Appendix A

Approvals

This research was conducted in accordance with, and under the following approvals (copies of which are included in this Appendix in the submitted original thesis):

1. A.C.T. Child and Adolescent Mental Health Services Research Agreement approved by the Director A.C.T. CAMHS, Ms. M. Carling and the Team Leader - The Cottage, Ms. K. Hampton, dated 30 June 2003.
2. A.C.T. Health and Community Care Human Research Ethics Committee approval No: ETH.5/03.322 dated 8 September 2003.
3. Bond University Human Research Ethics Committee approval Protocol No: R0310 dated 19 February 2004.

Appendix B

Adolescent Development and maturation

This Appendix provides the reader with a background to the complexities involved in the developmental and maturational stages of the adolescence and the emergence of mental health difficulties in order that they may better understand the factors involved in developing a day treatment and outpatient program for young people. This will lead to an understanding of the extensive issues involved in creating and developing an individual management plan for the young person undertaking treatment, issues involved in program curriculum development, day to day management and coordination of a day treatment program and issues involved in sustaining both the adolescent and staff interactions.

Development and maturation during adolescence

Chronologically, adolescence occurs between the ages of 10 and 19 years, and youth occurs between 15 and 24 years (World Health Organisation, 1993). Moreillon (1992), characterized adolescence as a period of transition with changes in:

- Biological development from the commencement of teenage years to full sexual and reproductive maturity of adulthood;
- Psychological development from the cognitive and emotional patterns of childhood to adulthood; and
- Changes in autonomy and dependency, from socioeconomic dependence to one of comparative independence.

The period of transition is marked by the development of physical changes in body size, growth and shape, changes in the level of hormones in both male and females as well

as considerable changes in cognitive development. Piaget (1955) described the cognitive changes in a way that related to the individual's emotional and social development. The period of adolescence from 12 to 19 years was described by Piaget as one of formal operations development. According to Piaget's theory, the adolescent has the ability to think in abstract terms, construct hypotheses, use ideas and imagination and distinguish fantasies, beliefs, probabilities and possibilities. The period prior to this was known as the period of concrete operations. The young person aged between 7 and 11years, had the ability to perceive relationships between things and was able to organize and classify concepts in a logical manner. At an age of about 14 to 15 the young person has the ability to develop abstract conceptions of social, ethical and political matters.

In contrast to a cognitive focus, Erikson (1968) related emotional development to both cultural and social expectations. Erikson described a series of stages from infancy through adolescence to adulthood to old age and death. Each stage was described in terms of the resolution of conflict. In adolescence, the conflict was described as the conflict between the establishment of personal identity and role confusion. Young adulthood was described as the conflict between intimacy and isolation, with the capacity for an intimate relationship and love as the positive outcome.

On the other hand, Blos (1970) described adolescence as a move towards independence from the family and a process of individuation. According to Blos, the adolescent who, when aged 3-4 years developed an internal model of the Mother, abandons the internal representation of the Mother through the adolescence period and develops real, loving relationships with other people.

Alestalo, Munnukka and Pukuri (2002) maintain that the adolescent's personality is still in the process of forming. The young person in getting to know their body, learning

to live with their sexuality and by achieving satisfactory social status amongst their peers, achieves a sense of identity. The relationship with the self, school, work and hobbies is important in shaping the individual's identity. School is an important activity in the adolescent's life and sometimes when problems arise school refusal can result. The process of adolescence has an impact on the child/parent relationship as the young person attempts to detach and become independent. Peers are an important source of support and security as the adolescent attempts to detach from parents. In addition the young person becomes future orientated as they prepare to leave school and move into work, marriage or family life.

Whilst there are many theories of emotional development in adolescence, Steinberg (1996) considers that they all have a common thread in that adolescence denotes a period where the individual has the ability to contemplate achieving a number of goals in reality. Steinberg maintains that, prior to adolescence, the ability in achieving goals had previously been largely fantasy. He maintains that the period of emotional development from dependence to independence is not always an easy path. The individual is faced with challenges and possible sources of anxiety, depression and confusion.

Regardless of whether the adolescent transitions through cognitive changes, conflict resolutions, separation and individuation from the Mother, identity formation or goal attainment changes, it is clear the adolescent goes through a magnitude of changes that require adjustment and adaptation. Until recently this level of emotional upheaval, through which adolescents pass, had been seen as a severe form of widespread adolescent 'turmoil,' of which adolescents would grow out of.

Longitudinal studies by Cantwell and Rutter (1994) have shown that a substantial number of adolescents go through these years relatively free of turmoil. There are individuals however who do experience difficult times.

Potential impact of failure to achieve developmental tasks

What of those who do not achieve the developmental tasks? MacLeod (1995) maintains that individuals who incompletely or negatively resolve previous developmental tasks may "take a maladaptive stance of fanaticism or rejection of cultural standards or may find safety in a passive stance resulting in bewilderment or role confusion."(p.111).

According to Schuster and Ashburn (1992), the individual fearing failure in identity formation and value resolution, may use tactics to avoid the pain of identity formation and responsibility. Possible tactics include:

- the use of drugs and alcohol,
- resorting to crime,
- truancy and/or school failure,
- delinquency,
- generalized depression,
- conflict with parents, and
- aggression.

These tactics however are not solely the behaviours of young people experiencing failure to achieve identity formation and value resolution. In addition, the effects of poverty, abuse, homelessness, unemployment, racial unrest, family conflict, family breakdown and academic pressure can add to the individual's difficulties resulting in

adverse effects on adolescent development (Choquet and Menke, 1989; Maag and Rutherford, 1988). Similarly, Goodyer (1990) found that:

> a multiplicity of…factors that give rise to the mechanisms associated with different psychiatric disorders. Single adversities are unlikely to result in a high proportion of cases within a general population. This is why even chronic family discord, if occurring as a single factor, is only a weak predictor of psychiatric disorder. (p.208)

It must be noted however, that not all young people experience many of the problems as cited. Some individuals are at a loss as to why they experience mental health issues and it can sometimes be explained by biological or organic disturbances. Steinberg (1987) describes genetic and chromosomal factors, neurological factors, and constitutional and temperamental factors as well as family and social influences as possible contributions to the development of a mental disorder. Table B1 outlines possible causes of mental health problems as described by staff in a range of services, responsible for providing help for young people.

Table B1

Causes of mental health problems

- Family issues:
  - conflict
  - child-rearing practices
  - communication
  - poor role models
  - single parent/step-parents
  - divorce/separation
  - working parents
  - transient families
  - State Wards, adoption
  - Parent psychopathology
  - Rejection lack of support
  - Violence
- Social causes:
  - Poor education
  - Unemployment
  - Poverty
  - Homelessness
  - Current economic climate
- Communication
- Physical and sexual abuse; neglect
- Powerlessness
- Helplessness and welfare system
- Society:
  - Pressure to conform
  - The "me" society, materialism
- Peer issues/relationships
- Education:
  - Learning problems
  - Failure
  - Teachers as role models
  - Problems of discipline
  - Intellectually disabled/language problems
- Independence issues:
  - Expected to behave like adults before ready
  - "authority" - rebellion
  - responsibility
  - Physiological problems; genetic causes
- Lack of school counselors
- Incarceration
- Developmental/transitional issues
- Drugs & alcohol/availability
- Parent alcoholism
- Risk taking
- Sexuality
- Alienation:
  - Isolation
  - Cultural differences
- Self-esteem
- Lack of experiential learning
- Traumatic events; loss; personal grief
- Emerging mental illness
- Geographical isolation
- World environment - e.g. threat of nuclear war
- Environmental causes - e.g. blood lead, insecticides
- Inadequate intervention/service gaps
- Lack of knowledge about mental health
- Creative people are often misunderstood and labelled
- Lack of rewarding, energetic activities e.g. sport, leisure activities, youth clubs
- Decline of religion
- Lack of support - community/school
- Individuals "fitting" society's values
- Working parents (both)
- Mixed messages - autonomy (adults to adolescents)
- Problems of identity
- Personality style/structure/temperament
- Important life events
- Stress
- Lack of order
- Learned behaviour

Source: Mental Health and Young People National Youth Affairs Research Scheme, 1992.

The multiplicity of possible causes for mental health issues for the young person as described above provide a greater understanding of the struggles and hardships the young person, who accesses treatment, endures. In developing and describing mental health services, it is important to understand the individual's developmental pathway and how some young people become emotionally disturbed during adolescence and develop maladjusted patterns of behaviour such as, suicide attempts, drug and alcohol abuse and delinquency.

In addition, studies of individuals with lowered emotional well-being in forms of helplessness and hopelessness, correlate positively with excessive substance abuse, delinquency, suicidal behaviour, low self esteem truancy, aggressiveness, disturbed eating and sleeping patterns, diminished interest in sport and exercise and poor relationship with friends and family (Macleod, 1995).

Macleod (1995) reviewed a study of 1518 students in Perth, WA. The aim of the study was to investigate the extent to which Australian adolescent's emotional well-being was associated with illness behaviour. Data on the adolescent's perception of self assessed health, physical symptoms and health service utilization were collected. Results indicated that the majority of students perceived their health as good, although 40% reported headaches, 34% reported aches and pains, 28% reported sore throats, 25 % reported stomach aches, 25% reported sporting injuries, 13% reported dizziness and 15% reported breathing problems. Females reported more depressive symptoms, the levels of which varied as a function of socio-cultural background. Adolescents from more advantaged areas reported lower scores than those from disadvantaged areas. Individuals with higher academic attainment also reported lower depressive scores.

It is interesting to note that individuals report significant illness behaviours regardless of their mental health status. Perhaps young people do in fact feel aches and pains because of the significant changes occurring in their bodies. These results may be indicative of adolescents 'normal' behaviour throughout these years. Although, adolescents with higher depressive symptoms reported more stomach-aches, dizziness, aches and pains, vomiting, sore throats, diarrhoea, breathing problems, accidents, blood noses and sporting injuries than adolescents with lower scores, the study did not allow for the direction of causality. It is possible that illness behaviours or symptoms may lead to depression rather than vice versa. An individual who feels ill or is not doing well at school may become depressed about it. Individuals may have a propensity for illness behaviours, anxiety or depression throughout this period and other difficulties in their life may have an impact on their mental health status. Individuals who reported more depressive symptoms used doctors, pharmacies, school nurses and emergency departments more often than adolescents with less depressive symptoms. An adolescent's level of emotional well-being was associated with aspects of their illness behaviour.

Furthermore, adolescents that referred to psychiatric care presented with a multitude of varying problems. Research by Alestalo, Munnukka and Pukuri (2002) explored the difficulties that made it necessary for health professionals to refer adolescents to specialized psychiatric care. The results indicated that 64.2% had difficulties in a number of areas. The majority of young people had difficulties related to self, followed by problems related to school, parents and peers. Figure B1 describes the young people's problems in the central spheres of their lives.

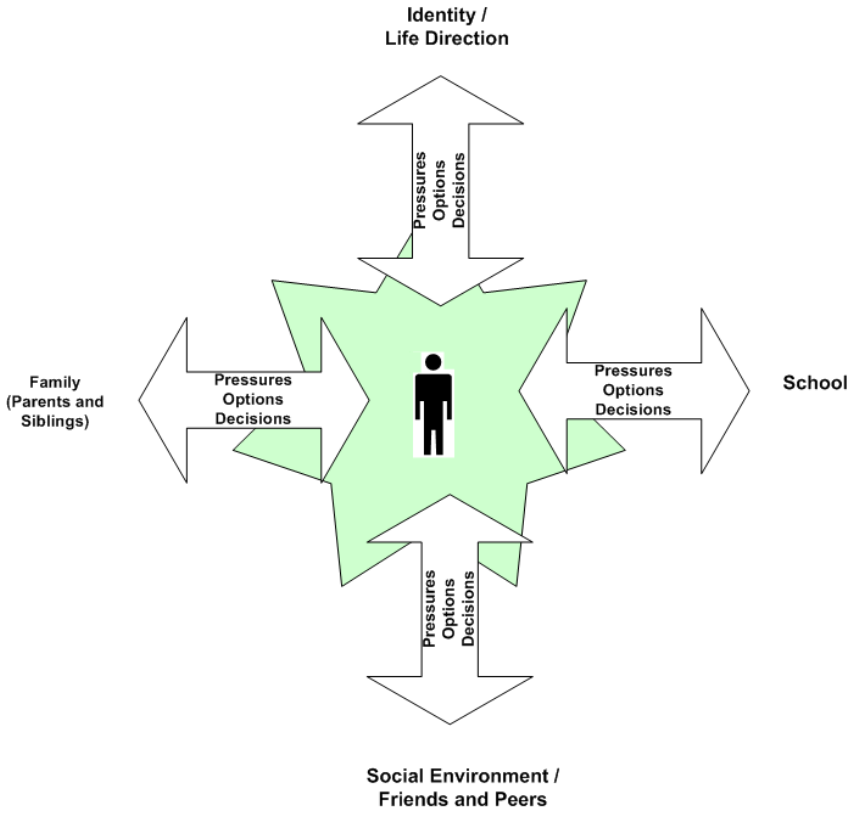

Figure B1. Young people's problems in the central spheres of their lives

Adolescence is a period of transition, during which significant social, biological, psychological, emotional and spiritual changes occur. Development and maturation in adolescence may be disturbed by variables related to one's life; one's self, experiences and the environment. The young person must deal with these changes as well as the conditions of modern society, which is characterized by a weakened family structure, rapid urbanization, competition for education and employment and exposure to drugs and alcohol. Some young people become emotionally disturbed during adolescence and develop maladjusted patterns of behaviour, such as suicide attempts, drug and alcohol abuse and delinquency. Some of the more serious disorders that appear in adolescence are psychosis, schizophrenia and manic depression.

With all these difficulties and problems it is obvious that challenges will arise in caring for adolescents in both day and outpatient treatment programs. Severely disturbed young people, some with conduct problems and some who come from dysfunctional home environments, create challenges for the staff. Adolescents often return to dysfunctional homes overnight, thus on return to the programs, the problems and frustrations reoccur. Treatment often raises issues of boundaries, communication and management. Hence staff stress can be a major issue.

In conclusion, it can be seen that it is vital to take into account the developmental pathways, the issues impacting upon adolescents, the illness behaviours and the problems associated with school, peers, family and life direction, when creating and developing a treatment program for adolescents. It is important for staff to have an understanding of the developmental, social and systemic factors in assessment and treatment (Birleson, 1997) to understand the stressors involved in treatment, which in turn can engender self discipline and growth in the young person and therapist.

Appendix C

The A.C.T. Child and Adolescent Mental Health Service Outpatient Treatment

The Child and Adolescent Mental Health Service (CAMHS), a division within Mental Health A.C.T. provides, amongst other services, an outpatient clinical/case management service. CAMHS is a community based adolescent mental health service, which provides specialised assessment, clinical/case management, crisis intervention, preventative services and direct treatment for children and young people up to the age of 18 years. CAMHS targets children up to 18 years who have:

- a moderate to severe mental health disorder or behavioural disturbance and/or
- a diagnosable psychiatric disorder where the condition is considered moderately to seriously detrimental to psychosocial development and/or leads to moderate to serious difficulties in the young person's social or family environment.

All clients attending the Child and Adolescent Mental Health Service undergo a comprehensive team assessment. Two Mental Health Clinicians interview the potential clients and their families and administer psychometric tests, over a period of approximately two hours. The process involves interviews of both the family and child together then separately. From this team assessment, the client is assigned, where appropriate, with a provisional psychiatric diagnosis prior to acceptance for CAMHS treatment. The team assessment outcomes are discussed at a meeting of the majority of the CAMHS staff and a decision is made whether or not the provisional

testing, interviews and diagnosis warrants treatment of the child and family at CAMHS or whether the client should be referred to another agency. Following the agreement to treat the client in CAMHS, the client is reviewed by a Child Psychiatrist, whereby a psychiatric diagnosis according to the DSM-IV-TR (2000) is allocated.

Clinical Management involves community-based assessments of the client and family, counselling, psycho-education, rehabilitation, crisis management, the support of individuals in maintaining social networks and relapse prevention. The clinical manager utilises various therapeutic approaches in treating the young individual, the aim of which are to assist in diminishing symptoms of psychopathology and to assist in strengthening the young person's self esteem, thus enabling the young person to function at a more optimum level in society.

During treatment of the client, CAMHS also works with the client's family/carers in order to educate them about mental illness in order that they may better assist the client in their treatment processes. The objectives of CAMHS are:

- to alleviate moderate to severe psychiatric, emotional or behavioural disturbance in children and adolescents
- to provide active support and consultancy to, and work in conjunction with other agencies and services for young people. (ACT Mental Health Services, 2001)

Service is delivered via two regional health centres, which are located in the South of Canberra, at Callam Offices, Phillip and in the North at the Belconnen Health Centre. The service comprises assessment and treatment to young people under the age of 18 years using a multidisciplinary framework, various group work programs and parenting groups and consultancy, collaboration and community education. CAMHS staff includes social workers, mental health trained nurses,

psychologists and psychiatrists. CAMHS aids young people experiencing such difficulties as, but not limited to:

- suicidal thoughts and behaviours,
- anxiety,
- fears and phobias,
- moderate to severe mood disorders and
- early psychosis.

The Clinician's primary treatment approach in CAMHS is clinical/case management. According to Burdekin (1993), case management is where one person is nominated to oversee the co-ordination of services for individuals who require access to a range of services. The person establishes and maintains a therapeutic relationship with the young person and ensures that, where appropriate, family members are included in decisions and management. The multiplicity of tasks and the complexity of work is described in Table C1.

Table C1

Clinical/Case Management Model

Assessment	• Work with clients to identify individual needs and service requirements. • Maintain up-to-date knowledge of clients' mental states. • Maintain awareness of clients' home environments and social/employment milieus.
Service Planning	• Work with clients to identify goals for service provision. • Work with clients to identify means of achieving goals and targets. • Develop formal Individual Service Plans.
Crisis Intervention	• Respond to acute/crisis needs of clients. • Facilitate specialist clinical services (e.g. psychiatrist review, hospital admission) as required.
Assertive Follow-Up	• Maintain regular schedule of home visits • Contact clients when they miss appointments. • Contact clients when alerted by concerned family, friends or significant others.
Advocacy	• Represent clients in their dealings with unfamiliar agencies or environments. • Advise and act on behalf of clients when they experience difficulties with people or agencies.
Brokerage	• Consult and liaise with other professionals and service providers. • Facilitate client access to services in the community.
Review	• Monitor impact of interventions. • Conduct routine re-assessments of mental status. • Conduct formal evaluation of treatment outcomes. • Review service plans.
Support	• Maintain regular contact with clients, including while they are in hospital. • Provide information, advice and support to clients at times when they require it. • Provide support to relatives and carers of clients.
Provision of specialist clinical services	• Counselling/psychotherapy/family work. • Skills training. • Administration and/or monitoring of medication. • Psychoeducation for clients and their families.
Accountability	• Record assessment data and Maintain records of all service planning, client contacts, case review / outcome evaluation.

(King,1997)

Young people meet with their Clinical/Case Manager once or twice a week, weekly or fortnightly depending on their need. Clinical/Case management involves

managing the client's entry into the service, managing treatment and coordinating the person's movement through the service and assisting with discharge

Throughout the course of treatment, the therapist and the client collaboratively develop a treatment management plan, where cognitive, emotional, biological, behavioural and social issues are considered. The psychosocial issues coupled with an understanding of the biological foundation of human behaviour are the essential components of the biopsychological treatment plan. Such issues include:

- Psychological (Therapy Approach)
    - Psychodynamic Theory
    - Cognitive-behavioural Theory
    - Individual Therapy
    - Interpersonal Therapy
    - Narrative Therapy
- Social Issues
    - Accommodation
    - Dealing with Agencies
    - Friends and social contacts
    - Family and relatives
    - Social systems - Church, school, sports, interests/hobbies, Scouts etc.
- Biological Aspects
    - Physical illness - asthma, allergies, headaches etc.
    - Sleep practices
    - Pharmacotherapy
    - Congenital disabilities

Appendix D

Program rationale and theory of day treatment

Day treatment programs are an extremely effective way of providing treatment for young people whilst maintaining them in the community setting rather than an inpatient or residential setting. Young people requiring supervision are able to benefit from educational services and receive daily psychotherapeutic interventions. A day program can provide the intensity of a group-oriented milieu and focus on family treatment, which is not possible with outpatient treatment. Theoretically, it is the milieu, therapeutic relationships and principles of program theory (as depicted in Figure D1 and described in the following paragraphs), that assist the young person in making changes. Ultimately improvements manifest in:

- Improved personal functioning
- Improved self esteem, coping skills and social skills
- Improved self control and interpersonal relationships and
- Improvements in the management of mental health disorder.

These improvements, in turn, bring about the planned program outcomes of improved mental health status, through greater awareness of self and others, understanding of the illness, the ability to manage relapse and a return to the community or school. .

The Milieu

The modality of treatment delivery at the adolescent day unit is through the use of a therapeutic milieu or therapeutic environment. In the context of an adolescent day program, Crouch (1998) uses the term milieu therapy to describe “a clinical setting in which the child’s peer group, facilitated by staff, help to emphasise the

strengths of the individual's capacity to cope with difficulties"(p.116). Gunderson (1978) argued that there are three qualities of the therapeutic milieu namely:

- the distribution of responsibility and decision making power
- clarity in treatment programs, roles and leadership, and
- a high level of staff/patient interaction.

The physical setting at the adolescent day unit reflects the treatment philosophy of the unit and provides cues to parents, individuals and families on community values and behavioural expectations (Cotton, 1993). The Day Treatment Program at the Cottage is described in detail at Appendix E.

The rationale behind the therapeutic milieu is that therapeutic growth within the adolescent can best take place when an adolescent's intact environment is utilised to encourage that growth. Gunderson (1978) maintains that the milieu is created and maintained by a continually evolving dynamic between the adolescents and staff members. Each facet of the milieu is designed to elicit changes in the young person's mind-set and behaviour, including social interactions. Gradual changes occur within the young person as they interact within the milieu.

The therapeutic relationships formed during this experience enable the young person to develop more mature coping mechanisms, thus supporting the client to conform to the environment's expectancies at The Cottage and at home. The types of relations that take place between clients and staff elicit small, incremental changes that allow the adolescent to understand him/herself, understand mental health issues and develop better management of his/her behaviour. The young person can further test out their new skills in their home, community and school.

How do these changes take place within the individual? The pathway to understanding oneself and others, gaining knowledge and coping mechanisms is lined

with the multitude of relations that occur between clients and staff at The Cottage. Learning opportunities take place in the milieu through these relations. The categories of learning opportunities are constructive feedback for both positive and negative behaviours, modelling (observational learning), peer/staff reinforcement and opportunities to practise (behavioural rehearsal). The program theory that is used at The Cottage is an adaptation of the more widely used and common learning/education theories whereby learning objectives, goals and processes are defined and designed against required outcomes. The program theory as used in the day treatment program at The Cottage is similar in content and structure to one recently published for mental health day programs by Wyatt (2002). Figure D1 provides a graphical depiction of the program theory of day treatment.

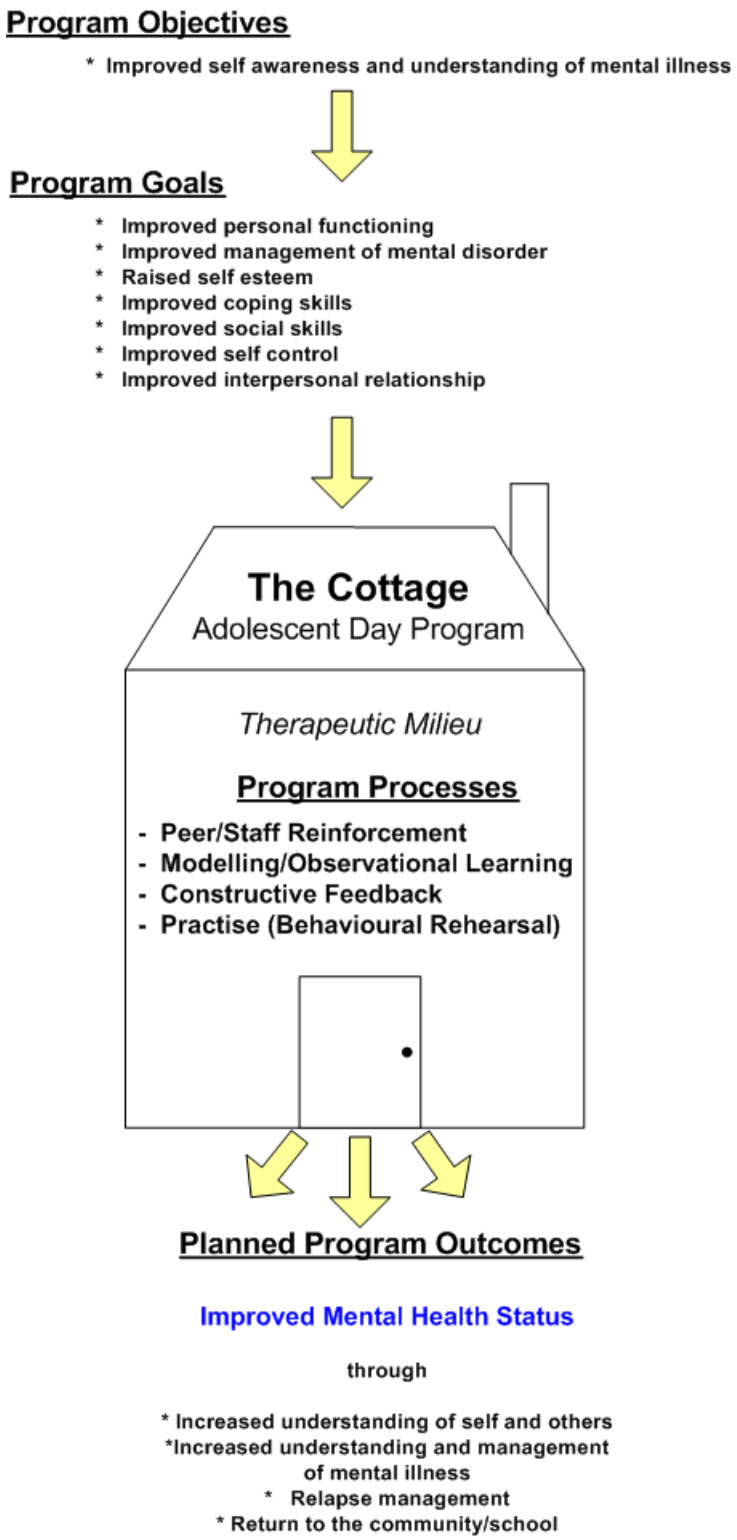

Figure D1. The Cottage Program theory of day treatment

Constructive Feedback

As depicted in Figure D1 constructive feedback occurs on a daily basis within the therapeutic milieu of the adolescent day program. The young person in day treatment is in constant interaction with staff or peers as he/she goes about the daily tasks of schooling, group work and creative activities. The constant contact provides ample opportunity for positive and negative exchanges to occur and for staff to provide constructive feedback about specific behaviours. Even young people with ingrained forms of disruptive behaviour have the opportunity to experience positive connections with staff. This interaction, according to the Social Information Processing work developed by Dodge (1986), influences the young person's future choice of behaviours. Dodge proposed that with each successful interchange a young person has, he/she is more likely to choose that strategy again in a different situation, thus gaining a greater sense of self efficacy and achievement.

The model proposed by Dodge (1986) assumes that young people have a mental database of past social interactions of both positive and negative outcome. Over time a type of blueprint or schema of past interactions is stored in the young person's memory. These schemas influence how the adolescent processes social cues, the response accessed in a social situation and the course that the adolescent chooses to enact. A young person in day treatment who experiences positive exchanges with constructive feedback concerning specific behaviours may learn to exhibit similar behaviours.

Modelling (Observational Learning)

Modelling is one of the program processes within the therapeutic milieu at The Cottage (Figure D1). The theory of modelling has its most prominent beginnings in the writings of Bandura (1977), who demonstrated learning in subjects who simply

observed another person but did not themselves perform explicit behaviours or receive direct reinforcement. Bandura asserted that the observer of a specific behaviour acquired a symbolic representation of a model's behaviour. This representation was stored in memory and retrieved at a later date when the observer needed to guide his or her own attempts at imitation.

The environment at the day treatment program enables young people to observe both staff and their peers' behaviours and consequences and model the appropriate behaviours. When a young person is rewarded for positive behaviours, the peers have the opportunity to observe the exchange and choose a similar behaviour for themselves, so that they too may have the chance to receive a reward. Similarly if a young person is given consequences for negative behaviour, the peers can observe the exchange and choose not to engage in that behaviour in the future.

Peer/Staff Reinforcement

Two principles of instrumental conditioning that are useful in modifying problem behaviour at The Cottage are positive and negative reinforcement (Seamon and Kenrick, 1994) whereby a response, it appears, is more likely to occur if it leads to positive reinforcement (the onset of a sought-after stimulus) or negative reinforcement of (the termination an undesirable stimulus). Staff at the adolescent day treatment program is trained to use a variety of reinforcement techniques for managing behaviours (see Program Processes in Figure D1).

The close encounters with staff and peers, during the daily program activities, provide innumerable opportunities for staff and peers to reinforce both desirable and undesirable client behaviours. The philosophies concerning behaviour at the Cottage are known to staff and clients and are reiterated at frequent intervals. Consequences for undesirable behaviours, such as aggression, violence, substance abuse etc are

immediate and constant across all situations and persons. The young person after consultation with the parent is requested to leave the program for a few days and have time for reflection. Other extrinsic reinforcement activities for negative behaviour include: time-outs, periods of constrained contacts with peers and loss of privileges. Consequences are predictable and consistent. Extrinsic rewards for positive behaviours include validation, gold stars for achievement in academic work and green cards with affirmations written on them.

Furthermore, in terms of reinforcement, peers also exert considerable influence on each other. Reinforcement that is provided by peers is often subtle and unintentional. A young person who fights after being bullied may decide that fighting "pays off" and becomes more aggressive or if he/she felt humiliated may become passive and avoidant. Peers serve as social models and inform others as to how to behave. A new person at The Cottage may watch a peer to see what behaviour is acceptable or otherwise. Peers also influence each other by discussing and debating issues and in group interactions, the peer group can set implicit or explicit norms on how individuals are supposed to look, think and act (Shaffer, 1994).

Practise (Behaviour Rehearsal)

In keeping with the social information processing model (Dodge, 1986), where clients can choose acceptable modes of behaviour after experiencing successful interchanges, the young person in day treatment has the opportunity to practise successful exchanges.

Throughout the day clients participate in a myriad of activities; each one of which provides the opportunity for practising newly learned behaviours. Young people sit around the dining table, talking with adults and their peers and practise their social skills. In group therapy they participate in role plays, where they are exposed

to different scenarios and asked to problem solve or demonstrate different behaviours. In the small environment of school, they often experience success and confidence for the first time. Those young people who excel at sport teach their peers and feel empowered. These skills are rehearsed at the Cottage and then tested in their home and community environment.

Appendix E

ACT Day Program

The Day Treatment Program of which participants attended was first established in 2001. The program is conducted in a separate building, The Cottage, which is located on the grounds of the Calvary Hospital in Canberra. The Cottage is part of the Child and Adolescent Service, which is a division of the ACT Mental Health Service. The clients are normally referred to the Day Program by the CAMHS clinical manager, or CAMHS Intake Team, but in some cases may be referred for entry assessment by another health agency.

The day program is provided to adolescents and their families who are experiencing moderate to severe prolonged emotional, behavioural or other mental health issues. Adolescents who are not functioning at an optimum level or individuals who have been absent from school for some time can access day treatment. Criteria for inclusion are that individuals have experienced long term psychiatric difficulties that have disrupted family, social or work functioning and that they are committed to treatment. They also have the capacity for group work and are aged between 12 - 18 years. Exclusion criteria from the program are individuals requiring 24-hour hospitalization, current substance abuse or severe intellectual impairment.

Program staff includes a Team Leader, Mental Health Nurse, Psychologists, Social Worker, Occupational Therapist, Teacher, Technical Officer and part time Receptionist. The CAMHS Psychiatrist is accessed for review of the client's condition. Although all patients undergo the standard course, the patient's treatment progress is reviewed at a weekly meeting with all staff involved and each client has an individualized management care plan which can involve the incorporation of more

individual treatment sessions in addition to the standard treatment offered. On entry to The Cottage, a therapist is assigned to each client. All therapists are not only involved in the treatment of their individual clients but are also involved with all clients via groups and informal interactions.

Program Design

Day treatment involves the provision of a structured treatment program for adolescents experiencing moderate to severe mental illness. Zimet and Farley (1985) consider that the basic assumptions underlying day treatment are:

1. Young people are more likely to cope effectively with their difficulties if:
    - The family system is engaged in the therapeutic experience;
    - The treatment setting resembles the individual's home environment as much as possible;
    - A highly interdisciplinary program is provided; and
    - Psychotherapeutic interventions (individual, conjoint, group or family therapy and/or support groups and parent effectiveness training) are utilised:
2. The day is organised as much around school experiences as possible; and
3. A specifically designed behaviour management program is implemented.

The model for day treatment at the CAMHS Adolescent Day Program is illustrated in Figure E1.

Figure E1. Model of Day Treatment

Central to day treatment is an intensive therapeutic milieu whereby cooperation amongst all staff occurs in order to create a safe environment where individuals feel they can work on their problems. The objectives of day treatment are to relieve anxiety, promote adaptive skills, improve interpersonal relationships, improve academic skills, gain self-awareness, enhance self-esteem and develop self-control in young people.

The ACT CAMHS adolescent day program is conceived as intensive treatment of the moderate to severely disturbed adolescent within the context of the family and community support systems. Intensive treatment is provided four days per week by a

team of people, primarily comprised of Mental Health Nurses, Psychologists, Social Workers, a Teacher and Visiting Psychiatric Registrars. The therapeutic team is also supported by a Technical Officer and an Administration Clerk. Treatment is multi-modal and may include pharmacotherapy, individual and family psychotherapy, family support, group therapy, skills training, psycho-education, creative expression and rehabilitation therapy depending on the assessed needs of the attending clients. The adolescent's existing supports are integrated into the day program. Family members are included in assessment, are consulted regularly and participate in parent evenings and educational transitioning procedures. Each client's referring or outpatient case manager is involved in the planning process and treatment, and is encouraged to visit the young person whilst at the program.

The day program, which may accommodate up to a maximum of 12 adolescents has 10 spaces for full-time or part time clients. Additionally, an after school program has been conducted on occasions, depending on individual requirements. Two spaces are left open to accommodate seriously disturbed individuals transitioning from hospital. The treatment setting is a small cottage with adjoining classroom, which is comfortable, cosy and has been specifically designed to resemble the child's natural environment as closely as possible. A quiet room is available for the young people should they feel distressed and require "time out" for a limited time.

The day is organised around school experiences, followed by group therapy on three of the four days with drama, creative expression, a community meeting, individual therapy and recreation filling in the remaining time. The program is flexible and adaptable to the needs of the group. Art therapy, exercise therapy, horticultural therapy and vocational work are also considered if there is a need for any of the clients.

Therapeutic Milieu /Therapeutic Environment

The modality of treatment delivery at the adolescent day unit is through the use of a therapeutic milieu or therapeutic environment. In the context of an adolescent day program, Crouch (1998) uses the term milieu therapy to describe "a clinical setting in which the child's peer group, facilitated by staff, help to emphasise the strengths of the individual's capacity to cope with difficulties" (p.116). Gunderson (1978) argued that there are three qualities of the therapeutic milieu namely:

- the distribution of responsibility and decision making power
- clarity in treatment programs, roles and leadership, and
- a high level of staff/patient interaction.

The physical setting at the adolescent day unit reflects the treatment philosophy of the unit and provides cues to parents, individuals and families on community values and behavioural expectations (Cotton, 1993). The adolescent day unit communicates warmth, openness and sturdiness and the capacity to care for young distressed individuals. Adolescents have their own space to talk, play games, play pool and listen to music.

The program timetable is presented in paper form and displayed on the wall for adolescents and families to see. Clear communication is adhered to and letters are sent out explaining any changes. The team leader and Senior Clinician are introduced to all individuals and families concerned. The Senior Clinician directs staff and makes decisions in collaboration with the Team Leader. To ensure the unit has a sense of security and safety, close interaction and effective monitoring takes place, combined with a relatively high staff/client ration of 1:3.

Gunderson (1978) maintains that the milieu is created and maintained by a continually evolving dynamic between the adolescents and staff members. In the day

program, adolescents are encouraged to examine their behaviour, recognise and label distressing feelings and explore different ways of expression. Staff interventions emphasise problem solving, conflict resolution and a tolerance for the individual's internal affective state. Staff provide frequent verbal feedback and support to the individual. Members of the staff work closely together using concepts of transference and countertransference to maintain a therapeutic environment. For example, they may notice the feelings and attitudes that the child has towards parents, siblings and significant others reflected in the feelings and attitude to specific staff members and peers. The child's behaviour can then be compared and contrasted to behaviour at home and then the similarities and differences found, used as a concept in family therapy.

Cultural Model of Milieu Treatment

There are two differing theoretical views of milieu treatment. Zeldow (1979) presents an argument for the cultural model, in which "milieu is a treatment in and of itself, separate from its component treatments"(p.461). This treatment emphasises the context in which treatment occurs particularly interpersonal relationships. A safe space is created where the patient can engage in treatment. In an inpatient setting Rubin (1997) describes the milieu as the daily events in an adolescent's life. The adolescent 's daily routines of meals, school, sport, group and individual activities, outings and bedtimes etc formulate an environment of nourishment, protection and socialisation. The therapeutic environment or community promotes a medium for the adolescent to accomplish therapeutic goals.

Additive Model of Milieu Treatment

Abroms (1969) describes "an additive model, wherein milieu is a structure to systemically apply specific interventions"(p.461). In attending day treatment, the

patients form a sort of captive audience so that in arriving for one activity they are available to receive other services that may be utilised in the program. For example, the child, in coming to the unit for alternative schooling, is available to receive group therapy, individual therapy, social skills or perhaps vocational skills. The milieu is the total structure, interventions and activities that are used in the treatment process. The staff share with the patient the impact the adolescent's behaviour has on others to gain insight and understanding of some of the motivations underlying his/her behaviour.

The milieu used in day treatment at the adolescent day program is derived from both of the above theoretical frameworks. The adolescent milieu functions as "an overarching supergroup" (Sylvan et al., 1999). The supergroup has an impact from both cultural and additive perspectives. The adolescents turn to their peers for identity formation. This association provides a powerful therapeutic attraction which causes the adolescent to want to come to the program thus receiving an 'added dose of treatment'. Through the therapeutic aggregation of adolescents and staff, the basis elements of therapeutic change can occur.

Essential Values to the Therapeutic Milieu

The A.C.T. Adolescent Day Program uses the five major therapeutic processes common to milieu therapy, according to (Gunderson, 1978), namely:

- containment/safety,
- structure,
- support,
- involvement, and
- validation.

Containment

Gunderson (1978) considers that the function of containment is "to sustain the physical wellbeing of patients and remove the unaccepted burdens of self control or feelings of omnipotence"(p.329). Containment is achieved at the unit, by the provision of a high staff/patient ratio, and an environment ensuring basic safety (an absence of sharp and dangerous objects and close supervision of the adolescents at all times). A staff member, referred to as a monitor is on duty throughout the shift. Individuals requiring timeout have immediate access to someone and the monitor is available for conflicts and crises that may occur. If patients are disruptive or at risk of injuring themselves, they are temporarily removed from the community. This may involve time out in the quiet room or going home for the day.

Consistent social and behavioural rules are central to containment. Prior to admission each child is given a copy of the unit's behavioural philosophy, which outlines the expectations to each person, and a behavioural contract for agreement. A system of cards is used at the unit, whereby a yellow card denotes a caution and a red card denotes time out. After two yellow cards are given the patient is excused from the activity and staff talk to the child before re-entry is permitted. Intermittent green cards in the form of green raffle tickets are given to individuals throughout the week for doing something positive or demonstrating 'nice' behaviour. A draw is held at the end of the week where an adolescent chooses a green card from the basket and the person selected, chooses a surprise from the basket of goodies. A secondary draw is held where the green cards are read and the individual with the most cards also wins a prize.

Structure

According to Gunderson (1978), structure refers to all aspects of the milieu, which "provide a predictable organization of time, place and person" (p.330) whilst Delaney (1992) structure is needed to "pace time on the unit, avoiding over-stimulation on the one hand and isolation on the other" (p.11). Structure fosters the development of ego strengths and self-control and enables the individual to consider consequences and delay impulsive actions. Structure is created through time use, rituals and activities. Inherent in the timetable at the adolescent day unit is a balance of busy and quiet time. The timetable is posted so that everyone can see it, community meetings are held which provide an opportunity for the individual to clarify and make suggestions for modifications. In addition, the consistent application of rules is enforced. The adolescents are expected, at least as much as permitted by their state of health, to take part in all aspects of the program, including school, group therapy, drama etc.

Support

According to Sylvan (1999), support refers to the way in which the milieu is "encouraging, empathetic, kind and nurturing" (p.467). Support attempts to enhance the young person's self esteem. In attempting to increase the young person's self esteem, staff need to have a genuine interest in the ideas and perceptions of the child and to have sensitivity to the child's inner world. Staff at the unit must be consistently available for the child. This may mean ensuring that the child is washed and dressed in the morning, that advice and information is given or that there is someone available to them to openly express their worries and intimate secrets. As well as the support from all staff, each child at the unit has an individual clinical therapist to confer with.

At the adolescent day unit, support is expressed through praise and encouragement. Acknowledgement of success is an important factor. Adolescents are encouraged to select activities that are geared to their strengths. There are opportunities for individuals to choose a more activities based program or a more verbally oriented program. Some individuals prefer to kick a ball, go on adventure walks, play basketball, do rock climbing whilst others prefer painting, drawing sculpture, creative expression or music etc.

Involvement

The process of involvement centres on the relationship with family, other young people, staff and the development of the child's behaviour within the unit system. Involvement is signified by those processes, which cause the young person to attend actively to their social environment and interact with it (Gunderson, 1978). Gunderson as considers that the purpose of involvement is to utilise and strengthen the person's ego and modify adversive behavioural patterns. Parental involvement is an integral part of the treatment. Parents participate in an initial lengthy assessment and are provided with a full description of the program. Rules of the program, expectations from child and parents and family, personal and unit goals are clarified. Clinicians make weekly contact with the parents and three parent nights are organised throughout the term. These initially have a focus on talking and support, followed by psycho-education and attention to specific needs. In the middle of the term an academic exhibition takes place whereby the teacher meets with the adolescent and parents and the child's work is on display. Family therapy is adhered to if there is a requirement.

As well, the milieu centres on the development and maintenance of peer groups and the role of responsibility. Involvement enhances natural development needs, such

as identity formation and the establishment of peer relations. Involvement with peers helps the adolescent find that they have friends with common interests and needs, thus enabling them to feel that they can contribute and participate in a community. Involvement is facilitated in the group situation. As stated by Simon (1986) "groups provide the adolescent with a variety of interpersonal experiences that can improve the range and control of affect and the social skills" (p. 562) of those adolescents who have experienced trouble getting along with others. Along with participation and the taking on of different program jobs, such as food preparation, cleanup, bin monitor, gardener, scribe and chair of the community meeting comes responsibility. This is sometimes met with resistance, however consistent and explicit guidelines for expected behaviour are adhered to.

Validation

Validation is also a necessary component of the milieu. Validation affirms a patient's individuality and requires that the staff are empathetic, sensitive and able to tolerate uncertainty. Validation supports differentiation of the self, which according to Bohlander (1995), is " the ability to distinguish between thoughts, and feelings in an emotional relationship system" (p.165). It provides a way for adolescents to understand connections between thoughts, emotions and actions and to select self-enhancing behaviours. As the young person moves toward independence the staff validate that the young person can trust their own strength and skill.

Validation occurs at the team level. If, the team decides that the needs of a child are not being met within the program, changes may need to be made to the program. The multi-disciplinary team meet and discuss the necessary changes to the child's individual management plan. Thus a child's behaviour needs to be continually

evaluated and ‘success’ or ‘failure’ seen and interpreted as a context of a continual monitoring and individual program modification process within the milieu.

Individual Therapy

Another necessary adjunct in the milieu treatment of seriously disturbed adolescents is individual therapy. In the initial stages of treatment the adolescent is likely to be antagonistic towards treatment and not overly collaborative. Masterson (1972) describes this as the ‘testing phase, whilst Rinsley (1982) describes it as the ‘resistance phase’. Adler (1985) maintains that

> The therapeutic alliance in its mature, stable form is usually only present in a later stage of treatment, although precursors or unstable forms of it may be visible earlier A sequence occurs in the successful therapy of primitive patients:
> 1. The establishment of stable self-object transference that sustain them,
> 2. the increasing capacity to appreciate the therapist as a real and separate person, and
> 3. the gradual ability to ally themselves with the therapist in the service of accomplishing work.” (pp115-116)

Precursors to collaborative work, the active participation in the treatment process and recognition of one’s own contribution to problems, may be acceptance of containment, formation of attachments, communication of symptoms, collaboration in a conflict free space and development achievement (O’Malley, 1990).

Individual contact enables the individual to form relationships with individual staff members, which can facilitate an attachment to the program as a whole. These relationships can provide the individual with access to an adult, other than their parent. In general the therapist focuses on problems highlighted in the program and issues that the individual may have difficulty in openly expressing in the group setting. At the unit, team confidentiality is employed whereby anything that is significant to the team for the child’s health and wellbeing is discussed at team meetings. The adolescent is made aware of this concept.

The Quiet Room

The quiet room at the adolescent unit is used as a 'treatment modality.' The use of the quiet room is a part of a continuum to reduce stimuli, provide time for reflection, diffuse aggravating circumstances and encourage behavioural control and self-mastery. Young people, when distressed, often request 'time out' in the quiet room. The room is situated away from the stimuli of the main living area of the cottage but within distance of the staff. There is a comfortable settee in it, a blanket and pillows. The walls are adorned with a pleasant painting and to ensure safety, there are no other protruding hooks or equipment in the room. During voluntary 'time outs' or compliant 'time outs', a staff member accompanies the young person to the room, talks with them for a few minutes and leaves them alone for approximately ten minutes, so that they can gain a measure of mastery in self- control. The staff provide empathic support and structure. Generally the young person then rejoins the main group.

Family Work

As stated, a significant component of milieu treatment of adolescents with a psychiatric diagnosis is family work. In a study of adolescents involved in treatment of depression, the adolescents whose parents were involved showed greater reduction on parent ratings of adolescent depression than those without parent involvement (Lewinsohn,1990). Waugh and Kjos (1992) in their study of day treatment compared behavioural outcomes of adolescent patients with high parental involvement with outcomes of patients with low parental involvement. High parental involvement was related to improvements in the patient's self-rating scales, reduced hospitalisation, and reduced pathology and severity ratings. The level of family pathology however confounded results. Emotionally troubled parents may lack the psychological

resources to commit to participation in the treatment program. Waugh and Kjos recommended further research of specific treatment modalities for this population, taking into account the influence of family pathology.

A number of studies have documented the presence of family dysfunction for adolescents with mental health issues. Dryfoos (1990) has described parental psychopathology as a significant factor, whereas DeBaryshe, Patterson and Capaldi (1993) have cited ineffective or aggravating parenting styles as an important aspect. Sylvan et al. (1999) maintain that specific areas that need to be addressed are: inadequate structure and limit setting, unrealistic academic, social and vocational experiences, psycho-education on the nature and severity of illnesses and issues around boundaries. In addition, it is important to meet the needs of families so that they can care for the adolescent with an emotional disability. Surveys of families with children who have an emotional disability have shown that family members need:

- information about the nature, treatment and prognosis of their child
- assistance in learning about and negotiating the service system
- advice and training to manage the young person's difficulties and
- assistance in fulfilling the caregiver demands, including respite care (Knitzer, 1982;Van Den Berg &Donner, 1987).

The task of working with families is further complicated by the adolescent's conflict around separation and individuation. The challenge for the staff member is to help the family function, whilst assisting the adolescent in developing independence.

Academic Integration

Finally academic and psychiatric integration is an important pursuit of the therapeutic milieu. Chronic, untreated psychiatric conditions lead to a series of events in which adolescents begin to encounter difficulties. These difficulties may progress to repeated failures, school refusal and truancy. Once this occurs the adolescent's academic difficulties spiral out of control. Thus the individual with severe mental

health issues requires a coordinated approach in transitioning back to school and preventing some of these difficulties. The program teacher, parent and clinicians meet with teachers, welfare officers and school counsellors at the child's school throughout the school term. A discussion evolves around the child's mental health status, the child's academic abilities and expectations whereby a coordinated plan is developed to transition the child back to school. This plan may involve greater involvement of academic staff, the school counsellor and may involve the selection of appropriate subjects for the child. The school may develop a plan for the child to meet with other school peers to promote smoother social integration.

Therapeutic Community

The overall objective of creating a therapeutic milieu, employing group therapy and using all the components as described above, is to develop a type of self sufficient community, a therapeutic community, whereby adolescents feel confident, strong and empowered. In acting out the roles in the therapeutic community it is hoped that the adolescents will learn new skills and eventually model these qualities in their own personal community environments.

The term therapeutic community describes a cohesive community where individuals have a significant involvement in decision-making and the practicalities of running the unit. The focus is on the community itself as the instrument of therapy. The therapeutic community is based on ideas of collective responsibility, citizenship and empowerment. The community is structured in such a way that encourages personal responsibility and avoids unhelpful dependence on the professional staff. Patients are seen as bringing strengths and creative energy into the therapeutic setting and the peers are seen as important as establishing a therapeutic alliance (Campling, 2001).

The therapeutic community is where the multidisciplinary team work together in collaboration with the adolescent utilising a community patient setting, to provide a microcosm of the real world. In the setting, various treatment modalities can be implemented. This allows for the active participation of staff in planning, implementing and evaluating patient treatment plans. The therapeutic setting is used for utilising different modalities, for observing behaviour, providing feedback and supporting behavioural change.

The therapeutic community at the adolescent unit has strong leadership and provides a 'safe frame' for therapeutic work. Group members and staff meet each week at a community meeting. A group member chairs the meeting and a group member takes on a secretarial role and scribes the meeting. The community meeting is task-oriented, psychotherapeutic at times and socio-therapeutic. During the meetings, activities are planned, duties (chores) are established, grievances are aired and group resistance is interpreted. Recognition of awards and reinforcement is attended to and requests and needs are made known and examined.

Whilst evidenced based guidelines recommend cognitive behavioural interventions for depression and anxiety (NHMRC, 1997), some therapists have a preference for psychoanalytic therapy, self-psychology, interpersonal therapy, solution focused or varying eclectic approaches. Due to the fact that treatment needs vary from client to client, it is important that the mental health practitioner assess the individual needs of each client and implement or modify therapeutic treatment accordingly.

Disorders that require specific treatment are obsessive-compulsive disorders, school refusal and post-traumatic disorders. Likewise, it is crucial that young people

with bipolar disorder and psychosis are recognised early and effectively treated to minimise the impact on the young person and family.

Group Therapy

A significant focus of treatment at the adolescent day program is group therapy. According to Garrick and Ewashen (2001):

> Group sessions offer a therapeutic space for adolescents to practise having a voice and to actively participate in their treatment and care". Group work provides the young person with a major source of feedback about behaviours that are annoying or pleasing to others and about cognitive processes that are self-depreciating or self-enhancing. It provides opportunities for peer reinforcement, for learning to deal with the idiosyncrasies of others and for gaining knowledge. It also offers a medium for the group leader to use many therapeutic procedures.(p.166)

Thus adolescents, in the group setting at the adolescent day program, learn to deal with others, to tolerate different perceptions and understand differences in themselves and others. Group approaches offer the individuals a unique opportunity to study the developmental trends and dynamics of human relationships (Ballard, 1999). The young adolescent, in observing and reflecting on his/her responses and that of others, can study and explore significant events that are affecting his/her current state that may assist in an understanding how he or she may act in the future. Under the guidance, protection and support of the group leaders and inherent group norms, learning new behaviours can take place.

Norms, expectations members place on each other as to proper behaviour, are established in the beginning stages of group work at the adolescent day unit and are reinforced if necessary by the group leader or group members. The primary purpose of the group norms is to establish common ground in which individuals can feel safe to air their concerns. They provide a means for relieving group members' anxieties by providing a common way of responding to ambiguous situations that require interpretation. Some norms exist at the commencement of a group, such as the

prevailing language, common courtesies, manners etc whilst others develop during group conduct. Group pressures are those norms exerted by the group or individual members to ensure some members 'tow the line.' At the contract stage of group work, norms may be set up such as confidentiality, disclosure interruptions and respecting others. Norms are generally sustained because members in the group recognise the need for, and want them. The norms provide security, comfort; assist the group leader in facilitating the group, thus aiding the achievement of group goals (Bundey et al., 1968).

Group pressures, those pressures exerted by the group or individuals to 'tow the line' are particularly important to note in group work with adolescents, because of the recognition of the importance of peer relations (Zimpfer, 1992). Hartup (1979) notes that adolescents are particularly susceptible to peer pressure and are particularly responsive to interventions that involve peers. They suggest several reasons why peer relations are important:

- Lack of sociability in boys and girls is associated with discomfort, anxiety and a general unwillingness to engage the environment
- children master their aggressive impulses within the context of peer relations
- sexual socialization cannot take place without peer relation and
- peer relations are related to a child's ability for role taking, which in turn is related to social competence.

The group, with its natural peer kinship, provides an intermediary step for practise of newly learnt behaviours prior to performance in the community

Model of Group therapy

In developing a group therapy model for adolescents participating in the day program, it was crucial to consider the target population as well as developmental and contextual factors of the adolescent (Garrick & Ewashen, 2001). Piaget's theory suggests that adolescents develop towards a more abstract formal cognition from a stage of concrete operational thinking, whilst Erikson's (1978) psychosocial model suggests adolescents struggle with issues of autonomy, identity, authority, independence, role clarification and peer relations (Townsend, 2000). Anna Freud (1958) described adolescence as a period of turbulence where the individual attempts to defend against infantile object ties. Blos (1967) also describes this period of individuation as a process of disengagement from internalised objects. Anna Freud (1958) and Blos (1967) emphasise the adolescent's defensive manoeuvres and developmental accomplishments that adolescents employ to combat the 'regressive pull' towards passivity, dependence and attachment to parental objects.

The psychiatrically disturbed adolescent according to Kaplan (1980) and Offer and Offer (1975) is especially vulnerable to the intensity of the struggle against regression and its disorganising and frightening effects. The ability to reach the task of autonomy and independence is severely compromised in the disturbed adolescent, due to deficits in ego development, self and object relations, problems in self esteem maintenance and intrapsychic and external conflicts. (O'Malley, 1990).

Admission to the adolescent day unit may increase the adolescent's experience of self as passive, dependent and powerless. Garrick and Ewashen (2001) maintained that adolescents, when initially admitted to day treatment often presented as developmentally younger than their chronological age. Adolescents on admission are

often resistant to forming an alliance with the treatment team. The three distinct sources of resistance are:

- the adolescent's perception that day treatment is coercive because it is empowered by adults
- the individual's normal insurgence against passivity and dependence, and
- the psychopathology of the disturbed adolescent, which heightens the parting from parents and the restrictiveness of the unit (O'Malley, 1990).

Given their psychological, emotional and cognitive state at this stage, they may be especially vulnerable and may present with minimal ego strength. O'Malley (1990) maintains that the adolescent may;

> fight against efforts to contain and confront their behavioural dyscontrol, and they avoid exploration of their personal pain and dysfunction because of character pathology, dynamic conflicts, and limitations in ego development (p.14).

To work with the vulnerabilities of this client group, the clinician must be verbally active, genuine in affect and not readily challenge an adolescent's defences or self-representations (Jacobs, 1996).

The model selected for group therapy in the adolescent day program is an integrated one. It is comprised of interpersonal and cognitive behavioural approaches within a feminist perspective.

Interpersonal Therapy

Interpersonal Therapy (IPT) is a time limited well-defined therapy based on the premise that interpersonal problems increase one's vulnerability to mental illness, such as depression. IPT is grounded on the interpersonal theories of Sullivan (1953) and the attachment theories as described by Bowlby (1969). These theories assert that individuals have an instinctive drive to form attachments with others and tend to shape interpersonal relationships with individuals in their life. The principal feature of 'good' mental health is one's ability to form effective relationships with others that sustain and support the individual. In general, the theory postulates that a person's

attachment style, which developed primarily through childhood, is relatively consistent within and across relationships with people, however can be modified positively or negatively through interactions with other individuals. The depressed individual often has difficulties in requesting and receiving psychological support in times of crisis leading to an increased vulnerability to depression. IPT therefore is designed to treat the symptoms of depression, to focus on the individual's attachment style and the individual's interpersonal relationships.

Interpersonal Therapy has been shown to be efficacious in outcome for adolescents experiencing depression. (Mufson, Moreau, Weissman, & Klerman, 1993) adapted interpersonal therapy for adolescents with major depression. This 12 weekly program focussed on issues around separation from parents, authority concerns with parents, developing dyadic relationships, loss and death of relatives or friends, peer pressure and problems of single parent families. A study showed that the program was associated with a reduction in symptoms, a high rate of remission of depression and improved social functioning (Mufsen,et al., 1994). Rosello and Bernal (1999) also reported on treatment effects of IPT. They found IPT had a significant impact on the reduction of depressive symptoms and improvements in self-esteem and social adaptation.

Yalom's (1995) interpersonal model of group therapy acknowledges the need for structure and containment. The model also values interpersonal group work as an important aspect in building cohesion and a sense of universality. Its focus is on improving the young person's current functioning in interpersonal relationships. The young members focus on problem identification from an interpersonal perspective and address issues and feelings.

The therapist when using IPT in group-work, explores specific problem areas, such as issues of loss, interpersonal disputes, role transitions, and interpersonal deficits. According to Yalom (1995), the therapist "activates the group and calls on, actively supports, and interacts personally with members" (p.463). Therapists provide structure, focus on the here and now, identify issues and reinforce the individual's strengths.

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) has also been found to be effective for treating adolescents diagnosed with depression. Nine controlled or comparative studies of CBT for adolescent depression have been carried out. Seven of the studies found CBT efficacious at the end of acute treatment. Reynolds and Coats (1986) researched 30 high school students with a diagnosis of depression. Their studies contrasted cognitive and behavioural activities, relaxation only or a waiting list condition. There were no significant differences between CBT and relaxation, however 79% of treated groups (CBT or Relaxation) were functioning in the normal range at the completion of treatment in contrast to none of the waiting list condition. Lerner and Clum (1990) reported CBT in the form of group problem solving, to be superior in treating young people with suicidal ideation than supportive group therapy. Fine, Forth, Gilbert and Haley (1991) found, at a nine month follow up, that groups treated using either therapeutic support group or social skills group models were equivalent on all measures. Rossello and Bernal (1999) found CBT and IPT superior to a waiting list condition in reducing self- reported depression.

Lewinsohn (1990) treated 59 depressed adolescents in the Adolescent Coping with Depression Course. Participants were randomly assigned to the course, a concurrent parent group or waiting list condition. The course included daily mood

monitoring, increasing pleasant activities, learning the connection between activities and mood, relaxation, identifying depressive thoughts, problem solving, communication, social and negotiation skills. Both treated groups improved significantly more than waiting list condition. Brent et al. (1997) used cognitive therapy with adolescents whereby 107 participants with major depression were randomly assigned to CBT, systematic behavioural family therapy (SBFT) or nondirective supportive therapy (NST). CBT emphasised psycho-education, exploration of issues of autonomy, problem solving, social and affect regulation skills. The SBFT emphasised engagement of the family, identification of behavioural patterns, communication and problem solving whilst NST emphasised an empathic relationship, expression of feelings and discussion of problems. Results indicated that remission was greatest with CBT (60%), versus 38% of SBFT and 39% of NST adolescents.

Cognitive behavioural group therapy focuses on identifying dysfunctional core cognitions of members and teaching plans and actions to change the cognitive thought patterns. The rationalist cognitive model assumes that individuals develop cognitive misconceptions that may evolve into irrational beliefs and perceptions of themselves, others and the world. Ellis (1992) suggests that rigid adherence to the unrealistic, absolute expectations may result in dysfunctional thoughts (obsessions), feelings (panic, depression and self hatred) and behaviours (phobias and compulsions).

Primary cognitive techniques used in group therapy at the adolescent day unit are goal setting, self monitoring, identification of distorted cognitions and counter cognitions and affect management, including relaxation and impulse control techniques. The therapist challenges the dysfunctional thinking by engaging members in role-plays, written activities and homework to assist members in understanding the

connections between, thoughts feelings and behaviours (Corey, 1995). The young person is supported in analysing his/her own cognitions, labelling the self defeating statements appropriately and then supported in observing and rehearsing new, more appropriate self statements. The individual is taught to reinforce oneself covertly. In practising these skills, the individual participates in warm-up activities and closures, psycho-education sessions and activities on; self-awareness, understanding depression, management of depression, understanding anxiety, management of anxiety, anger management, assertiveness skills, social skills training and communication.

Feminist Theory

Finally, the Feminist theory is also an important theoretical underpinning of group therapy in the adolescent day program. McGraw Schuchman (1997) considers that the Feminist theory has:

> constructs which guide the practise of therapy such as building on competencies, recognising power imbalances, using growth (vs. illness) model of therapy, developing a sense of community, emphasising autonomy and self direction, challenging therapeutic distance, and utilising self disclosure in helping relationships (p.103).

The therapist critically examines the role of power in-group, in treatment and in the context of the individual's lived experience. The influences of power, position, cultural biases and the societal/political context are explored in group therapy and as a result the client is validated, empowered and has a more contextual understanding of his/her circumstances.

An example of this practice is the psycho-education, art therapy group. The focus of the group is to explore adolescent health and wellbeing. The adolescents take responsibility for the project, research and explore concepts that impact. on adolescent health and wellbeing. They employ the use of different mediums, including art,

computer, staff knowledge etc, discuss them at length and then form a debating team. They argue a point of view based on their research. The discussion is videoed by fellow adolescent colleagues, developed and disseminated to the staff and family. Inherent in this discussion are issues of power, their position in society, relationships, autonomy and self- responsibility.

Appendix F

Day Treatment Research Tables

Tables F1 and F2 provide a summary of previous research into pre-adolescent and adolescent day treatment programs including methodological problems.

Table F1

Summary of Research that has examined the effectiveness of day treatment for pre-adolescents

Authors	Sample Size (N) Ages	Gender F	Gender M	Intervention Duration	Study Design / Instruments	Outcomes / Results	Methodological Problems
Grizenko, N., Papineau, D., and Sayegh, L. (1993)	30 Aged 5-12 years	7	23	4.4 months (mean) Day treatment versus wait list control	Prospective study Hare Self Esteem Scale, Revised Child Behaviour Profile, Depression Self Rating Scale, Index Peer Relations	Improvement in deviant behaviour, self perception, peer relations, family functioning maintained at 6 months F/U	Not randomly assigned Inequitable sample males versus females
Grizenko, N. (1997)	33 Aged 5-12 years	3	30	4.4 months (mean) Day Treatment	Prospective 5 yr F/U	73% attending school Improvement maintained on all measures Mean scores in problem range for self esteem	No control group Possible gender effects
Tissue, R. and Korz, A.C. (1993)	88 Aged 5-14 years at entry	10	78	Psycho-educational Centre 39 months (mean)	Retrospective 8 yr F/U	61% of young people were working, in school, or both.	No control group No standardised measures
Sack, W.H., Mason, R., and Collins, R. (1987)	79 Average age 6 years at entry	22	57	18 months (median) Psychiatric Treatment Centre	Retrospective 7 yr F/U Chart Review	90% attending school (60% of these in special education). 32% of children institutionalised at some stage.	No control group No standardised measures
Erker, G.J., Searight, R.H., Amanat, E., and White, P.D. (1993)	61 NS	14	47	16.3 months (mean)	Retrospective 10 yr F/U of children assigned to day treatment v. residential care	In both programs 2/3 of children improved	Not randomly assigned
Gabel, S., Finn, M., and Ahmad, A. (1988)	52 Age 4-12 years	12	40	Children's Day Hospital Duration 6 months	Retrospective study of charts	56% required residential treatment	No control group No standardised measures Not randomly assigned
Kiser, L. J., Millsap, P. A., Hickerson, S., Heston, J., Nunn, W., Pruitt, D. B., et al. (1996).	114 Aged 5-18 years	37	63	38 months Partial hospitals	Prospective study with a one year follow up	Improvement in behaviour, family function and peer relations	No control group. Wide age range of sample 5-18yrs

Authors	Sample Size (N) Ages	Gender F	Gender M	Intervention Duration	Study Design / Instruments	Outcomes / Results	Methodological Problems
Hundert, J., Cassie, J.R.B., and Johnston, N. (1988)	68 Aged 6-12 years	NS	NS	8.1 months (mean)	Prospective study: Comparison of characteristics of children in day treatment, Behavioural adjustment class, Out Patient treatment, adjustment class	Outcome across four treatments did not differ on most measures.	

Note: F/U = Follow-up NS = Not Stated

Table F2

Summary of Research that has examined the effectiveness of day treatment for adolescents

Authors	Sample Size (N) Age	Gender F	Gender M	Intervention Duration	Study Design / Instruments	Outcomes / Results	Methodological Problems
Rayner, J., and Woodward, A. (2000)	11 (13-18 yrs)	5	6	Youth Day Programme (12 week duration).	Prospective evaluation: using Coopersmith Self-esteem Inventory, BDI, CBCL, Core Family Functioning Questionnaire , Youth Form Parent, Case manager form	Reduction in reported difficulties with depression/anxiety, delinquent behaviour. Increase in coping behaviour activities, socialization and family adjustment	Inadequate non-random sample size. No control group
Yelland, C., Hubbard, S., McLean, S., and Hodgkiss, S. (2002)	52 (12-16yrs)	43	9	Adolescent Services Enfield Campus (ASEC) Day program. Duration not identified.	Prospective evaluation: using CBCL,YSR, PI, SPPA	Significant improvements in mental health, behaviour and self esteem	Limitations in use of SPPA as not completed by large proportion of sample and validity and reliability of PI as a measure. Gender effects in sample due to majority of males.
Piper, W.E., Rosie, J.S., Azim, H.F.A., and Joyce, A.S. (1993)	120 (15-57 yrs)	80	40	Day treatment for clients with affective and personality disorders. Duration 18 weeks.	Prospective randomised day treatment versus delayed treatment design with F/U study 8 months post treatment. 17 outcome variables of interpersonal functioning, psychiatric symptomology, self esteem, life satisfaction, defensive functioning and treatment objectives	Significant improvement in 4 of 5 areas studied: interpersonal functioning, symptomology, life satisfaction, self- esteem, severity of disturbance associated with objectives. Improvements maintained at follow up.	Research did not allow comparisons with other forms of treatment/placebo activities. Research did not determine if particular components of program were responsible. Reduction of sample size in F/U assessment may have had impact on outcome.
Silvan, M., matzner, F.J., and Silva, R.R. (1999)	31 (14-19 yrs)	21	10	Adolescent Alternatives Day Program, (AADP) Non-schizophrenic Duration: 6 months.	Prospective evaluation using truancy rates pre/post program, Severity of Illness (Clinical Global Impressions scale) and changes in overall functioning (GAF scores)	Reduction in truancy rate from 65%to 25%. Improvements in CGI and GAF scores.	No control/ comparison group Non random sample

Authors	Sample Size (N) Age	Gender F	 M	Intervention Duration	Study Design / Instruments	Outcomes / Results	Methodological Problems
Milin, R., Coupland, K., walker, S., and Fisher-Bloom, E. (2000)	55 (12-19yrs)	22	33	Adolescent day Treatment Unit (ADTU) Ottawa. Duration: Mean 30 months, SD 5.7months	Prospective evaluation over 3 yr period, using pre/post standardised measures: CBCL, parent/teacher/youth, Piers Harris Self Concept Scale, BDI, RCMAS, SAICA, Family Assessment Measures. Life Events scale, satisfaction surveys	Significant improvements in individuals with internalising disorders, Improvements in behaviour, global functioning, decreased levels of depression, academic grades. Risk factors included parental psychopathology, family disruptions.	High attrition rates. No control/comparison group
Blackman, M., pitcher, S., and Rauch, F. (1986)	31 (Mean age 13.8 yrs)	23 (DT) 5 (EV)	6 (DT) 5 (EV)	Comparison of day treatment versus evening treatment. Duration: Average stay 4-10 months.	Retrospective chart review of treatment. Standardised measures used: Piers Harris Self Concept Scale, Kovacs Child Depression Inventory, CBCL, Family Assessment Measure, BDI	Gains in patient's self-concept, reduction in depression, remission of somatic complaints and anxiety for both programs. Little objective change in family adjustment	No control, non-random sample.
Kettlewell, P.W., Jones, J.K. and Jones, R.H. (1985)	62 (13-18yrs)	30	32	Adolescent Day Program Duration: 8-12 Weeks	Prospective one group pre-test/post test design using outcome measures: Child & Adolescent Behaviour Problem Checklist, Goal Attainment scaling, Assessment of Current Functioning Scaling.	Improvement across a variety of areas; greatest impact in peer relationships, school and control of emotions (anger, anxiety, depression). Conduct problems and Substance abuse more resistant to change	Lack of control group difficulty in obtaining follow up data to measure effects of partial hospitalisation and not influence of other treatments
Kiser, L.J., Ackermnan, B.J., and Pruitt, D.B. (1987)	private hospitals 205 (mean age 15.6 yrs) Day Treatment: 72 (13.0 yrs mean)	82 29	123 43	Comparison of costs of day treatment versus hospitalisation for adolescents. Average length of stay 2-4 months	Retrospective data evaluation: Population difference, costs, lengths of stay and costs, insurance reimbursement, diagnostic category	Day treatment less expensive per day shorter stays in inpatient facilities result in no significant differences	Difficulty in establishing costs due to many variables involved.

Authors	Sample Size (N) Age	Gender F	Gender M	Intervention Duration	Study Design / Instruments	Outcomes / Results	Methodological Problems
Prentice-Dunn, S., Wilson, D., and Lyman, R. (1981)	50 (6-16 yrs)	NS	NS	Analysis of cases discharged from residential and day treatment programs. Duration: 1 year	Retrospective data analysis of the influence of 9 client factors on behavioural ratings.	The child's IQ, age, parental involvement and living situation predictors of behavioural rating improvement. Parental involvement, race, IQ predictors of academic gains.	Clients/ treatment not unitary phenomena i.e. neglected type/severity of behavioural disturbance. Only 2 outcome measures used. Treatment outcome should be measured as multi-dimensional and multi-directional.
Jansen, D.P. (1986)	46	NS	NS	Adolescent day treatment changes-individual oriented to family oriented	Retrospective chart analysis of outcome data: placement history in 1983 and 1984 and follow-up questionnaire information.	Results of program changes were positive with decreased out of home placements, shorter treatment delivery, decrease in problematic behaviour fewer families in need of counselling	Information gained from charts therefore possible room for error
Waugh, T.A. and Kjos, D.L. (1992)	50 (13-17 yrs)	24	26	Adolescent Day treatment program (Chicago) Duration: 6.5 weeks (average length of stay)	Prospective pre/post test design using 2 instruments: the Behaviour Rating Profile and the Louisville Behaviour Checklist.	High parental involvement related to improvement in ratings (school, home), reduced hospitalisation Reduced pathology and severity of child	Results confounded by level of family pathology, attrition of parental sample. Lack of control study.
Bouhlas, L. and Bond, N. (2000)	NS (17 -24yrs)	63%	37%	Evaluation of Day treatment (Perth Clinic). Duration: Open program: NS Closed Program: 8 weeks	Prospective pre test/post test and F/U outcome measurement of depression, anxiety, self esteem, locus of control, patient and parent satisfaction	Statistically significant changes in depression, anxiety, self esteem and locus of control ratings at the .05 level for open and closed groups Discrepancy in feedback from parents re inclusion in open program.	No control study. Use of inadequate clinical measures.
Jainchill, N., Hawke, J., De leon, G., and Yagelka, J. (2000)	485	141	344	Evaluation of treatment for adolescents with substance use problems. Duration: NS	Post-treatment status of completers versus non-completers in residential therapeutic communities. Psychiatric interview, information on drug use and criminal activity obtained.	Drug use for completers significantly less for one-year post treatment across al drug and alcohol categories. Significant reductions for criminal activity greater for completers.	Retrieval rate of sample was only 64% Use of Marijuana appeared to be understated. Reliability of self reported data

Authors	Sample Size (N) Age	Gender F	 M	Intervention Duration	Study Design / Instruments	Outcomes / Results	Methodological Problems
Stewart, M.E. (1994)	NS 12 -18 yrs	NS	NS	Walden House Adolescent Program (Residential) Duration: 12-18 months	Outcome study regarding length of time of residential treatment for drug addicted, emotionally disturbed adolescents.	Length of time in treatment is significant factor contributing to post treatment success Specific treatment plans developed in first 15 days improve success rate of clients Successful outcomes occur at 9 months of treatment and improve thereon.	No control study 21% attrition rate
Huestis, R. and Ryland, C. (1990)	50 including 22 parents and patients. 19 parents only 9 patients only 13-18 yrs	NS	NS	Partial Hospital Treatment. Duration: 3-9 months	Retrospective analysis of charts. F/U interview. Instrument used: Level of function scale	Two of eight descriptive correlates clinically significant: age at admission and family history of substance abuse. Diagnosis, severity and learning disabilities were significant. Improved peer relationships were significant.	No control study Difficulty in obtaining complete and accurate data from charts Various diagnosis, few neurotic disorders Comparing different interventions over time is difficult
Orchard, J.M. and MacLeod, R.J. (1990)	97 12-19 yrs	NS	NS	The Youth Services Day Program Duration: average 54 days	Retrospective chart review analysing outcome criteria: attendance, adaptation to community on discharge,	Attendance rate of 69% 80% of adolescent attended school or work and 76.7% lived at home, or some other non-institutional living situation	No comparison study Difficulty in obtaining retrospective information over 2 year's duration from charts.
Ginsberg, S. (1987)	70	NS	NS	Arizona Youth for Change (AYC) day hospital program	Prospective outcome data and F/U studies at 3, 6 and 12 months, evaluating problem areas, school enrolment, areas of greatest improvement and cost containment.	92% reported that child had improved or stayed the same in 80% of problem areas 67% enrolled in school Improvements in: sharing feelings of anger, enhanced relationships, aggression and disobedience.	Preliminary information No standardised measures used No control study.

Note: F/U = Follow-up, NS = Not Stated, DT = Day Treatment, EV = Evening Treatment, BDI = Beck Depression Inventory,

CBCL = Child Behaviour Check List, YSR = Youth Self Report, GAF = Global Assessment Functioning, CGI = Clinical Global Impressions, RCMAS = Revised Children's Manifest Anxiety Scale, SAICA = Social Adjustment Inventory for Children and Adolescents, PI = Problem Inventory, SPPA = Self Perception Profile for Adolescents.

Appendix G

Information Statement For Research Participants And Their Parents/Guardians and Consent Form

WODEN / TUGGERANONG
CHILD & ADOLESCENT
MENTAL HEALTH SERVICES
Level A2 Callam Offices, Callam St
Woden ACT 2606
Phone: 02 6205 1469

Fax: 02 6207 5266

SCHOOL OF HUMANITIES AND
SOCIAL SCIENCES

Bond University
Queensland 4229
Phone: 07 55952522

Fax: 07 55952545

INFORMATION STATEMENT FOR RESEARCH PARTICIPANTS AND THEIR PARENTS/GUARDIANS

An evaluation of mental health gains in adolescents who participate in a structured day treatment modality.

My name is Jenny Fothergill and I am presently undertaking a Doctorate of Health Science at Bond University, Gold Coast under the Supervision of Dr. Norman Barling. As part of this course I am required to carry out a research project. As I am the Senior Clinician at the A.C.T. CAMHS Adolescent Day Program, and there is an ongoing commitment to monitoring program effectiveness and providing improvement, where possible, in the treatment of clients, I have decided to conduct research into the effectiveness of the program. The aim of the research is to evaluate whether an adolescent who attends a more intensive treatment schedule, such as the structured day treatment program, shows a higher level of improvement in mental health gain than a client that does not receive as intensive treatment. I will use both clients that have attended and some that have not attended the program in order to compare the two.

This statement will provide you with information about the research program, the procedures and your rights. Participation in the research project is voluntary and it will be up to you if you want to take part. Participation is not compulsory and if you do chose to take part you may withdraw at any stage. No-one will force you to take part or to remain in the program if you don't want to. There will be no penalty or discrimination against you if you decide not to take part or withdraw after the program starts. It is entirely up to you. Your ongoing treatment will not be affected if

you do not want to participate or continue. If you do want to take part I will ask you to sign the attached consent form before I commence the actual research.

During your period as a client at CAMHS you will or have undertaken a number of psychometric tests and interviews. These tests are used to assist your Case Manager in assessing your needs and the tailoring of your treatment in order to provide you with the best treatment for your individual case. This research that I undertake will be based on the changes in your test scores. I will extract the information from your files and will not require any further involvement from you above what is currently planned as part of your treatment. The information that I extract from your medical records, held by CAMHS, will be coded to ensure that there is nothing in my research data that could be used to identify you in any way. Your name or any other identifying features will not appear in any of the reports or papers. Your confidentiality will be maintained. Once I have completed the analysis on all of the client data the research database will be deleted. At no time will any of your medical records be removed from the safe and secure CAMHS environment. The data collection will run over a three month period during which time you will not be required to do anything outside of what is normally required of you during treatment.

I plan to publish the results of this research through appropriate organizations and journals where the information may be used by other mental health practitioners to better plan and implement treatment for other young clients like yourself. In this way your assistance in this research may assist personnel at CAMHS to not only assess potential improvements in your treatment, but may also assist them in providing improved treatment for all clients. Although, whilst every attempt will be made to use this data to improve levels of treatment, it may not directly benefit your treatment depending on the outcome of the research and your current treatment program.

This project has been approved by the A.C.T. Health Human Research Ethics Committee (ACTHREC project number ETH.5/03.322) and the Bond University Human Research Ethics Committee (BUHREC project number R0310). Should you have any complaint or queries concerning the manner in which this project is conducted, please do not hesitate to contact either the ACT Department of Health Ethics Committee Secretary or Bond University Research Ethics Committee at the following addresses:

ACT Department of Health Ethics Committee Secretary
Second Floor
North Building
London Circuit CANBERRA ACT 2601
Telephone: (02) 62050846

OR

The Complaints Officer
Bond University Research Ethics Committee (BUHREC)
Bond University Research Institute
Room 232, Level 2, Conference Centre
Bond University Gold Coast QLD 4229
Telephone: (07) 55954194 Fax: (07) 55955009

Email: Mignon Kendall : (mignon_kendall@bond.edu.au)

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

If you are willing to participate in this research project could you please complete the attached consent form making sure that both you and your parent/guardian sign the form.

Regards

Jennifer Fothergill
BAppSc(Nursing), BAppSc(Psych), GradDip(Community Counselling)
MMH

Consent Form

WODEN / TUGGERANONG
HUMANITIES AND
CHILD & ADOLESCENT
MENTAL HEALTH SERVICES

Level A2 Callam Offices, Callam St
Woden ACT 2606
Phone: 02 6205 1469
Fax: 02 6207 5266

SCHOOL OF

SOCIAL SCIENCES

Bond University
Queensland 4229
Phone: 07 55952522
Fax: 07 55952545

Consent Form to Participate in a Research Project

I, _____(name of participant)

of _____ _____ _____
(Street) (Suburb/town) (State & postcode)

have been asked to consent to my participation in a research project entitled:

An evaluation of mental health gains in adolescents who participate in a structured day treatment modality.

In relation to this project I have read the attached **INFORMATION STATEMENT** and have been informed of the following points:

1. Approval has been given by the ACT Department of Health Ethics Committee and the Bond University Human Research Ethics Committee.
2. The aim of the research is to evaluate whether an adolescent who attends a more intensive treatment schedule, such as the CAMHS structured day treatment program, shows a higher level of improvement in mental health gain than a client that does not receive as intensive treatment.
3. The results obtained from the study may or may not be of direct benefit to my medical management.
4. The procedure will involve the researcher accessing my medical records at CAMHS in order to extract information relating to psychometric test scores. I will not be required to provide any further involvement above what is currently planned as part of my treatment.
5. My involvement in this project may be terminated if any of the following circumstances develop:

- If I or my parent/guardian request that I be withdrawn,
- If I do not continue in CAMHS treatment for a period of approximately three months and hence do not complete the full set of psychometric tests.
- If the overall project is terminated for any reason.

6. Should I have any problems or queries about the way in which the study was conducted, and I do not feel comfortable contacting the research staff, I am aware that I may contact:

   The ACT Department of Health Ethics Committee Secretary
   Second Floor
   North Building
   London Circuit CANBERRA ACT 2601
   Telephone: (02) 62050846

   OR

   The Complaints Officer
   Bond University Research Ethics Committee (BUHREC)
   Bond University Research Institute
   Room 232, Level 2, Conference Centre
   Bond University Gold Coast QLD 4229
   Telephone: (07) 55954194 Fax: (07) 55955009
   Email: Mignon Kendall : (mignon_kendall@bond.edu.au)

7. I can refuse to take part in this project or withdraw from it at any time without affecting my medical care.
8. I understand that the results of the research will be made accessible and that my involvement and my identity will not be revealed.
9. In giving my consent, I acknowledge that the relevant Health Department Staff directly involved in the study, may examine my medical records only as they relate to this project.
10. After considering all these points, I accept the invitation to participate in this project.

Date: __/____/2003 **Client Signature:**_____

Parent/ Guardian Consent:

I _____(parent/guardian name) **being the Parent / Guardian** (please circle the correct relationship) **of** _____ (client's name) **having read the INFORMATION STATEMENT, considered the points above and discussed the research project with the client, provide my agreement to their participation.**

Parent/ Guardian Signature: ----------

Investigator's Signature: _____

Appendix H

Result Tables and Graphs

Table H1

Participant Demographics

	Outpatients		Day Treatment Clients	
	n	(%)	n	(%)
Gender				
Males	9	(45.0)	5	(22.7)
Females	11	(55.0)	17	(77.3)
Entry Diagnosis				
Schizophrenia and other Psychotic	1	(5.0)	4	(18.2)
Mood Disorders	8	(40.0)	12	(54.5)
Anxiety Disorders	10	(50.0)	6	(27.3)
Somatoform Disorders	1	(5.0)	0	(0.0)
Using Tobacco				
No	15	(75.0)	16	(72.7)
Yes	5	(25.0)	6	(27.3)
Using Alcohol				
No	15	(75.0)	18	(81.8)
Yes	5	(25.0)	4	(18.2)
Using Illicit Drugs				
No	16	(80.0)	19	(86.4)
Yes	4	(20.0)	3	(13.6)
On Prescribed Medication				
No	5	(25.0)	1	(4.5)
Yes	15	(75.0)	21	(95.5)
Mental Health Problems in other Family Members				
No	3	(15.0)	9	(40.9)
Yes	17	(85.0)	13	(59.1)
Problems with Police				
No	17	(85.0)	17	(77.3)
Yes	3	(15.0)	5	(22.7)
Suspended from School				
No	16	(80.0)	19	(86.4)
Yes	4	(20.0)	3	(13.6)

Table H2

Axis 1 Co-morbidity diagnosis comparison between day treatment clients and outpatients

Axis 1 Primary Diagnosis	Total Number	Axis 1 Co-morbid diagnosis						Total with Co-morbid Diagnosis	
		None	Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence	Substance-Related Disorders	Schizophrenia and Other Psychotic Disorders	Mood Disorders	Anxiety Disorders	N	%
Out Patients									
Schizophrenia and Other Psychotic Disorders	1			1				1	100
Mood Disorders	8	5	1				2	3	37.5
Anxiety Disorders	10	6	1			3		4	40.0
Somatoform Disorders	1						1	1	100
Total	**20**							**9**	**45.0**
Day Treatment Clients									
Schizophrenia and Other Psychotic Disorders	4	2		1			1	2	50.0
Mood Disorders	12	3	1				8	9	75.0
Anxiety Disorders	6	2				4		4	66.7
Somatoform Disorders	0							0	
Total	**22**							**15**	**68.2**

Table H3

Participant Schooling/Employment Attendance

	Pre initial treatment n (%)	Post initial treatment n (%)	3 Months after completing initial treatment n (%)
Outpatients			
No attendance	12 (60.0)	10 (50.0)	2 (10.0)
Part-time attendance[1]	6 (30.0)	6 (30.0)	6 (30.0)
Attending/repeating Day Program	0 (0.0)	0 (0.0)	6 (30.0)
Full-time attendance	2 (10.0)	4 (20.0)	6 (30.0)
Day Treatment Clients			
No attendance	20 (90.9)	2 (9.1)	2 (9.1)
Part-time attendance[1]	2 (9.1)	2 (9.1)	2 (9.1)
Attending/repeating Day Program	0 (0.0)	12 (54.5)	0 (0.0)
Full-time attendance	0 (0.0)	6 (27.3)	18 (81.8)

Note: 1 - Includes clients attending home schooling.

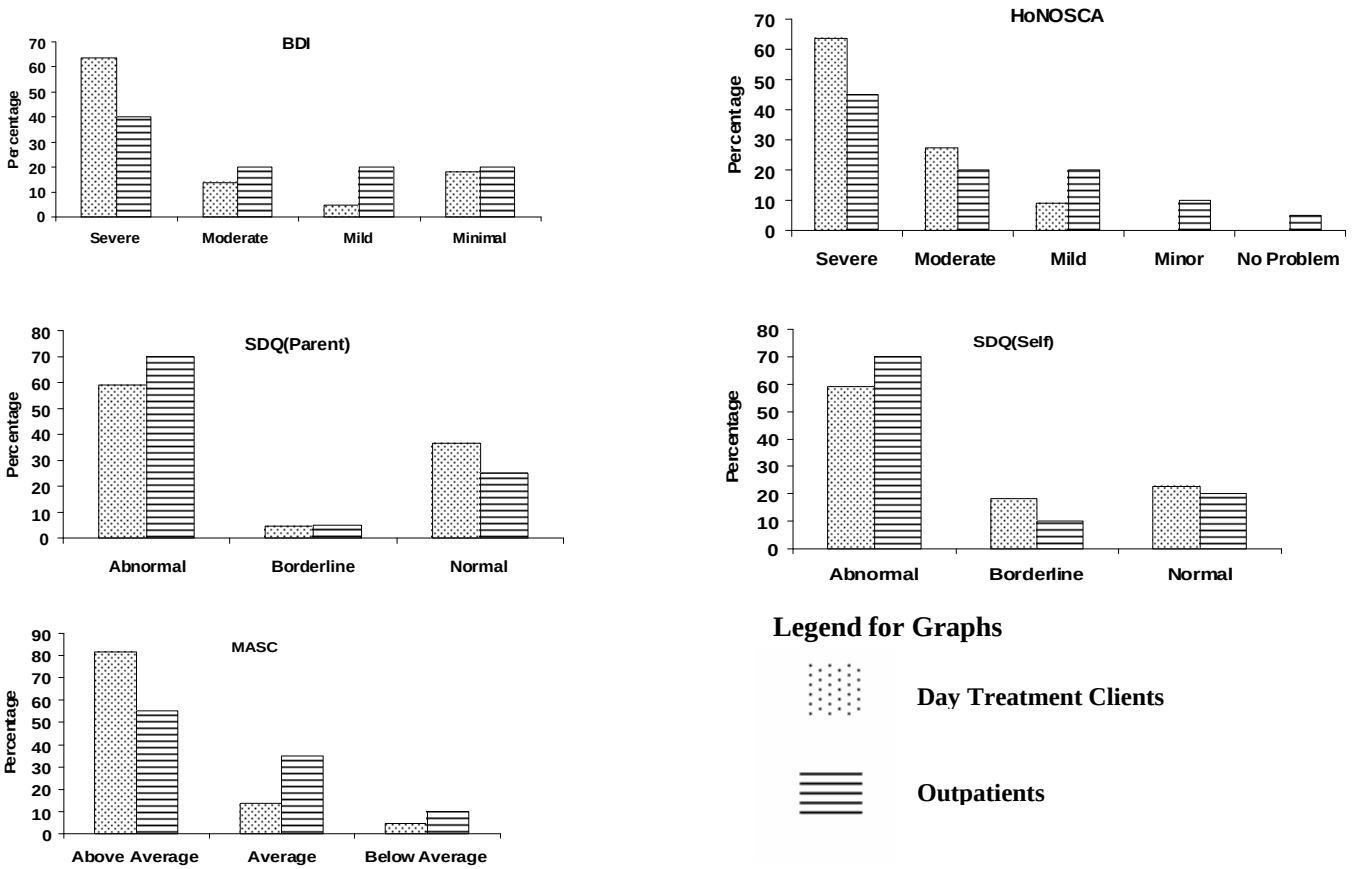

Figure H1. Comparison graphs of Symptom Severity based on pre-test outcomes between day treatment clients and outpatients

Percentage change in instrument score

The percentage change for each subject was calculated from each of the pre and post test outcome scores using the following formula:

(Pre-test Score - Post-test Score) ÷ Pre-test Score

Figure H2 depicts the results of the application of the percentage change formula for each gender within each group as calculated from the outcomes of the individual instrument. The results indicate that overall, day treatment females reported superior percentage improvements to outpatient females. However, the results indicate that overall males in day treatment reported lower percentage change results than males in the outpatient group. With the exception of the staff rated HoNOSCA, the graphs indicated that overall the severity of the symptoms for day treatment males increased following treatment.

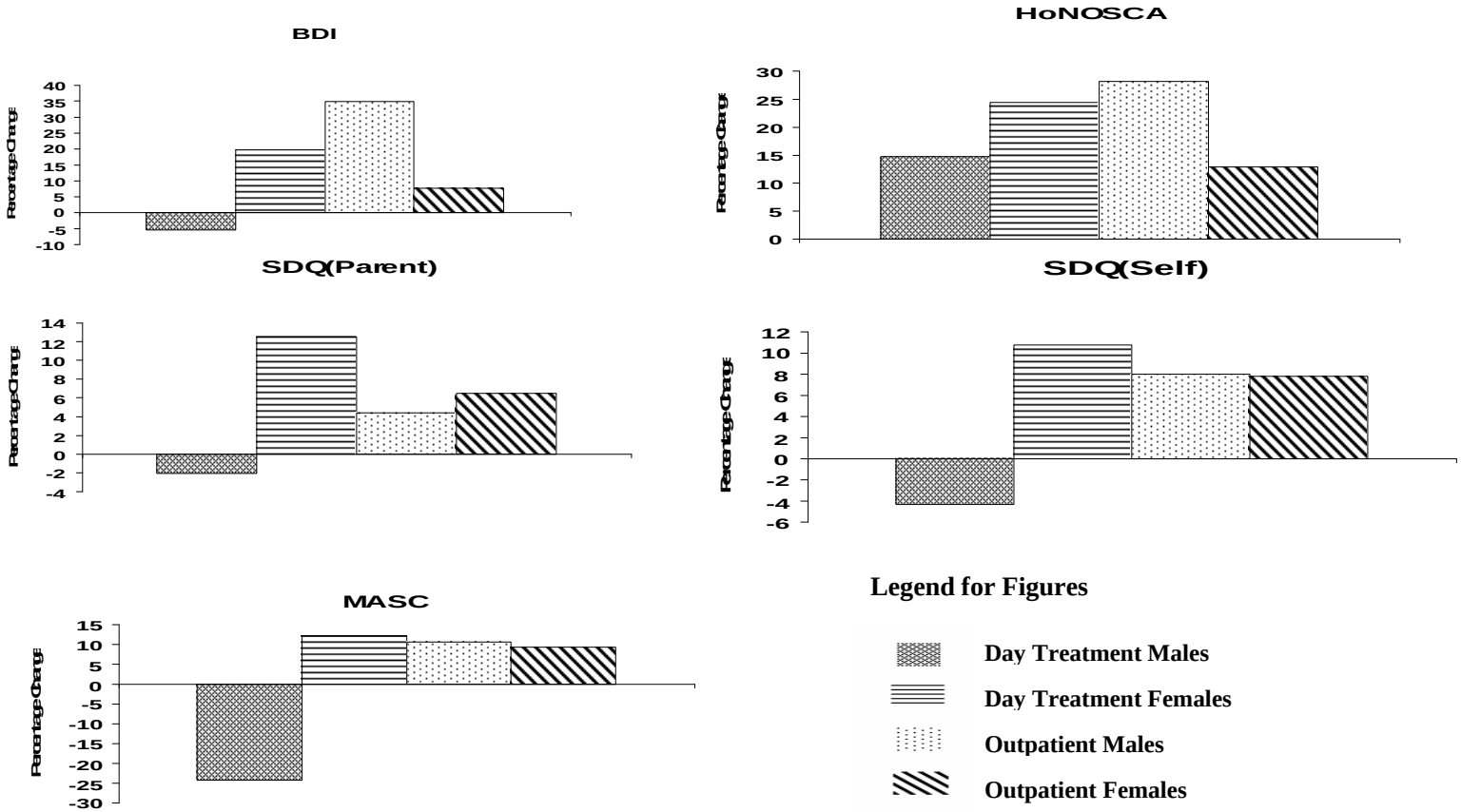

Figure H2. Comparison graphs of Symptom Severity percentage change based on respective pre and post-test outcomes between day treatment clients and Outpatients