomes imperative and invaluable. Caution is therefore required in

the interpretation of these findings, with particular reference to the conclusions of preceding chapters.

CHAPTER 9

STAFF AND PATIENTS' PERCEPTIONS OF THE PROGRAMME

1. INTRODUCTION

Staff perceptions provide one of the best sources of data on some of the programme characteristics related to programme effectiveness (Ellsworth, 1983). Posavac and Carey (1992) similarly comment that programme personnel are a very valuable source of evaluation data and their comments are particularly important in the interpretation stage of the evaluation. They however caution that staffs' subjective evaluations can be biased and accuracy can be improved by obtaining multiple sources of data.

Patients' perspectives have been valued to a lesser extent. Although patient ratings provide a rich source of data from those directly experiencing the programme, these are subjective (Ellsworth, 1983). Furthermore, participants may like or dislike the programme for reasons not connected with its goals (Weiss, 1972). Adolescents, in particular, are noted to not always be the best source of information (Loeber, Green & Lahey, 1990) and preference is given to data obtained from significant others in their lives (e.g. parents and teachers) (Ellsworth, 1983).

Taking into account these limitations, and in an attempt to obtain multiple sources of data, this chapter provides the perspectives of the clinical staff of the milieu programme, as well as those of the programme participants, although to a lesser extent.

2. METHOD

All clinical staff¹⁷ were requested to complete a semi-structured questionnaire and/or participate in semi-structured interviews. Eleven staff members completed the

¹⁷ Clinical staff members included the psychiatry registrars, the psychology intern and the Masters Social Work student, all of whom were at the Centre for a minimum period of four months.

questionnaires, and interviews were conducted with seven members of staff. Semi-structured questionnaires were administered to all the patients on the programme at the time of the evaluation ($n=12$). Patients were asked to rate a range of sessions, commenting on the usefulness of each session.

3. RESULTS

The method of 'open coding' as described by Strauss and Corbin (1990) formed the basis of the analysis of the transcribed interviews and questionnaires. Open coding involves a line-by-line analysis of transcripts to label phenomena, identify concepts, and group concepts into categories.

Prior to presenting the findings, a few comments regarding the administration of the questionnaires and interviews are worthy of note. In general, the majority of staff members demonstrated a substantial amount of interest in the questionnaires and interviews, both of which revealed a wealth of data. However, staff required numerous reassurances with regard to confidentiality and anonymity, with some commenting on their anxiety and caution in completing the questionnaire. One staff member requested a second questionnaire in order to alter the negative comments made in the original questionnaire. Unfortunately, the original questionnaire was not accessible to the author. Two staff members demonstrated reluctance in completing the questionnaire.

The analysis of the data resulted in the following categories being identified, each of which will be discussed in detail below:

- (i) *Organisational and leadership problems*
- (ii) *Lack of evaluation*
- (iii) *The Centre as an academic teaching unit*
- (iv) *The therapeutic programme*

(i) *Organisational and leadership problems*

There was consensus amongst staff that the organisational structure and functioning of the Centre was problematic. Staff highlighted the lack of an organisational chart, depicting the various disciplines of the clinical team. This was a direct consequence of the milieu therapeutic principle of democratisation and the notion of the 'flattened hierarchy', where there is equality among all members of staff. Several expressed discontent with these principles which failed to be practically applied:

- *they say it's a flattened hierarchy, but it's a delusion*
- *there is a hierarchy here ... you can see it*

Allied to this was the lack of delineation of the responsibilities of each staff member:

- *an 'understanding' exists of each staff's role but this becomes blurred*
- *no job descriptions exist.*

However, this was once again a result of milieu therapy principles which stipulates that staff roles should be flexible with everyone capable of performing each others roles.

Problems of staff dynamics were discussed at length by almost all respondents:

- *Slater known for 'difficult dynamics' and people don't want to go there.*

Numerous factors were commented on, one of the most important being the lack of cohesiveness within the multi-disciplinary team:

- *distinct differences and separateness amongst the different disciplines*
- *... fight for control*
- *they don't value each other.*

Secondly, there was consensus amongst staff that there was an unequal distribution of work among the clinical staff team:

- *the workload being carried by a few core members*
- *an unequal spreading of the clinical load.*

However, what was clearly apparent was the difference of opinion with regard to those not actively contributing, which differed to a large extent along the lines of disciplines rather than individuals. While some were of the opinion that they were carrying the workload:

- *Nursing staff end up being the workhorses, taken advantage of and unappreciated*
- *nursing staff is the backbone of the unit, but get very little recognition,*

others argued the contrary:

- *think they do all the work it's an organisational problem*
- *minimal work being done ... there is a perception that staff work hard.*

Once again, it appears that these organisational problems stem from the lack of clarity of staff's role and function within the Centre, as proposed by milieu therapy.

Shortage of staff members was highlighted as a central problem by several. However, an investigation of the number of staff members from 1994 to 1996, found that the number of permanent clinical staff in 1996 equalled that of 1994 (see Table 17).

Table 17: Number of clinical staff employed at the Centre 1994-1996¹⁸

1994	1995	1996
1 administrative nurse	1 administrative nurse	1 administrative nurse
4 psychiatric nurses	4 psychiatric nurses	5 psychiatric nurses
1 psychiatrist	1 psychiatrist	1 psychiatrist
2 psychologists	2 psychologists	2 psychologists
1 social worker	1 social worker	1 social worker
1 occupational therapist	-	-
3 drama therapists	2 drama therapists	1 drama therapist

Staff identified the strong, authoritarian leadership style to be problematic, resulting in principles of democracy being minimised. The majority of staff expressed an inability to freely and openly voice their opinions:

- *people are too scared to confront*
- *experience ... is of being afraid (paranoid) and shut up (unable to talk honestly) conspiracy of silence.*

This failure to ensure democratisation was clearly of concern to the clinical staff team. They commented that multidisciplinary team decisions were virtually non-existent and that unilateral decision-making often went undisputed:

- *challenges to thinking differently, challenges to knowledge ... challenges to authority amongst staff are extremely threatening. This extends to even differences of opinion being threatening... Thus it is hard to have open fruitful debate*

¹⁸ The number of staff members as at August 1996 when the evaluation was conducted. Subsequent to this month, the administrative nurse and drama therapist resigned.

- *they make decisions without the rest of the team having an opportunity to express their views especially the patient's individual therapist.*

In addition, the inconsistency of the decision-making process was expressed:

- *I'm still struggling to understand the criteria for decision-making regarding management of patients.*

The extent of directiveness of the leader was consistently alluded to:

- *doesn't like to be challenged or asked to think about things differently style can be very directive and often introduces own issues rather than exploring their issues.*

What was significant about the decision-making processes was its impact on the treatment and management of patients. This pertained particularly to decisions regarding patients' suitability for the programme:

- *decisions especially assessments have become automatic and patients get boxed or pigeon-holed too automatically;*

their management while on the programme:

- *team can assume things*
- *no parents should be written off as inadequate until properly assessed;*

patients' premature discharge:

- *I don't think we deal appropriately with rebellion, anger and acting out.... tend to expel patients who don't comply and behave ... drop-out rate high;*

and patients' diagnoses:

- *disregards DSM-IV*
- *I know diagnoses will be changed.*

Several staff members questioned the appropriateness of the leader of the milieu programme:

- *a psychologist who understands the dynamics ... would be more appropriate*
- *a focus and staff understanding of psychodynamics would make a huge change in the nature and effectiveness of intervention,*

and criticised the leadership's erroneous, grandiose perceptions of the Centre, which were based on self-satisfaction:

- *high degree of ... paranoia/suspiciousness in unit - expressed primarily against 'outsiders' ... which makes working here quite an isolated experience*
- *paranoid feeling that everyone out there is 'bad' and 'doesn't understand the work we do'.*

While the strong leadership was criticised by several, one staff member commented on the void which exists when the leadership was absent:

- *the cherry on the top is gone... a power struggle exists between ...*

This however once again is a reflection of the organisational problems mentioned earlier.

In addition to the problematic leadership, staff commented on the ruthless nature of the recruitment of personnel for the Centre:

- *either thrown out or rejected*
- *a fairly fast turnover of staff*
- *staff shouldn't be thrown out when they cannot cope*
- *Jy is reg of weg.*

Other staff-related problems included personal issues of individual staff members:

- *staff have unresolved issues which play into their work with each other and with patients;*

power struggles amongst staff:

- *there is underlying competition;*

and a general lack of respect for each other:

- *one's personal life ... is exposed to the entire permanent team*
- *lack of trust and confidentiality.*

Staff unanimously perceived the working environment as unpleasant at the time of the evaluation:

- *no cohesion amongst staff*
- *extremely depressing.*

(ii) *Lack of evaluation*

Several respondents summarised the functioning of the Centre (as a result of its leadership) as reactive rather than reflective:

- *a knee-jerk response unit*
- *assumptions often made automatically.*

This, allied to the lack of open communication, resulted in decisions in all spheres of the programme being acted upon mechanically without due reflection. There was a clear lack of deeper understanding of issues pertaining to patients, staff and the Centre as a whole:

- *unit would benefit greatly from more reflection ... reflection about patient issues and staff issues*
- *no time, space or commitment to reflection about the process of the milieu... We (do) not (think) about the dynamics of the milieu as whole or about how staff dynamics intersect with patient/unit dynamics.*

The rigidity of the somewhat overly-structured therapeutic programme was of concern to many:

- *sessions must be flexible enough to respond to patients' immediate needs*
- *each patient's treatment needs to be assessed individually.*

Rigidity, erratic decision-making, and lack of reflection were clearly considered the primary reasons for the premature discharge of some patients:

- *(names of patients mentioned)..... were thrown out ... did not voluntarily leave ... told to leave.*

Staff expressed the need for reflection and psychodynamic understanding of these patients in particular.

Of concern to some staff members was the deterioration of, not only the Centre's programme as a whole:

- *unit is stale*
- *organisation is fragile, defended,*

but also its internal therapeutic functioning:

- *therapy is in danger of stagnation*
- *ways of understanding patients are stagnating*
- *the past 2 years have seen a decline in the work ethic and general standard of therapy.*

Two staff members attributed these factors to a lack of innovation and evaluation within the Centre:

- *no journal clubs no in-house training for staff*
- *little dedication to ongoing learning*
- *techniques applied and reapplied almost mechanically .. approaches are not continually re-evaluated*

and the deliberate isolation of the Centre:

- *we should be drawing from other units' experience literature/research etc.*
- *not just form our subjective experience*
- *no new ideas coming in to Slater.*

(iii) *The Centre as an academic teaching unit*

Trainees varied in their perceptions of the adequacy of the Centre as an academic training hospital. This was primarily a result of clear distinctions made between the staff members responsible for their supervision and training, two of whom were described as providing inferior quality teaching:

- *largely waffle!*
- *good teacher but loses focus on the level of understanding of the students*
- *my specific needs around were never acknowledged*
- *training is compromised because trainees are infantilized. They are not allowed to take responsibility.*

Only one staff member's input was considered beneficial. Marked differences were noted between the comments regarding this staff member and the ones mentioned above:

- *learnt about dynamics*
- *very supportive and understanding*
- *able to be involved and ask questions*
- *superb and indispensable*
- *meaningful dynamic thinking occurred.*

Some trainees' perceptions of the Centre as an academic training unit were positive:

- *learnt more from my stay at William Slater than my last three years of varsity*
- *Slater was a useful experience,*

while others' gains were clearly minimal:

- *could have learnt everything in 2 weeks*

- most stressful... 80% of time cannot be spontaneous
- treated like a child
- individual therapy devalued
- demoralising experience.

(iv) The therapeutic programme

On a scale of 0-10, permanent clinical staff members ($n=6$) and patients on the programme at the time of the evaluation ($n=8$), were asked to rate the following sessions: group therapy, individual therapy, evocative therapy, drama therapy on a Wednesday, family therapy, growth games, life skills, and relationships, where 0 denoted that the session was of no benefit to patients, 5 implied that it was sometimes important, and 10 implied most significant. Only patients in the fourth week of the programme onwards were included, resulting in a sample of eight. The ratings were as follows:

Table 18: Comparison of staff and patient ratings on therapeutic and other sessions of the therapeutic programme.

Therapy and other sessions	STAFF RATINGS ($n=7$)							PATIENT RATINGS ($n=8$)							
	Group	8	10	10	10	8	8	8	5	7	5	10	10	8	5
Individual	8	5	7	5	8	5	8	10	6	10	10	9	8	10	10
Evocative	7	10	8	8	8	5	7	0	4	5	4	8	5	10	10
Drama (Wed)	7	10	8	8	7	4	7	5	5	5	6	6	8	5	9
Family	6	10	10	9	9	8	6	3	-	5	-	-	-	10	9
Growth games	4	5	10	5	8	8	4	6	4	10	4	3	5	-	8
Life skills	8	10	10	8	9	10	8	8	6	5	9	4	10	8	8
Relationships	4	10	10	7	8	9	4	10	3	5	9	7	6	5	4

The most noteworthy finding of this table is the discrepancy amongst the staff in their ratings of individual therapy. While some staff members rated this form of therapy not significantly important:

- *adolescents find it difficult to talk about themselves*
- *adolescents can only tolerate so much individual therapy*
- *most of the adolescent's issues are in relation to their peers..... work needs to be done in the milieu,*

others were of the opinion that individual therapy was lacking in the Centre:

- *it is a healthy dependence which can continue after the patient leaves*
- *a bit more time for individual therapy needed*
- *individual therapy devalued*
- *essential part of effective case management. Someone must be responsible and 'in charge'.*

What is even more noteworthy from the table is the number of patients who rated individual therapy as important:

- *an in-depth look at myself*
- *assists me in finding out who I am*
- *easy to talk to my therapist can tell her everything.*

The ratings of evocative therapy and drama therapy differed between patients and staff, with the latter finding these sessions more beneficial than the patients. Possible reasons for this are the length of these sessions, as well as the fact that both sessions involve an in-depth focus on a minimal number of individual patients, some of whom may not have been the protagonist yet.

The research unit was highlighted as significantly impacting on the therapeutic milieu programme, primarily since one of the senior clinical staff members was an integral part of both:

- *research should be separated completely*
- *since the research unit opened, less energy were put into the milieu*
- *the introduction of an active research department leaves the consultant with a conflict of interest.*

The research unit of the Centre did not form part of the evaluation.

Although several staff members commented very positively on the Centre's therapeutic programme:

- *great success*
- *excellent,*

providing a crucial service:

- *plays an important role in assisting young people*
- *provides structure, containment for very disturbed adolescents,*

some staff members highlighted that there have been significant drawbacks:

- *has certain successes but monumental failure with certain patients,*

while others emphasised the need for appropriate patient selection for the programme:

- *a major success when the patient is motivated and appropriately assessed*
- *co-operation from family and patients is essential.*

With regard to the length of the programme, the majority of staff members were in agreement that the 12-week period was of sufficient duration. Others however felt that a shorter period of 8-weeks may be preferable in order that patients not become too dependent on the staff. One staff member felt the need for the Centre to function as an outpatient unit, allowing adolescents to attend school and thereby not be removed from their everyday functioning. It was felt that the programme provided a false sense of progress resulting in some patients not able to effectively function after discharge from the Centre. One staff member was unable to comment on whether the length of the programme was adequate:

- *no idea. This is one of the problems - we have thought about, researched, or committed ourselves to finding out the experience of others doing this kind of work.*

This once again highlights the need for adequate reflection about the programme.

In conclusion, what was clearly evident from the majority of questionnaires and interviews conducted was the need for the therapeutic programme to be evaluated:

- *the milieu is not sufficiently monitored*
- *the programme as a whole requires periodic evaluation and review.*

4. DISCUSSION

What this chapter demonstrates is the complexity of the organisational functioning of the William Slater Centre and the impact of this functioning on the therapeutic programme. The central debate of this chapter is whether the difficulties experienced at the Centre are intrinsic to milieu therapy or whether they are a reflection of the Centre itself. The author is of the opinion that the problems highlighted by the staff cannot solely be attributed to the faulty underlying philosophy on which the therapeutic programme is

based. That fundamental flaws in milieu therapy impact on the organisational functioning of the Centre and the therapeutic programme is indisputable. However, as suggested in the literature (LeCuyer, 1992), milieu therapeutic principles need to be questioned, updated and tailored to the needs of patients and their presenting problems, and this could be accomplished through research. Thus, while the following discussion demonstrates that the milieu therapeutic principles are central to the difficulties highlighted in this chapter, it is also the nature of the Centre itself which contributes to its malfunctioning.

What is evident from this chapter's findings, as well as the chapter on the monitoring of the therapeutic programme, is the discrepancies between the theory and practice of milieu therapy. What appears to be at the core of the difficulties described by the staff is the organisational structure and functioning of the Centre. This stems primarily from milieu therapeutic principles and concepts such as the flattened authority pyramid, role blurring, democratisation, etc. Some of the literature suggests that these principles are ideological, impractical and in need of revision (Morrice, 1979; Scherer, 1992). Since the William Slater Centre merely adopted milieu therapeutic principles, without conducting research into the viability of this form of treatment for adolescent psychiatric patients, it appears inevitable that it would experience problems similar to those highlighted in the literature over the past few decades. This will be expounded on in the following chapter.

One of the most significant findings of this chapter is the impact of management of the milieu programme on individual patients. This is evident from the premature discharge of patients, the diagnoses attributed to patients, and the lack of clarity with regard to the selection of patients. What is perturbing is the lack of evaluation and reflection of the Centre, which implies a continuation of the status quo. While reference is not made to all the findings, the following concluding chapter draws heavily on this chapter.

CHAPTER 10

DISCUSSION AND CONCLUSION

1. INTRODUCTION

In broad terms, this thesis aimed to evaluate the William Slater Centre's psychotherapeutic milieu programme. This was accomplished by focusing on the structure, the process, and the outcome of the programme. In this manner, it was possible to provide a comprehensive evaluation of a range of aspects of the programme. The overriding goal therefore was not to determine by a 'yes' or 'no' the effectiveness of the programme. Instead, what was envisaged is that the evaluation (and this chapter in particular), could provide guidelines with regard to the improvement of the William Slater Centre and its therapeutic programme.

2. AIM

This concluding chapter attempts to summarise the findings of the evaluation by drawing on the central underlying themes which are apparent throughout the thesis. Thus, a summary of each chapter is not provided. Instead, this chapter aims to provide an indication of the deficits of the programme in the hope that these would be beneficial to the future functioning of the William Slater Centre and its psychotherapeutic milieu programme.

3. DISCUSSION

3.1. STRUCTURE, PROCESS AND OUTCOME OF THE CENTRE'S PROGRAMME

The William Slater Centre for Adolescents is one of the few psychiatric units which provides intensive psychotherapeutic treatment for emotionally and psychologically disturbed adolescents. It targets a historically neglected group, who in recent years have received much attention internationally and nationally. The facilities at the Centre appear adequate and well-maintained, with attempts made to ensure that the environment is conducive to milieu therapy. The staff at the Centre are professionals, several of whom are experienced. Thus, it appears that the infrastructure required for an adolescent milieu therapeutic programme, is available at the Centre.

The profile of adolescents assessed and admitted to the Centre suggests that more clarity is required with regard to the selection criteria for admission to the programme. This is evident from the lack of discrepancy between those adolescents admitted to the programme and those failing to be admitted. It could thus be hypothesised that the Centre is not selective in its patients and that those excluded from the programme are possibly suitable for milieu treatment.

The monitoring of the William Slater Centre's programme demonstrates that the programme functions in accordance with its structured weekly timetable, with few amendments. The programme is clearly implemented as planned by the staff of the Centre. What is less explicit is the extent to which the programme functions according to milieu therapeutic principles. This forms the core of the remaining discussion of this chapter.

The brief short-term outcome evaluation demonstrates significant improvement in the depressive states of adolescents. It can confidently be stated that depressed adolescents

admitted to the therapeutic programme are discharged at end of a 12-week period with significant alterations in their mood states. The extent to which this can be attributed to the programme itself is unknown.

3.2. DRAWBACKS OF THE WILLIAM SLATER CENTRE

3.2.1. LACK OF KNOWLEDGE OF MILIEU THERAPY

What appears to be some of the central underlying flaws in the Centre's programme are the lack of knowledge, and the lack of clarity, with regard to milieu therapeutic principles and, more importantly, the application of these milieu principles to the William Slater Centre's programme. While these may be considered merely *some* of the factors contributing to the decline of the Centre's therapeutic programme, they are perhaps the most significant contributing factors to the difficulties encountered in the programme. The lack of clarity of staffs' own philosophical viewpoints and the Centre's philosophical beliefs with regard to milieu therapy suggests that the programme is perhaps not as theory-driven as it is proposed to be. Lack of clarity of staffs' viewpoints on milieu principles is a commonly cited reason for the downfall of milieu programmes in general (Fourie, 1994). It is essential that staff and the institution's beliefs, and the practical application of these beliefs, be compatible, since different individuals holding different views may result in conflicting ideas of the milieu programme (Fourie, 1994). This is clearly apparent at the William Slater Centre where no guidelines or policy documents exist outlining *how* the philosophy is put into practice, resulting in staff holding different views on the functioning and practices of milieu therapy. This is evident from the debates around the role of individual therapy and family therapy in the milieu programme, as well as several staff members' discontent with the authority pyramid. According to Fourie (1994), the presence of an in-service training programme should prevent the problem of lack of knowledge. This is however absent at the Centre.

Since the central underlying philosophical tenets of the programme have not been clarified and operationalised, the inherent flaws of the milieu therapeutic principles themselves only adds to the difficulties encountered in the programme.

3.2.2. LACK OF OPEN COMMUNICATION

Several researchers are of the opinion that open communication (Stanton & Schwartz, 1954) and open resolution of staff conflict are essential components of effective insight-oriented milieu treatment (O'Kelly & Azim, 1993), although it is difficult to implement (Hoffman, 1980). The William Slater Centre appears to make few attempts at fostering an environment conducive to open communication. This is evident from the staff group sessions, the decision-making processes amongst staff, and the lack of criticism entertained at the Centre. Hoffman (1980) comments that open communication can best be achieved by flattening the vertical administrative hierarchy. The barriers to open discussion at the Centre are possibly attributable to the hierarchical authority pyramid, where the leadership is primarily involved in the resolution of problems and the making of decisions. It is this very factor which Stanton and Schwartz (1954) alert to, saying that the failure of leaders to address staff conflict openly aggravates the situation within a milieu setting. This is the subject of the following limitation of the Centre.

3.2.3. AUTHORITY AND LEADERSHIP

Authority and leadership issues were expressed as areas of concern to several staff members at the Centre. While it is evident that one individual assumes the leadership, it appears that this position is enforced by the medical hierarchical system, with no apparent consideration of the milieu therapeutic principles of the flattened hierarchical system and democratisation. The lack of open communication, reinforced by the presence of strong leader, has resulted in essential milieu therapeutic principles being disregarded. Researchers and clinicians have, as early as the 1950's, alerted to the importance of clarity about authority and control (Redl & Wineman, 1951,1952; Rioch

& Stanton, 1953; Zeitlyn, 1967). This clarification is crucial since these issues tend to be 'blurred' or vague, creating unnecessary difficulties between staff (Mawson, 1979). Main (1980) too highlights the importance of openly discussing staff rivalries in milieu, instead of merely attributing conflicts to the concept of role-blurring. Throughout the literature on the treatment of adolescents, emphasis has been placed on the importance of dealing with staff tension and communication (Redl & Wineman, 1951,1952; Rioch & Stanton, 1953). The lack of open communication at the William Slater Centre implies that staff tension remains largely unresolved.

Related to the problems of authority and leadership, is the principle of democratisation, which is particularly problematic in the milieu setting, since a democracy requires a good leader although a leader is not ideal for a milieu. In an attempt to address this paradox, Scherer (1992) suggests that there should be acknowledgement that different situations need different leaders which should be determined according to ability. Individuals should feel free to express their views and have their contributions valued. Liberman (1983) too is of the opinion that it is only when different professional roles and skills are respected and valued that real teamwork come occur. Ideally, mutual participation by all staff members should be encouraged, while maintaining clarity in status and role hierarchies.

Parry-Jones (1986) presents an interesting perspective on the multidisciplinary team which is a common feature in the services provided for disturbed adolescents. He argues for the critical scrutiny and questioning of the effectiveness of this concept, since no model of multidisciplinary work exists. He highlights that practical choices have to be made about the way staff collaborate taking into consideration differences in the status and levels of competence of the staff and the fact that they are not necessarily collaborating as equals. This is particularly problematic for milieu therapy where the flattened hierarchy assumes that everyone is equal. Thus, while the classical principles of democratisation and flattened hierarchy are in themselves problematic, it appears that

researchers and clinicians have attempted to adapt and revise these principles. This is possibly a route which the Centre's programme could benefit from.

Staff at the William Slater Centre expressed particular concern and discontent about the flattened hierarchy principle and the lack of specificity and clarity with regard to responsibilities among staff. As early as the 1950s, Maxwell Jones (1953) emphasised that clear concepts of the different staff roles should be developed and staff should be aware of the roles of the other team members. Furthermore, each individual has a particular function to perform and must have a clear notion of how this function is applied.

4. CONCLUSION

In conclusion, it appears that the difficulties encountered by the Centre (as highlighted in previous chapters), are a result of, amongst other factors, (i) the lack of clarity by staff of milieu principles, (ii) the lack of reflection and evaluation at the Centre, and (iii) the inherent flaws of the principles of milieu therapy. Although a fairly bleak picture has been painted of milieu therapy in general and the William Slater Centre's milieu therapeutic programme, there is a challenge to continuously question, clarify and update milieu concepts (LeCuyer, 1992). Since therapeutic milieu programmes are flexible they can be adapted and what is needed is the will and drive to bring about change in a systematic manner (Fourie, 1994). While certain concepts of milieu therapy may not be practical, it is possible to adopt the positive functional aspects of this treatment modality (Karasu et al., 1977).

In the light of the rationalisation policies confronting mental health services, it may well be that the findings of the present evaluation may assist in ensuring the effectiveness of the William Slater Centre's psychotherapeutic milieu programme. What is hoped is that the present evaluation can provide some indication of the most pressing areas requiring

attention in order that this service for adolescents and young adults in need of psychological or psychiatric intervention be maintained.

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Appendix A

Projected budget for April 1996 - March 1997

STAFF DETAILS	Number of staff	Average annual salary	Total annual cost
NON-NURSING			
Housekeeping supervisor	2	22 000	52 832
Cleaner II	1	19 200	23 842
Cleaner I	1	18 000	26 364
Total	4		103 038
NURSING			
Senior Nurses	5	68 000	344 864
Total	5		344 864
ADMINISTRATION			
Clerks	2		90 098
Social worker	1		79 066
Occupational therapist	1		96 200
Gardener	1		19 077
Consultant in charge	1		139 578-155 370
Clinical psychologist (Full-time)	1		R63963 - 71055
Clinical psychologist (5/8)	1		R39978 - 44412
Total	8		527 960 - 555 278

OTHER			
Drama therapist	1		18 000
Pharmacy dispensing			7 000
Consumables			23 000
Catering			12 000
Transport			21 000
Stationery			17 000
Total			91 000
GRAND TOTAL	18		1 066 862 - 1 094 180

Appendix B

Weekly schedule of the William Slater Centre's psychotherapeutic milieu treatment programme

WILLIAM SLATER PROGRAMME

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
COMMUNITY	STAFF	COMMUNITY	STAFF	COMMUNITY	STAFF	COMMUNITY	STAFF	COMMUNITY	STAFF
	8:15 - 9:00 PRESENTATION PATIENT FEEDBACK		8:15 - 9:00 EVOCS PLANNING		8:15 - 9:00 PRESENTATION EVOCS FEEDBACK		8:15 - 9:00 STAFF GROUP		
9:00 - 9:30 INTRO/BUSINESS W-END FEEDBACK/ WEEK PLANNING	9:00 - 9:30 INTRO/BUSINESS W-END FEEDBACK/ WEEK PLANNING	9:00 - 10:00 GROWTH GAMES	9:00 - 10:00 GROWTH GAMES	9:00 - 11:00 DRAMA THERAPY. NEW PATIENTS FUN DRAMA	9:00 - 9:30 SUPERVISION WITH RAY (next presentation)	9:00 - 10:15 RELATIONSHIPS	9:00 - 10:15 RELATIONSHIPS	9:00 - 10:00 CAREERS	
9:30 - 11:30 DRAMA	9:30 - 11:30 WARD ROUND				9:30 - 11:00 STAFF S.VISION WITH JENNY & GARY (excl. nursing staff)	10:30 - 11:00 COMMUNITY MEETING	10:30 - 11:00 COMMUNITY MEETING		
					11:00 - 11:10 DRAMA FEEDBACK				
11:00 - 11:30 TEA	11:00 - 11:30 TEA	10:00 - 10:45 TEA	10:00 - 10:45 TEA	11:00 - 11:30 TEA	11:00 - 11:30 TEA	11:00 - 11:30 TEA	11:00 - 11:30 TEA	10:30 - 11:00 TEA	10:30 - 11:00 TEA
11:30 - 12:30 GROUP & F. BACK. NEW PATIENTS ADMITTED	11:30 - 12:30 GROUP & F. BACK	10:45 - 12:30 EVOCS. NEW PATIENTS COLLAGES	10:45 - 12:15 EVOCS	11:30 - 12:30 GROUP & F. BACK	11:30 - 12:30 GROUP & F. BACK	11:30 - 12:30 GROUP & F. BACK	11:30 - 12:30 GROUP & F. BACK	11:00 - 12:00 GROUP & F. BACK	11:00 - 12:00 GROUP & F. BACK
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	12:30 - 13:00 W/END PLANNING	13:00 - IND/FAMILY THERAPY
13:30 - 14:00 PATIENT MEETING				13:30 - 14:00 PATIENT MEETING					
14:00 - 15:00 SEX EDUC/ CRAFTS	14:00 - 15:00 SUPERVISION WITH RAY (next presentation)	14:00 - 15:00 LIFE SKILLS	14:00 - IND/FAMILY THERAPY	14:00 - 15:30 SPORTS	14:00 - 15:30 SPORTS	14:00 - 15:30 FUN DRAMA	14:00 - 15:30 STAFF ADMIN. MEETING. IND/FAMILY THERAPY		
	15:00 - IND/FAMILY THERAPY				15:30 - IND/FAMILY THERAPY	15:30 - 16:00 FAREWELL TEA	15:30 - 16:00 FAREWELL TEA		

Appendix C

Brochure of the William Slater Centre for Adolescents and Young Adults