

# **AN EVALUATION OF INPATIENT FAMILY TREATMENT IN A CHILD PSYCHIATRIC SETTING**

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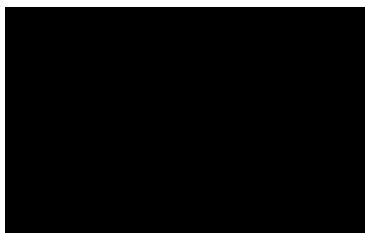
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## STATEMENT OF AUTHORSHIP

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I further declare that this study has adhered to the ethical principles as established by the Victoria University Ethics Committee and the Ethics Committee of the Austin & Repatriation Medical Centre Human Research Ethics Committee.



Donna Volk

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## ABSTRACT

Child psychiatric treatment currently faces challenges, which centre on accountability regarding treatment effectiveness, which are derived from a range of social, economic and political developments. Identifying effective treatment options for work with multi-problem, treatment resistant families, presents as a significant further challenge. Full family inpatient treatment has been utilised as one unique therapeutic option. To date, few systematic empirical studies have been conducted in the child psychiatry inpatient area to evaluate programmes outcomes, and fewer still concerning family inpatient treatment. No studies have comprehensively integrated process and outcome evaluation. The aim of the present study was to evaluate the outcome and processes of a dedicated, short-term, multi-modal, inpatient family treatment programme. The research comprised two complementary stages, integrating quantitative and qualitative research designs. Stage 1 analysed archival data, comprising standardised measures of the referred child and sibling (Achenbach CBCL), parent (GHQ-28) and family functioning (McMaster FAD), administered at admission and discharge. The subject sample involved 29 families consecutively admitted to the programme from 1995 to 1997 (IP mean age 8.82 years, range 4-13 years). Stage 2, conducted 30 months later, adopted a retrospective, qualitative approach, using in-depth individual interviews with 10 former clinicians of the programme, exploring their perceptions regarding the programme's theoretical orientation, practices and outcomes. Stage 1 findings clearly indicated improvements in perceived child, parent and family functioning between the time of admission and the time of discharge. The Stage 2 study found that the programme was experienced as operating within a broad-based theoretical orientation with a systemic foundation, drawing on psychodynamic, cognitive-behavioural, and other theoretical principles. The main strengths of the programme emerged in its overall structure and planning, and the holding frame provided by the supportive therapeutic milieu. Potential programme limitations included certain differing agendas between families and the team. The research generated implications for integration of theory in this field and for specific dimensions of practice in intensive, short-term work with treatment resistant multi-problem families. Implications for outcome and process research methodology are also discussed, with a particular emphasis on exploring mechanisms of therapeutic change

## **CHAPTER 1**

### **TREATMENT IN THE CHILD PSYCHIATRIC SETTING**

In recent decades, the child and adolescent mental health field, together with all other fields of health services delivery, has been increasingly alive both to the increased needs in the community and to economic pressures requiring minimisation of costs. In this context, child and adolescent mental health services around the world have been actively seeking procedures and practices, and theories underlying them, which will deliver to the community more effective outcomes. Part of the push has been increased attention to the conduct of empirically sound, methodological research.

This present study represents the enterprise of a particular child psychiatric service to address the need for systematic investigation of its practice. One aspect of this service's practice has been the innovative development of psychotherapeutic intervention including treatments directed toward family systemic dynamics for children and their families, as observed in inpatient family treatment. The investigation was firmly grounded in an appreciation of the history of the practice of child psychiatry and growing attention to family systems intervention practice and research which seem to be appropriate to these types of interventions.

In this first chapter, treatment in the child psychiatric setting, and its development over time, is reviewed. First, approaches to child psychotherapeutic interventions are explored. An emerging integrationist approach to child psychiatric treatment is outlined. Second, inpatient child psychiatric treatment is reviewed. The historical context of this intervention, the treatment population involved, and the role and function of the therapeutic milieu, incorporating transference and countertransference issues, multidisciplinary team dynamics and the advantages and disadvantages of this approach, are all addressed. Third, within this context, inpatient family treatment is presented. Again the historical context of this intervention, as well as the advantages and disadvantages of this approach are outlined, along with a review of the family programmes noted in the international literature. Team members' experiences and team dynamics in working with troubled families are noted. Finally, issues for establishing an evidence base for treatment in the child psychiatric setting are then raised.



## 1.1 Child psychiatric psychotherapeutic treatment approaches

The child psychiatric setting has developed since its beginnings in the first part of the twentieth century. Within the child psychiatric setting today, which incorporates inpatient, outpatient and day patient or partial hospitalisation treatment modalities, psychotherapy remains a mainstay of psychiatric treatment (McClellan & Werry, 2003). A range of psychotherapeutic treatment approaches are usually available to the child and his or her family, and it has become common practice for therapists to integrate different interventions in response to the needs of parents and their children at different stages in the treatment process (Armbruster & Fallon, 1994; Diamond, Serrano, Dickly, & Sonis, 1996; Kazdin, 2000). This multi-modal approach recognises that child disorders are often linked with parent, family and contextual factors, with parent and child influences noted to be reciprocal, bidirectional, and interdependent (Bell & Harper, 1977; Deater-Deckard, 1998; Lerner, 1991). As such, a multi-modal approach addresses the often multi-faceted presentation of child psychiatry difficulties (Armbruster, Chock, Tanner, & Holmes, 2002). The aim of treatment is to use multiple procedures that appear suited to the complexities of the presenting problems and individual features of the case. The most common of these interventions are outlined below, namely individual child psychotherapy, group work, parent work, and family therapy interventions.

### 1.1.1 Individual child psychotherapy

Individual child psychotherapy incorporates a range of intervention approaches, the most traditional being psychodynamic psychotherapy, with cognitive behavioural treatments being increasingly utilised.

#### 1.1.1.1 Psychodynamic child psychotherapy

Anna Freud (1946) and Klein (1932), independently but often in reference to one another, evolved techniques to enable clinicians to adopt a psychoanalytic therapeutic approach to children. Winnicott (1965; 1971) addressed the importance of the emotional 'holding' environment and the concept of the transitional area between self and object, while Bowlby (1969; 1973; 1980) and Ainsworth, Blehar, Waters and Wall (1978)

addressed issues of attachment and loss in reference to the parent-child relationship, as additional components in psychodynamic child psychotherapy

As a general rule, psychodynamic child psychotherapy treatment involves the use of toys, games, and other devices to engage children in a process of self-exploration with an adult who is friendly but tries, within a trusting relationship, to draw attention to the unconscious determinants of the child's behaviour. The therapist uses the child's fantasy, games, and associations in conjunction with other sources of data from the family and school to construct a hypothetical picture of the child's unconscious mental life and current emotional concerns. In this way, the therapist aims to help the child understand his or her emotional responses, confusions, concerns about the body, the unconscious meaning of presenting symptoms, anxieties about unconscious aggressive or sexual impulses, and worries about his or her relationships with caregivers, siblings and peers (Target & Fonagy, 2001).

One type of psychodynamic therapy for children is play therapy. The theoretical underpinnings of play therapy are derived from child psychotherapy and child development and research literature (Russ, 2001). Play is viewed as a natural form of expression in children, can be used as a vehicle for the development of insight and working through of concerns, and provides the opportunity to practice with a range of ideas, behaviours and interpersonal behaviours and verbal expressions. Child development theory and research highlights the central role that play has in facilitating cognitive and emotional development. Play has been linked to the development of cognitive processes important in both logical and creative problem solving, to general adjustment as the child learns to integrate and modulated their emotions, and is used to practice with and try out various coping strategies for different situations (Russ). In the therapeutic setting, the therapist builds upon these functions of play which occur in normal play situations. Play therapy is facilitated by creating a safe environment, giving permission for play to occur, actively facilitating play, and labelling the thoughts and feelings expressed (Russ). The aim is to enable the child to expand the range of his or her exploratory experience in symbolic play and in this process to gain insight into the links between thoughts and feelings.

### 1.1.1.2 Behaviour and cognitive-behavioural therapy

The focus on behaviour therapy is on providing new learning experiences in treatment as a means of changing behaviour. The psychology of learning provides a conceptual view of how problems may develop and also be altered. Behavioural treatment focuses on practice, training, learning new skills, and developing response repertoires in the situations where the behaviour presents (Kazdin, 2000). The techniques of child and adolescent behaviour therapy can be categorised as attempting to produce either of two kinds of behaviour change. They aim either to strengthen, develop or maintain particular behaviours, using procedures such as positive reinforcement, modelling, cueing, and social skills training, or to reduce or eliminate behaviours, using procedures such as stimulus change, time out and desensitisation (Jacobs, 1998; Vitulano & Tebes, 2002).

In a child psychiatric inpatient unit, behavioural therapy techniques are widely used, and often in combination with other therapeutic frameworks. They are applied on the ward and in the hospital school, as rehearsals for application at home and in the base school setting (Jacobs, 1998). Staff often utilise a verbal or written contract, which specifies the expected behaviour (where and when and how often), as well as what the child can expect if the set target is not met, or if certain unacceptable behaviours occur. The ward milieu setting can be used to provide support in the regular, routine and consistent implementation of such a programme (Jacobs).

In cognitive-behavioural therapies, the focus is on cognitive processes (involving attributions, beliefs, problem-solving skills) as the basis for therapeutic change (Kazdin, 2000). Treatment approaches share a common assumption that the individual can be assisted to redress dysfunctional attitudes and behaviours and to learn more adaptive strategies and skills such as self-control, effective communication and negotiation. This is achieved by reinforcing prosocial and socially sensitive behaviour, challenging irrational beliefs and faulty logic, by self instruction and positive self-statements, and also by involving more traditional behavioural change techniques (Herbert, 2001).

There is a wide range of cognitive-behavioural techniques. A common example in child work is problem-solving skills training (PSST). PSST has been well utilised for externalising disorders in children (Kazdin, 1998). Drawing on externalising difficulties

as an example, PSST is based on the assumption that antisocial behaviour is due (at least in part) to cognitive processes, such as a tendency to attribute hostility to others inappropriately, and poor capacity to understand social situations and solve interpersonal problems (Rubin, Bream, & Rose-Krasnor, 1991, cited in Roth & Fonagy, 1996). The aim of PSST is not to solve a particular problem for the child, but to teach a general strategy that can be implemented for a range of difficulties (Hudson, 2001).

### 1.1.2 Group work

Group work is a further psychotherapeutic strategy that has been increasingly employed in treatment in child psychiatry, and is often used in conjunction with other treatment modalities such as individual therapy and family therapy (Dwivedi, 1998a; Kymissis, 1997). A number of advantages are observed using group work as a mode of treatment. First, in contrast to individual therapy, group work can be undertaken in a range of settings, may initially be perceived by both the parents and the child as a less threatening therapeutic option, and can afford a more economic use of the therapist's time (Reid & Kolvin, 1996). With regard to the specific advantages provided for the patients, effective group work can be particularly helpful to facilitate socialisation, enhance self esteem, and help children see and reflect on the impact of their behaviour on others (Arnold & Estricher, 1985; Keepers, 1987). Group work may also enable the child to rediscover some of his or her own psychological strengths and weaknesses by observing the behaviour of others, and can facilitate the exploration of relationships, different models of social behaviour, and varying perspectives on situations (Reid & Colvin). It can help children to learn to delay gratification, manage feelings, explore abstractions and values, cultivate creativity, and give of oneself to others. Moreover, group work can also help to improve a sense of interdependence as well as autonomy (Dwivedi, 1998b).

While, in general, every child or adolescent could be considered as a candidate for group therapy, clear indications for candidacy include children with separation anxiety, poor self-esteem, and poor social and interpersonal skills, or non-assertive and isolated young people. Individuals for whom group therapy would not be considered a viable option include those who are actively psychotic or suicidal, or who are misusing chemical substances or alcohol. Moreover, violent, aggressive, or impulsive patients need to be carefully evaluated for inclusion in group therapy (Kymissis, 1997).

The two most influential theories on group work are psychodynamic theory and learning or behavioural theory. Most group techniques are derived from one or both of these two theories (Kymissis, 1997; Reid & Kolvin, 1996).

#### 1.1.2.1 Psychodynamic group work

In psychodynamically oriented group work, the therapeutic aim is to enable four or five younger children, or six to nine older children or adolescents, to become a group, and gain a deeper understanding of their own behaviour. With younger children, the focus is on following play principles, while older children and adolescents utilise verbal interactions. In becoming a group, the individuals need to recognise and value the uniqueness of each group member, and come to understand those others as also representing aspects of themselves. The group provides an opportunity to explore and capitalise on interactions between peers, the children, and the therapist(s), as well as present and past interpersonal experiences, and family relationships (Reid & Colvin, 1996).

#### 1.1.2.2 Cognitive and behavioural group work

Child and adolescent group work drawn from cognitive and behavioural principles provides valuable opportunities for group reinforcement of desired behaviours, which for many children is more powerful than individual reinforcement. The group also provides human resources and opportunities for role playing, rehearsing, modelling, multiple assessments and feedback. It can be viewed as a natural laboratory for experimenting with social relationships, brainstorming, discussion and learning (Dwivedi, 1998c).

#### 1.1.3 Parent work

The goal of parent work – to help the child by helping the parent – is derived from the working model that is child centred and family focussed. The integrity of the family is maintained wherever possible (Stroul & Friedman, 1996). Regardless of the child's presenting difficulties, it is usually seen to be helpful for the clinician to have meetings with the parents or other caregivers to work at enhancing their understanding and

sensitivity to their child (Target & Fonagy, 2001). Ideally this work is characterised by both a selective and flexible use of different, clinically indicated treatment modalities. Such modalities can vary in depth, intensity and duration, depending on the internal or external situation of the parent at a particular time (Armbruster et al., 2002).

#### 1.1.3.1 Parent education and cognitive-behavioural parent work

Parent education and cognitive-behavioural parent techniques can be a very useful adjunct to both inpatient and outpatient programmes. Parent education involves the clinician providing concrete suggestions and strategies about the management of child behaviour that are explicit, easily understood, and quickly implemented (Josephson, 2002). Cognitive behavioural techniques such as Parent Management Training (PMT) have been shown to be very successful in working with parents with children with externalising behaviours (Kazdin, 1997; McMahon, 1999). As noted by Patterson and colleagues (Bank, Patterson, & Reid, 1996; Patterson, 1986; Patterson, Dishion, & Bank, 1984), parents of aggressive children often do not adequately monitor and set limits on their children or reinforce prosocial behaviour. This can lead to a coercive family environment on which sibling conflict may emerge, and eventually lead to and perpetuate aggressive and antisocial behaviours by all children in the family (Fagan & Najman, 2003). The PMT intervention utilises social learning principles to develop positive prosocial behaviours and decrease deviant behaviour through positive reinforcement (Armbruster et al., 2002). These techniques can suffice to interrupt behavioural problems, particularly where the problems are mild or the parents are merely inexperienced. Parents benefit from learning how to set limits and foster a child's independence, and from acquiring relevant facts regarding child development (Josephson).

While parent education and cognitive behavioural approaches address presenting difficulties from a very practical perspective, they need not be viewed as in competition with a more psychodynamic understanding of parenting problems and their origins (Morris & Jacobs, 1998). These practical approaches are often indicated if the parents have limited capacity for reflection and their observing ego function is restricted (Armbruster et al., 2002). For some parents, when these practical approaches are only partially effective, or completely ineffective, underlying parental psychopathology or

marital conflict are often seen to impair the parent's capacity to respond to this input Josephson (2002). For other parents, an initial cognitive behavioural approach opens up the possibility of addressing well-defended areas of experience for future individual psychodynamic work (Morris & Jacobs).

#### 1.1.3.2 Psychodynamic parent psychotherapy

In his description of psychodynamic parent psychotherapy, Ferholt (2002) utilised the concept of the parental mental portrait of the child as a framework for a psychodynamic understanding of the enduring patterns of parental thoughts and feelings that characterise every parent-child relationship. Crucial elements in understanding the child in the context of the family in parent work include the individual history of each parent, the marital history, and the family style including the degree of available affection and support, and the amount of conflict and anger and how this is managed in the family (Armbruster et al., 2002). For example, when a parent's family of origin interactional experiences were traumatic or conflictual, they can predispose the parent to initiate problematic parent-child relationships (Davidson, Quinn, & Josephson, 2001).

The challenge of parent work is to facilitate the parents' understanding of their relationship with their child, and to assist them to achieve some resolution of their own conflicts which are manifest in their behaviours and are linked to their interactions with the child (Armbruster & Fallon, 1994). For instance, the therapist may highlight distortions affecting the relationship, such as a mother identifying her son with her husband, and unconsciously expressing the anger she feels for the husband to the son, who is an easier and more available target (Target & Fonagy, 2001). In theory, once the parents' intrapsychic issues and conflicts are identified, worked through, and resolved at some higher level of integration, the child should be less burdened with the parent's emotional legacies (Armbruster et al., 2002).

Parent work may also address aspects of the child's environment or family which seem to impinge on the child's development, and explore ways of freeing the child from avoidable stress. Discussion of the child's symptoms aims to help the parents to develop more awareness of the nature of the child's difficulties and feelings and (often) insight into possible reasons for these to have arisen and become entrenched (Target & Fonagy,

2001). Connections between external events and stresses and symptoms, whether they are somatic, emotional or behavioural, can be highlighted. Such work often helps the parent to think more objectively and productively about the child, and can facilitate finding ways of overcoming obstacles to the child's positive development (Target & Fonagy).

#### 1.1.4 Family therapy interventions

Family therapy interventions have also come to be used extensively in interventions in child psychiatry.

##### 1.1.4.1 Origins of family therapy: A historical perspective

Family therapy emerged in the 1950s in a variety of different countries, services, disciplines and therapeutic traditions (Carr, 2000). Goldenberg and Goldenberg (1996) noted five seemingly independent scientific and clinical developments as setting the stage for the emergence of family therapy. These were (1) the extension of psychoanalytic treatment to a full range of emotional problems, eventually including work with whole families; (2) the introduction of general systems theory, with its emphasis on exploring relationships between parts that make up an interrelated whole; (3) the investigation of the family's role in the development of schizophrenia in one of its members; (4) the evolution of the fields of child guidance and marital counselling; and (5) the increased interest in new clinical techniques such as group therapy. Each of these developments were seen to contribute in an understanding of the interdisciplinary roots of family therapy (Goldenberg & Goldenberg).

As Carr (2000) noted, the central insight that intellectually united the pioneers of the family therapy movement was that human problems are essentially interpersonal, not intrapersonal, and so their resolution requires an approach to intervention which directly addresses relationships between people. The pioneers of family therapy agreed that therapy targeting family relationships should be grounded in theoretical frameworks which privileged interpersonal factors over personal characteristics, and which took account of the family as a social organisation (Carr).



#### 1.1.4.2 Family systems theory as applied in child psychiatry

Understanding of the relationship of family processes to the development and maintenance of childhood behavioural and emotional problems has developed over time within the family therapy movement (Dadds, 1995). While models of family therapy vary in their theoretical position and treatment approach, certain basic concepts set family therapy apart from individual child psychotherapy. In family therapy, the family is viewed as a system, with family members as interdependent parts. Psychological dysfunction is viewed as a product of transactions in the system, and symptoms as reflecting patterns of interaction (Cordell & Allen, 1997; Herbert, 2001). Thus the child's behaviour is consequently functionally related to the context the family provides for child development (Dadds). The unit of treatment is viewed as relationships within the family rather than the child within the family (Becvar & Becvar, 1988).

A number of advantages and disadvantages have been noted in the usage of family therapy with children. The main disadvantage is focussed on the perceived difficulty in actively incorporating children into the work. Including children in family sessions has been seen to add to the complexity of treatment and necessitates that the therapist be comfortable with nonverbal, play-oriented modes of communication as well as interpretation of meaning on a metaphoric level (Cordell & Allen, 1997). Korner (1988) has observed that children's tendencies to provoke unconscious emotional responses in adults, as well as to behave disruptively in sessions, can lead to their exclusion from sessions.

In contrast, other clinicians maintain that the inclusion of children in family sessions is highly productive (Keith & Whitaker, 1981; Zilbach, 1986). Some family therapists view the child as a barometer of family or marital tensions, or they may work to improve communication between the parents, which may or may not ameliorate the child's symptoms (Cordell & Allen, 1997). Children's direct style of communication can alert the therapist to vital information, and children can become allies in promoting change. Zilbach, Berger and Gass (1972) noted that parents can be confronted with ways in which the problems affect all family members, and later difficulties with siblings can thus be prevented. Moreover, Korner (1988) attests that

children have an ethical right to benefit from interventions aimed at remedying family difficulties.

#### 1.1.4.3 Family therapy approaches

Carr (2000) identified different schools of family therapy accorded differing levels of prominence to the role of family relationships in problem formation, the maintenance of problems, and problem resolution. Some have focused predominately on problem-maintaining interaction patterns and methods of disrupting these rigid repetitive cycles of interaction. These include the strategic, structural, cognitive behavioural and functional family therapy schools. Others have addressed family members' belief systems, scripts and narratives, which underpin the problem-maintaining interaction patterns. These are noted in the constructivist, the original Milan systemic school, social constructionist, solution-focused, and narrative family therapy disciplines. A third focus of therapeutic concern within the field of family therapy, according to Carr has been the broader historical and social context, out of which problem-related belief systems, scripts and narratives have emerged. Examples of this school include the transgenerational, psychoanalytic, attachment-based, experiential, multisystemic, and psychoeducational family therapy orientations.

As Combrinck-Graham (1990) explained, family therapy approaches work primarily with whole families, embracing the children's contributions to the families' experience of wholeness as important elements of the therapy. These approaches, the most prominent of which are systemic, structural, strategic and psychodynamic conceptualise children's difficulties as functional within the family system. Problem resolution is directed through changing the family's emotional atmosphere (as in psychodynamic object relations therapy), family organisation and structure (as in structural family therapy), or in increasing the avenues for managing relationships (as in strategic family therapy). These theories are utilised in child psychiatric settings, and most actively in inpatient family admission programmes.

#### 1.1.4.3.1 Systemic family therapy

The systemic family therapy model (Haley & Hoffman, 1967; Hoffman, 1981; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978) views the family as a system, akin to a cybernetic system, in which each family member's behaviour is dependent on each other family member, and views each relationship as reflexive and having an equal power of influence in terms of the whole system. Thus, the family is seen as a whole group and change is aimed at this systemic level by targeting the information in the system for change (Dadds, 1995).

The Milan systemic tradition points to family myths and the system of meaning and their relation to the individual perception of reality (Boscolo, Cecchin, Hoffman, & Penn, 1987). For instance, the use of the 'family premise' concept and techniques such as 'circular questioning' for systemic understanding of problems and symptoms, aid in the facilitation of alternative family systemic meanings of the experienced problems (Boscolo et al., p.34)

Larner (2000) observed that through the 1990s, psychoanalytic understanding has more consistently been introduced into systemic family therapy, particularly in Australia and Britain. Byng-Hall (1973; 1979) heralded the importance of unconscious family mythology in systems therapy, and his more recent work has linked the psychoanalytic concept of secure attachments in an empirical research model to both systemic and story metaphors in family therapy (Byng-Hall, 1995a; 1995b; 1998). Myths, scripts, legends and family stories all provide 'a way of thinking about repeating patterns of family interaction' (Byng-Hall, 1995a, p.136). The family narrative articulates what is repeated in the family experience as a system or pattern. This is a stability of repetition which none the less contains the possibility of change and difference as the telling of a more hopeful, integrated story (Larner).

Flaskas (1996; 1997) has also contributed significantly to a psychoanalytic understanding of systemic therapy by mapping awareness of the emotional quality of the therapeutic engagement on to a systemic understanding of relational processes and repetitive patterns of interaction in family therapy. Luepnitz (1988; 1997) has been another important figure who has introduced psychoanalytic thinking into systemic

family therapy, utilising object relations theory as part of a feminist critique of family therapy, to explore gender, power and subjectivity issues in the family.

#### 1.1.4.3.2 Structural family therapy

The major tenet of the structural family therapy school, derived from the work of Minuchin and colleagues (Minuchin, 1974; Minuchin & Fishman, 1981), is that behavioural and emotional problems result from structural characteristics of the family system, and thus changes to an individual's symptoms can be effected by changing the family structures that support these problems. The importance of interconnectedness between the family organisation and individual well-being is emphasised (Minuchin).

In structural family therapy, the family organisation, and most importantly roles and boundaries, are seen as central to the experience of individuals in the family. The boundaries are viewed as the conceptual markers of differentiation between individuals and subsystems representing the family's management of both roles and proximity. Dysfunctional structures point to the covert rules governing family transactions that have become inoperative or in need of renegotiation (Combrinck-Graham, 1990; Goldenberg & Goldenberg, 1996)

Within this framework, as Combrinck-Graham (1990) commented, some forms of childhood difficulty are seen as associated with enmeshment, with diffuse boundaries characterised by lack of role clarity and overinvolvement, while other difficulties are associated with disengagement, where boundaries separate individuals in the family too rigidly. In contrast, in healthy families, the parent-child boundary marks the differentiation of parent and child functions, preserving functional family hierarchy, and separating the marital/parental subsystem from the child system. Structural family therapists assist families to achieve a more functional organisation.

Structural family therapy is geared to present-day transactions and gives higher priority to action than to insight or understanding. All behaviour, including symptoms in the identified patient, is viewed within the context of family structure (Combrinck-Graham, 1990). Family mapping provides a simple observational technique for charting the family's transactional patterns. Structural interventions are active,

carefully calculated, even manipulative efforts to alter rigid, outmoded, or unworkable structures.

Enactments (having the family demonstrate typical conflict situations in the therapy session) and reframing (the therapist's relabeling or redefining a problem as a function of the family's structure) are therapeutic techniques frequently used to facilitate a transformation of the family structure. The ultimate goal is to restructure the family's transactional rules by developing more appropriate boundaries between subsystems and strengthening the family's hierarchical order (Goldenberg & Goldenberg, 1996). A further concept introduced by Minuchin and Fishman (1981) was that of 'joining': 'The family moves only if the therapist has been able to enter the system in ways that are sytonic with it' (p.125). By joining the family and accommodating to its style, structuralists gain an understanding of the member's way of dealing with problems and with each other, ultimately helping them to change dysfunctional sets and rearrange or realign the family organisation (Goldenberg & Goldenberg).

#### 1.1.4.3.3 Strategic family therapy

Strategic family therapy is not seen to be associated with particular leading founders (Luepnitz, 1988). However, Madanes (1984) provided a useful overview of this approach which highlights the contributions from children to the solutions reached by the family. A child's symptoms are understood as metaphors about the family's situation. Through enactments in which family members pretend to be in the relationships metaphorically represented by the symptoms, the family's repertoire of interactions is expanded, increasing flexibility and adaptation (Combinck-Graham, 1990).

Strategies such as paradoxical interventions and circular questioning may be used in strategic family therapy. In a paradoxical intervention, the clinician makes a demand contrary to expectation, such as a request to exaggerate a symptomatic family pattern. Prescribing the covert function of these family interactions can render them explicit and as such be brought under conscious control where antecedents to the behaviour can then be explored. In circular questioning, the clinician does not directly confront the

symptomatic individual but rather explores patterns of family communication. These techniques may not be useful, of course, for families whose members are cognitively or emotionally unable to process subtlety, or with families with young children (Josephson, 2002).

#### 1.1.4.3.4 Psychodynamic family therapy

The psychodynamic family movement, pioneered by Ackerman in the 1930s, integrates both psychoanalytic and family systems theory (Dadds, 1995). Unconscious factors and developmental history are held to be important, as in traditional psychoanalytic theory, and these unconscious processes are thought to become manifest in terms of current family processes. Thus the therapist aims to explore each family member's unconscious conflicts at the individual level and in terms of how they are expressed and maintained by current family relationships.

The psychodynamic position today is largely based on object relations theory, with the emphasis on the individual's primary developmental need for attachment to a caring person, and the analysis of internalised psychic representations (objects) that continue to seek satisfaction in adult relationships. Framo (1976; 1981; 1992), Skynner (1981) and Scharff and Scharff (1987) have provided examples of object relations therapeutic approaches to family therapy.

Framo (1976; 1981; 1992) held that insoluble intrapsychic conflict, derived from the family of origin, is perpetuated in the form of projections into current intimates such as spouse and children. He focussed on working through and ultimately removing these introjects. Framo saw couples alone, in a couple's group, and finally conducted separate sessions with each partner and members of his or her family of origin.

Skynner (1981) contended that adults with relationship difficulties have developed unrealistic expectations of others in the form of projective systems related to childhood deficiencies. Marital partners, often with incompatible projective systems, attempt to create in the marriage a situation where the missing experience can be supplied, the deficiency remediated by the other partner. The couple may transmit these onto a child, who becomes symptomatic. Therapeutically, Skynner attempted to facilitate

differentiation between marital partners, so that each could become more separate and independent.

Scharff and Scharff (1987) emphasised how the provision of a therapeutic holding environment allowing for transference and countertransference interpretation, families can be assisted to address the past to enable them to function as effective containers of the complex emotions of experienced by their family members. This process assists the family to confront and work through emotional entanglements and projective identifications, and to become skilled in managing developmental stress while supporting one another's need for attachments, individuation, and personal growth.

#### 1.1.4.4 Further directions in family therapy

More recent directions in family therapy have included the postmodern constructivist approach and the integration of multiple family therapy perspectives.

##### 1.1.4.4.1 Postmodern constructivist

Goldenberg and Goldenberg (1996) described the postmodern constructivist approach as focusing on the meaning or shared set of premises a family holds regarding a problem. Advocates of this position have argued that no single objective reality exists. Rather, multiple socially constructive views of the same observation coexist, according to the personal experiences of the observers. Reality exists only in the context of each person's set of constructs for thinking about it. The postmodern therapist is interested in engaging families in conversations in which language and the meaning given to events take precedence over behavioural consequences or family interactive patterns. Examples of this viewpoint have included solution-focused brief therapy (deShazer, 1985; 1988; 1991), solution-oriented therapy (O'Hanlon and Weiner-Davis, 1989), the collaborative language systems approach (Anderson & Goolishian, 1988; 1990), narrative therapy (White & Epston, 1990), and the reflecting team approach (Anderson, 1991; 1993).

#### 1.1.4.4.2 An integrated approach to family therapy

As noted by Josephson (2002), a contemporary approach to family therapy in the treatment of child psychiatric disorders focuses on integration of systemic, psychodynamic/developmental, and behavioural perspectives. This integrated approach addresses the relationship between family processes and intrapsychic development, emphasising both the interdependence and the unique life experience and individual development of each family member. The emphasis on life experience draws together the concepts of developmental and psychodynamic psychiatry with some of the current notions of narrative in family therapy. For instance, explained Josephson, when a parent's developmental experiences have been negative, such as through sexual abuse, parental harshness or parental indulgence, they can predispose that parent to initiating pathologic family interaction. These developmental experiences in part can predict the manner in which the parent negotiates the transitions of the family life cycle in the next generation. The family's passage through the life cycle and the associated interactions contribute to the definition of the inner world of the developing child.

#### 1.1.5 Broad based or integrationist approach to child psychiatry treatment

The integrationist perspective found in some recent family therapy approaches has also been applied more widely in the conceptualisation of child psychiatry interventions. As already highlighted, presenting difficulties in child psychiatry are often multi-faceted and therefore require a broader range of interventions than any one treatment modality can provide. Typically, the discussion regarding an integrationist approach has centred on the use of individual and family therapy approaches, and has drawn upon the gamut of theoretical and practice schemas that have emerged in child psychiatry from its beginnings. Malone (1983) mooted this approach over two decades ago, stating that 'the issue is how to combine family, subsystem, and individual interviewing in order to explore effectively the interplay between levels within the family system and to determine whether the family, subsystem, and individual treatment are indicated separately or in combination, at one time or in stages over time' (p.241).



Sugarman (1986) analysed the interface of individual and family therapy in respect of work in the adult sphere. He presented therapy models that 'simultaneously focus on more than one level or a rapid oscillating movement between two levels' (p.2). In the integrated approach, aspects of both individual and family viewpoints are employed to 'form a patchwork or mosaic of individual and family components'. Such an approach can afford greater flexibility and effectiveness of treatment. The therapist can combine the best of both components so that the main focus is not on individual or family work but on resolution of the presenting difficulties.

Kahn (1986) provided a synthesis of individual and family work in which there was a simultaneous focus on each individual's inner processes, and also on the larger processes of the family group. In this model, the therapist may see a particular individual for short periods of individual work and have parallel sessions with other family members as well. To assist in coordinating the process, a co-therapist's involvement is often beneficial. The therapist can engage in negotiations with the family early in the assessment process about the types of sessions planned, but also flag the possibility of changing formats as therapy proceeds.

Racusin and Kaslow (1994), in reference to combining individual child and family therapies, asserted that the advantage of this perspective is that it offers an understanding of human complexity permitting treatment flexibility, specificity, and adaptability to diverse patient populations. Moreover, an integrationist perspective can enhance the efficacy of each modality, can be tailored to match the therapist's clinical style, and offers advantages in training, encouraging the developing therapist to grapple with complex clinical matters (Lebow, 1987; Sugarman, 1986).

However disadvantages of combining treatment modalities have also been observed. First, the potentially contradictory epistemological foundations of the therapies may confuse both the therapist and the family (Racusin & Kaslow, 1994; Sugarman, 1986). Secondly, the use of extra interventions may dilute commitment to each modality and/or lead to a failure to appreciate the unique contributions of each modality, resulting in poor empiricism and unnecessary expenditure of resources. Moreover, difficulties in monitoring treatments, due to the complexities associated with

formulation and implementation of effective treatment plans, may also be experienced (Racusin & Kaslow).

In reality, individual child psychotherapy has often been offered in the context of a broader treatment programme that may include guidance for parents, family therapy, group therapy, and consultation with the child's school. The therapist may modify the child's behaviour by intervening within this system (Cordell & Allen, 1997).

More recently, Kazdin (2000) suggested that an integrationist or 'broad-based' treatment package, drawing together a range of treatments that have been empirically validated, may be indicated for clinical problems that are multiply determined, protracted and resistant to other forms of treatment. Individual child psychiatry inpatient and child psychiatry full family inpatient programmes have typically adopted a multi-modal approach to treatment. Patients generally receive multiple treatments including medication, individual psychotherapy, group treatment and recreational therapy, as well as a ward-based milieu therapy. Kazdin has criticised such approaches as 'shotgun' interventions in the absence of clarity of theoretical orientation and linking the same with planned evaluation and evidence of treatment effectiveness.

In contrast, Kazdin (2000) proposed, as an example of a broad-based treatment approach, Henggeler and Borduin's (1990) multisystemic therapy (MST), developed for working with adolescents with severe delinquency and behaviour problems (Henggeler, Rowland, Halliday-Boykins, Sheidow, Ward, Randall, Pickerel, Cunningham & Edwards, 2003; Henggeler, Rowland, Randall, Ward, Pickerel, Cunningham, Miller, Edwards, Zealberg, Hand & Santos, 1999). MST is an integrative family-systems approach to treatment in which the conceptual view focuses on multiple systems and their impact on the individual. The child is viewed as embedded in multiple systems – for example family (immediate and extended), peer, school and neighbourhood. Presenting issues from within these systems serve as a basis for selecting multiple and often quite different treatment procedures (Henggeler & Borduin). Thus MST can be viewed, according to Kazdin (1998) as a package of interventions that draws on distinct techniques of other approaches, such as PSST, PMT and marital therapy. These techniques are then utilised when working

with the child and their family. The focus of treatment is on inter-related systems and how they affect each other. Similarly, Sourander and Piha (2000) articulated a treatment model systemically linking child psychiatric inpatient treatment with the professional outpatient network. The child, the family, and the ward community together are seen as an extended therapeutic system. The ward subsystem interacts with both the family system and the professional network.

Finally, Fonagy, Target, Cottrell, Phillips, and Kurtz (2002) recently described ‘an emergent pan-theoretical model in child and adolescent health intervention, which draws its inspiration from a combination of biological, systems, cognitive-behavioural, and psychodynamic perspectives’ (p.394). They pointed out that this model has been inferred from attitudes, rather than explicitly declared, guiding the objectives of intervention strategies rather than the procedures of interventions themselves.

## 1.2 Inpatient individual child psychiatric treatment

Psychiatric inpatient treatment has developed as an important part of the system of psychosocial care for children that encompasses outpatient services, partial hospitalisation or day programmes, and inpatient services. Individual child psychiatric admission has been the most traditional form of inpatient management (Hildebrand, Jenkins, Carter & Lask, 1981).

### 1.2.1 Historical and current context: Treatment approaches and philosophies

Historically, the theory behind individual child admission arose from the influence of psychoanalysis, and the concepts of the milieu and milieu therapy (Epstein, 2004). In the early days of treatment, psychological development and conflict were emphasised over interpersonal and social factors. Children were treated in isolation, with families then being perceived as obstacles to treatment (Henao, 1985). Residential settings, such as those established by Bettelheim (1949; 1960; 1967) and Redl and Wineman (1951; 1952), were set up as therapeutic milieus based largely along psychoanalytic lines.

However, in the latter half of the twentieth century, significant changes occurred in child inpatient treatment. First, there were notable developments in the fields of child psychotherapy, child psychopharmacology, and family therapy. These developments led to inpatient treatment to incorporate perspectives other than the classic psychoanalytic perspective, and to be viewed as a part of continuum of care, ranging from outpatient, community-based to inpatient hospital treatment settings (Epstein, 2004). Second, inpatient treatment was reformulated as a tapestry of many therapies (for example individual, group and family therapy, psychopharmacology, intensive case management, special education services, and therapeutic recreational activities), rather than an exclusive therapeutic milieu (Fahlberg, 1990). Third, philosophies of inpatient treatment moved from broad goals and an expectation of slow change, to more focussed goal directed therapies such as cognitive behavioural and behavioural management techniques, within a more family-centred practice (Green & Jacobs, 1998a).

Moreover, as Green and Jacobs observed and as is discussed in Section 1.3.9 below in further detail, a number of challenges (from social, economic and political developments in many countries, and from within and between professional groups) have further altered the face of child psychiatric inpatient treatment, and led to increased accountability in practice and significantly shortened average length of inpatient stay. This in turn has placed heavier reliance on families and other support systems (Cafferty & Leichtman, 2001) and dictated a greater emphasis on community-oriented care (Jensen & Whittaker, 1989).

### 1.2.2 Rationale and indications for child inpatient treatment

Nevertheless, despite these social, economic and political pressures, as Leventhal and Zimmerman (2004) observed, the profession of child psychiatry has a clinical and ethical obligation to provide a full continuum of services to meet the needs of all children and their families. Inpatient treatment is can be viewed as a meaningful and effective part of this continuum, playing a critical role in the spectrum of available treatments, serving a number of different constituencies. First, inpatient units are a resource for some of the most difficult and complex presenting problems in child psychiatry practice (Green & Jacobs, 1998a). Those children who have proven to be

treatment resistant as outpatients, may be more appropriately treated in an inpatient setting (Crouch, 1998). Secondly, social services can see the inpatient unit as a resource for children for whom care issues and psychological morbidity often co-vary. Thirdly, paediatricians often seek out the inpatient unit for help with children experiencing psychosomatic and conversion difficulties (Green & Jacobs). Fourthly, the courts often view the inpatient unit as a useful place for structured and intensive assessment for medico-legal purposes, particularly for planning future care placement (Green & Jacobs; Sourander, Helenius, & Piha, 1995). Overall, then, brief psychiatric hospitalisation can permit focussed treatment and allows time to evaluate the child, determine family strengths and resources and develop longer term treatment plans (Sourander et al.).

### 1.2.3 The child inpatient unit population

In the context of the child psychiatry inpatient unit catering for a number of different constituencies, the patient population has been found to be notably heterogenous (Green & Jacobs, 1998a). Drawing on Achenbach's (1991a) broad internalising and externalising categorisation and the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV, American Psychiatric Association, 1994) listing of 'disorders usually first diagnosed in infancy, childhood or adolescence', the main diagnoses for a child inpatient population to typically include both externalising disorders (attention deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder), and internalising disorders (depression, childhood anxiety disorder, separation anxiety disorder, reactive attachment disorder).

Other conditions in an inpatient population may include pervasive development disorders, elimination disorders, learning disorders, motor skills disorders, and communication disorders. In addition, within a systemic frame of reference, relational problems (parent-child relational problem, sibling relational problem) may also be included as a primary Axis I diagnosis, or as an Axis IV secondary diagnosis to an Axis I and/or Axis II diagnosis (American Psychiatric Association, 1994). Of note, comorbidity of disorders has been found to be extremely common in child psychiatric settings (Kazdin, 1995). This issue is further discussed below, in Section 2.1.1.3 of Chapter 2.

#### 1.2.4 Multidisciplinary inpatient team structure and functioning

Inpatient treatment has been described as a dynamic group activity, in which team organisation has to adapt. Green and Jacobs (1998b) outlined several key issues which aid in the functioning within inpatient team dynamics. First is clarity of the whole team regarding the primary task of the unit and, within that, strategic tasks that need to be accomplished at different phases of the admission. Secondly, it is important that roles are well differentiated with respect to these tasks and operationalised in a manner that is clear how each role task relates to the whole enterprise. Thirdly, protocols are viewed as valuable to define role tasks and their integration in a common purpose. Fourthly, boundary management is seen as essential. Considerable care must be taken regarding who manages the main boundary events around the inpatient process – that is admission, discharge, treatment choice, negotiation and external management. Finally, a sense of humour in working through of role conflicts, and a feeling ultimately of great satisfaction in the overall pursuit of difficult tasks. Green and Jacobs considered these as both markers and rewards of healthy team functioning in a complex environment. Each of these key issues (along with clinical supervision and staff sensitivity groups which will be reviewed below in Section 1.2.7) can assist in inpatient team functioning.

#### 1.2.5 The therapeutic milieu, boundaries, containment and the ‘potential space’

The therapeutic milieu of a child psychiatric unit can be viewed as the mainstay or central nexus of the programme. According to Gunderson (1978, cited in Crouch, 1998), the milieu is created and maintained by a continually evolving dynamic between staff and patients. He identified five key therapeutic elements as underpinning the milieu. First, the maintenance of a safe and containing environment keeps the child out of physical danger and promotes a sense of self-control. Secondly, a highly structured programme prevents over-stimulation or isolation of the individual child. Thirdly, physical and emotional support which makes the child feel secure and enhances self esteem. Fourthly, the collective involvement of the child, family and staff in the unit regimen facilitates an understanding of the child’s difficulties. Fifthly, continuous evaluation of therapeutic interventions ensures that individual needs are met. The overall aim of the inpatient milieu is to provide a structured and

consistent environment designed to allow the child to establish a sense of security, to promote interactions leading to the child developing satisfying interpersonal relationships, and to provide meaningful activities (Sourander et al.,1995).

Within a therapeutic milieu, boundaries are seen to be crucial. In general, boundaries ensure that the integrity of a system as a whole is protected and that different parts of the system have a functional autonomy (Sourander & Piha, 1996). Within a child psychiatric inpatient setting, such boundaries facilitate a holding environment in which the team contain the extreme feelings and behaviours of the children who test the limits of these therapeutic boundaries. Schneider and Cohen (1998) identified the importance of the team establishing and maintaining these clear and understandable external boundaries and limits, so that the child's internal boundaries and limits can resonate with the external ones.

In this way the therapeutic milieu may be viewed in Winnicott's terms as a 'transitional object' (Winnicott, 1971, p.2) between regression and health (Schneider & Cohen, 1998). However, in order for emotional growth through meaningful communication to occur a 'potential space' (Winnicott, 1971, p.107) is necessary. The 'potential space' is an important concept that allows for the emotionally disturbed child to rebuild ego strengths and develop appropriate defenses to be able to grow in a healthier manner (Schneider & Cohen). The therapeutic milieu can provide this 'potential space', as it offers continuity and establishes belonging, both crucial concepts in relation to human development, according to Schneider and Cohen.

#### 1.2.6 Transference and countertransference within inpatient clinical practice

Within the therapeutic work of a child inpatient unit, issues of transference and countertransference can be activated quite dramatically. Transference reactions are described as highly irrational, primitive and inappropriate feelings and responses. Clinicians are often experienced as if they were the parents, siblings or other important figures of the patient's past and present lives (Bandler, 1987). Clinicians need to be highly aware of their own feelings aroused by this process, to prevent destructive re-enactment of a process that may be a maintaining factor for the patient's problem. The patient's behaviour on the unit may also be compared and

contrasted with behaviour at home, and similarities and differences used in family work (Hildebrand et al., 1981).

Clinician's responses to the patients' transferences, as well as to other aspects of the patients' personalities, can be thought of as countertransference (Bandler, 1987). The figures (or objects) in the child's internal world and their relationships together are projected onto the therapist, who receives them and provides an opportunity for them to be re-experienced and evaluated in a new relationship (Magagna, 1998). Under pressure from the patients, particularly pressure that is not conscious, staff can find themselves acting in ways unusual for them, forgetting their roles and feeling critical of colleagues whose work they respect (Bandler).

As Magagna (1998) explained, once it has become evident that the patient is experiencing a particular anxiety, its true nature may only become fully apparent by careful observation of not only what is going on between the therapist and the patient, but also of what is going on inside the therapist, what is being transferred by the patient to the therapist, and what exactly this feels like. Through the therapist's ability to discriminate between the different emotions evoked in himself or herself, a clearer picture of both the internal world of the patient and the patient's pattern of interactional behaviour emerges.

Hinshelwood (1987) noted that in the middle phase of therapy, as the various emotional links with the child and the family deepen and intensify, the multidisciplinary team group dynamics surrounding the child's treatment become suffused with the inner emotional dramas of both the family and the treatment team. Magagna (1998), in her own multidisciplinary team experience, recognised that in this middle phase of therapy, there is often competition and conflict between the team members, which re-enacts difficulties within the family, and between the team and the family. This is often dealt with by projecting negative feelings back onto the parents and child. If the team does not sort out the underlying conflicts that are generated between and within team members, the child's therapeutic progress is impeded. It is therefore important, she stated, that both the parents work together in making decisions, and similarly the team members need to work co-operatively together with each other and with the parents.



### 1.2.7 The role of clinical supervision and staff sensitivity groups in inpatient practice

Winship (1995) remarked, in the experience of adult psychiatry, that through the process of group clinical supervision some semblance of understanding can be brought to patient-staff dynamics experienced in an inpatient setting. In application to child psychiatry, as Bandler (1987) observed, when working with extremely troubled families, it is important to ensure the possibility of working together as a team, that there is thinking about and understanding of transference and countertransference issues. Such understanding can lead not only to a lessening of staff strain, but also a greater understanding of the patients and how to work with them.

In disentangling patient-staff dynamics, the aggregate experience of the team as utilised in group clinical supervision can be beneficial (Winship, 1995). The role of the facilitator in a supervision group involves making full use of the resources and creativity of the group (Pedder, 1986), and creating an environment that enables staff to feel more capable of thinking on their feet in their clinical practice (Winship). The facilitator helps team members to think in a collaborative manner and to look beyond the manifest content of the presenting material. Difficult emotions that remain unconscious may block clear thinking. The sharing of experiences enables staff to feel that they are not alone with regard to their feelings and the distress they may encounter in their work. Group supervision can provide a space in which team members can begin to bring into consciousness those emotions. In this way the resources of the group facilitates the achievement of a sense of containment (Winship).

Staff conflict can be understood as clinically relevant in terms of the supervision process that helps staff to identify what belongs to them and what belongs to the patient. Of note, however, not all staff conflict can be, or should be linked to the experience of working with the patient. Staff, in their own right, have their own interpersonal conflicts to work through. A staff sensitivity group, is the forum to address interpersonal material of the staff (Winship, 1995).

As Winship (1995) observed, in settings that have both clinical supervision and staff sensitivity group, there is likely to be a cross-over of experience. Staff sensitivity groups should offer a supervisory learning experience, and a group supervision process should foster an atmosphere of sensitivity to the needs and feelings of their colleagues. However, in order to ensure that the boundaries of these two approaches are not blurred unnecessarily, it is important that the group supervisor has experience and training in facilitating staff sensitivity groups and clinical group supervision.

#### 1.2.8 Criticisms of child inpatient treatment

Historically, most of the theoretical objections to individual child inpatient treatment have been based on a more comprehensive understanding of child development and psychology, and the shift from an exclusive focus on the intrapsychic to wider systems thinking (Baker, 1988). Drawing on this systemic perspective, several areas of concern related to individual child psychiatric admission have been identified. First, the family may use hospitalisation as an attempt to exclude one member from its midst as an effort to regain equilibrium. The child, consequently, may feel rejected, or a 'mad' or 'bad' person (Brendler, 1987; Brown, 1991; Nakhla, Folkart, & Webster, 1969). Conversely, the family may resist change because of its continuing need for its disturbed member, who plays an important balancing role in the family dynamics (Brown). From a different point of view, an individual child admission may convey the underlying message that the child and the parents are the problem, and that the treatment facility has the answers. Such a message serves to disempower the family (Brendler; Brown; Nakhla et al.). Again, if the child responds to treatment, the parents can then feel inadequate or incompetent, and the child may feel caught between the parents and the treatment setting (Brown).

However, as Green and Jacobs (1998a) reported, today most inpatient child psychiatry units have moved towards a family-centred approach in their practice. Methods have been devised to keep a family focus while admitting the child and looking toward family restoration. For example, Sourander and Piha (1996) described, in their work of a short-term family-oriented child psychiatric treatment programme in Turku, Finland, how the interaction between the family and the ward was viewed as the basic structural element of the child psychiatric inpatient treatment.

Criticism has also been voiced regarding what has been perceived as a lack of programme planning linked to evidence of treatment outcome in child inpatient programmes. As discussed above, Kazdin (2000), in his review of psychotherapy for children, noted that inpatient programmes often run a 'shotgun' approach to interventions, rather than the broad-based treatment derived from empirical evaluation. As a matter of course, children in inpatient programmes may receive multiple treatments, including medication for their main symptoms, a form of psychotherapy, group treatment (such as social skills) and recreational therapy (for example art or music), in addition to a ward-based therapeutic programme. As Kazdin pointed out, due to the lack of evaluation it is unclear whether any of these treatments add incrementally to treatment outcome.

### 1.3 Inpatient family child psychiatric treatment

#### 1.3.1 Historical context of inpatient family intervention

The early experience of family inpatient treatment was in the context of admission to adult psychiatric facilities, specifically psychiatric hospitals (McLoughlin, 1996). Traditional ward settings were modified to accommodate groups rather than individuals, with the average family group size admitted being three (Bowen, 1960; Grunebaum, Weiss, Hirsch, & Barret, 1963; Main, 1958). In all the cases described in the literature of the 1950s and 1960s, the identified patient was psychotic, and in most cases the parent was the patient (Combrinck-Graham, Gursky, & Brendler, 1982).

In contrast, literature of the 1980s focussed upon family admission in child psychiatry upon treating families where at least one child in the family had a diagnosed psychiatric condition, presenting with significant emotional and/or behavioural disturbances (Brendler & Combrinck-Graham, 1986; Bornstein, Belcher, & Buamgartner, 1985; Dydyk, French, Gertsman, & Morrison, 1982; Siegel & Whitmont, 1990).

According to Combrinck-Graham (1985), the uses of psychiatric hospitalisation as an intervention in the family fall into three categories. The first category is where the

whole family is identified as a patient (Abroms, Fellner, & Whitaker, 1971; Combrinck-Graham et al., 1982). The second category is where the aim is to use the family's resources in the treatment of disturbed family members and to preserve role functions in the family during the intensive inpatient treatment phase (Bhatti, Janakiramaiah, & Channabaasavanna, 1980; Combrinck-Graham et al.; Grunebaum et al. 1963; Nakhala et al.; 1969; Whitaker & Olsen, 1971). The third category is where the purpose of the family admission is to use the hospital as a laboratory for change in familial relationships (Abroms et al.; Bhatti et al.; Combrinck-Graham et al.; Nakhala et al.; Whitaker & Olsen).

### 1.3.2 Rationale and advantages of inpatient family intervention

Child psychiatric inpatient family treatment programmes have been conceptualised as providing a number of important treatment opportunities and specific advantages over other modes of intervention. These include diffusing the focus on the referred child, and adopting a broader family systems approach to the difficulties, creating an opportunity for intensive and comprehensive assessment of the presenting difficulties, which can lead onto the development of intense therapeutic relationships between family members and clinicians, and providing peer support for both the parents and the children (Brendler, 1987; Byrne & Jones, 1998; Comrinck-Graham et al., 1982; Siegel & Whitmont, 1990).

Family inpatient admission has been seen as challenging the family's conviction that the problem resides solely within the child, serving to destigmatise the referred child while giving therapeutic attention to each family member. More specifically, as Brendler (1987) explained, the symptomatic child can be understood as one part of a larger dysfunctional unit, in that the identified patient's behaviour is regarded not just as an expression of individual dysfunction, but also as an expression of family dysfunction. The symptoms are viewed as being maintained by the family's patterns of interaction, and possibly by professionals who are part of the therapeutic system. The family is seen to be using only a limited repertoire of its available resources, and is encouraged to recognise that it has the capacity and flexibility to develop alternative ways of interacting (Brendler).

The identified patient's behaviour changes as the family's interactional patterns and structure change (Brendler, 1987). For example, using the basis of the concepts and techniques of structural family therapy, the team and the family work towards the restoration and development of a clear hierarchy and clear, permeable boundaries. It is a structure which fosters competence in all family members and flexibility, conflict resolution, and co-operation within the family system (Minuchin, 1974).

A family admission facilitates the family to own and be responsible for the patient and the problems, diminishing any desire to exclude or reject them, and thereby lessening feelings of failure, guilt and anger in all family members. Furthermore, separation, which could be damaging to the individual and the family or so intolerable that the hospitalisation of an individual is very difficult or impossible, is precluded. Moreover, a whole family admission prevents the splits and alignments between patient, family and hospital which are often the areas where conflicts and anxieties are acted out to the detriment or even break-up of treatment (Combrinck-Graham et al., 1982).

It is not just the family system but also the wider system which is taken into consideration within a systemic approach to child psychiatric admission. Hanrahan (1986), reflecting on inpatient family intervention, considered that the family and the inpatient unit together can create a new functional system that offers the family opportunities for growth and change. Whole family admission programmes operating within a systemic framework, promote the whole family as the unit of investigation and focus on change within the whole family, rather than just the individual.

A second broad advantage of full family admission is that it may provide the opportunity for an intensive and comprehensive assessment of the presenting difficulties, in a wide range of settings, by clinicians from different theoretical backgrounds (Byrne & Jones, 1998). The close contact between the nursing or direct care staff and the family members affords unrivalled opportunities for observation of the parent-child relationship, both in what they observe objectively, and in what they are made to feel in response to each family member's projections. This can enable the team to draw more accurate conclusions about the nature and quality of the parent-child interaction and to plan effective treatment approaches. Moreover, this has

distinct economic and clinical advantages to having a clinical team with training and experience concentrated in one assessment and treatment centre.

A third opportunity afforded by family inpatient treatment, as observed by Siegel and Whitmont (1990), is for the development of intense therapeutic relationships between family members and treating team members. Daily contact between direct-care staff, clinical staff, and the family means that treatment plans can evolve concurrently with changes in the family. Daily contact with nursing or direct-care staff assists in developing a relationship that parents find crucial to their improvement. The parents can observe staff using an alternative parenting style and nursing staff actively model techniques such as limit setting, clear verbal communication, conflict resolution, support-delivery, and a relaxed but competent approach to child rearing. This model is available all the time. Parents are encouraged to use these techniques, with supportive feedback from staff. Parents are also encouraged to strengthen their leadership role and choose not to abdicate responsibilities (Siegel & Whitmont).

In addition, in the context of the formation of a strong therapeutic relationship, the case manager can often be firmer and more confronting of an inpatient family with issues such as the use of physical punishment or destructive criticism, and parental threats to extrude the child from the family. Similar confrontation on an outpatient basis might result in withdrawal from therapy. The confrontation is better tolerated due to the amount of support for the family in the inpatient therapeutic milieu. Putting a stop to physical punishment, in particular, can have a claming effect on all family members (Siegel & Whitmont, 1990).

The fourth main advantage provided by inpatient family admission is peer support for family members (Siegel & Whitmont, 1990). For the children, their goals frequently involve the development of social skills in the school context. The discussion of peer interaction can make a strong contribution to the content of family therapy sessions. The parents can also benefit from peer support – from staff who are trained to reinforce parenting efforts, and from other parents living in the Unit. Siegel and Whitmont found that families often discover they share similar difficulties, which can reduce their sense of isolation.

Finally, family hospitalisation can provide the chaotic family a safe and supportive context (Siegel & Whitmont, 1990). This involves not only emotional and behavioural support, but also includes physical help in managing the children, free housing and food, excursions into the community, modern laundry facilities, and on-site recreational opportunities that many families do not have in their own home setting such as a swimming pool and trampoline.

### 1.3.3 Criticisms of inpatient family intervention

A number of criticisms or perceived disadvantages of the practice of inpatient family treatment have also been identified. These issues centre on the inpatient setting provide a false situation, concern regarding the removal of the family from their friendship and social network, the subsequent creation of dependency and separation issues, along with a range of unique pressures experienced by being part of a hospital community including transference and countertransference issues. Finally the cost associated with full family admission is reviewed.

First, Byrne and Jones (1998) observed that an inpatient setting may be seen to provide a false situation for the family and therefore is not able to provide an accurate picture of the family's functioning within the home environment. A family may either 'fake good' (p.304) or alternatively under-perform if placed under undue pressure in a stressful environment. Certainly, every clinical assessment situation, even in the home, creates something of a false atmosphere. However, Ainsworth et al. (1978) demonstrated that the relationship that has evolved between the parent and child is evident in both naturalistic and contrived laboratory settings, and cannot be hidden by a sudden change in, for instance, the parent's responsivity to the child. Therefore, a parent faking of parental availability will not engage an insecure, avoidant child. Similarly, a mother failing to respond under stress will not prevent her secure child from seeking support that has been grown to be expected (Byrne & Jones).

A second concern regarding inpatient family treatment centred on the removal of members of the family from their friendship and social network, and their local community (Bornstein et al., 1985). The family might come to feel encapsulated from the real world, shielded from their wider family and other influences and stresses

(Byrne & Jones, 1998). Moreover, Bornstein et al. observed in their experience with the Travancore Child and Family Centre in Melbourne, Australia, that at times the programme may interfere with the parents' work commitments and the children's schooling. In the experience of this programme, where possible the parents continued with their employment, and the siblings of the referred child attended their own schools. In this way, the therapeutic programme was flexibly arranged around these commitments (Bornstein et al.).

A further concern regarding inpatient family treatment, linked to issues about the family being removed from their social network and general community, is related to issues of dependency on the hospital by the family (Bornstein et al., 1985; Byrne & Jones, 1998; Siegel & Whitmont, 1990) and professionals in the community (Byrne & Jones). First, families can assume a dependent stance in relation to the facility's highly supportive environment and staff, without being able to use the facilities to bring about internal family change. However, as shown in the experience of the Travancore programme, after a family has been admitted in crisis, an important step in planning a further period of treatment admission is the clarification of whether the parents' goals include seeking further support or working at changes in the family's pattern of functioning (Bornstein et al.). This can serve to limit the issues of dependency. Secondly, professionals in the community may be resistant to resuming a high level of contact and support for the family following discharge (Byrne & Jones). Planning and working at collaboration with external agencies from the point of referral and throughout the family inpatient period, as well as providing an outpatient consultative service post-discharge, may contain concerns regarding the resumption of outpatient or community management with these challenging families.

A potential by-product of the above stated dependency issues could be played out in separation difficulties for the family from the supportive inpatient programme (Byrne & Jones, 1998). The process of separation from the inpatient setting and the team can, however, be managed with knowledge of the issues involved for the family. This process can be utilised as an event in the family's life, which affords them the opportunity for an appropriate leave taking and transition, contrasting to previous experiences of separation and loss (Byrne & Jones).



Another concern related to inpatient family treatment, is the range of unique pressures and strains the family may experience being part of the hospital community. As Bornstein et al. (1985) observed, not only is the family placed in a new environment with different daily routines, there is also some loss of privacy, a level of scrutiny of family functioning by others and a sense of loss of freedom and control of their own destiny. Moreover, in programmes where more than one family is admitted at any one time, the family have to adapt to other children and families impinging on their personal space, and to various groups and meetings which are part of the milieu programme (Bornstein et al.). Siegel and Whitmont (1990) also reflected on the loss of privacy for these families, as well as the general stigma of being in a psychiatric hospital.

A further potential disadvantage of inpatient family treatment, noted by Chiesa, Drahorad and Rocco (1998) in their work with families admitted to the Cassel Hospital in London, centred on transference and countertransference issues experienced by treating team members. As described above in Section 1.2.6, and will be further elaborated on in Section 1.3.7 in particular reference to working with inpatient families, transference and countertransference issues are seen as a by-product of such intensive, focussed work with severely dysfunctional multi-problem families. However, if such issues were not addressed and managed by the treating team, they could certainly actively undermine therapeutic treatment.

A final concern lies in the cost of family inpatient treatment compared to other forms of treatment. Churven and Cintio (1983) contended that a characteristically short-term family inpatient programme ensures that it is economic compared with traditional individual admission programmes for severely disturbed children which had typically been longer. Byrne and Jones (1998) also attested to the economic advantages of having an experienced multidisciplinary team concentrated in the one setting enabling them to more accurately draw conclusions about the presenting difficulties. In all, Bornstein et al. (1985) observed, that the costs associated with inpatient family treatment need to be balanced against the usual alternative costs of long admission of the child alone and prolonged involvement by multiple agencies.

In summary, as indicated above, such disadvantages may be addressed, and the impact of such factors on the quality of the assessment and treatment may be minimised. Of note, however, certain contraindications or exclusion criteria in reference to inpatient family treatment have also been identified.

#### 1.3.4 Contraindications of inpatient family intervention

The first potential contraindication for family inpatient treatment is when it would be deemed too emotionally threatening for the family, and may result in the family members becoming increasingly and highly defensive (Bornstein et al., 1985). This has been well noted in cases when the parents have an overwhelming need to focus the family's problem on a particular child and to avoid giving attention to their own serious marital or personal problems. In such families, there is often serious psychopathology in at least one parent (Bornstein et al.).

A second potential contraindication for family admission would be when a parent has a major psychiatric or personality problem which could impact negatively on children of other families within the programme. Highly disturbed families require an intense concentration of therapeutic resources, demanding increased time commitments from staff and placing serious stress on the staff's capacity to avoid being drawn into the family's pathological systems of interaction (Bornstein et al., 1985).

Moreover, family inpatient treatment is not indicated in situations when temporary separation of the child from the family is required. For example, children with serious disturbances in personality integration, such as borderline psychosis, may initially require separation from a parent with severe psychopathology who is viewed to be contributing to the child's disturbance. Another example may occur with adolescents requiring distance to establish a degree of autonomy in relation to their family. In these cases, family admission may be helpful at a later stage, once sufficient improvement in the child has occurred, to allow more adaptive responses to parental and family pathology within a supportive therapeutic setting (Bornstein et al., 1985).

Siegel and Whitmont (1990) identified a number of other clear exclusion criteria in reference to family inpatient treatment, namely, when there is a risk of physical or

sexual abuse but in the absence of disturbed behaviour in the child, when there is need for temporary accommodation, and for children with long-term delinquency or developmental delay. Moreover, they deemed it inadvisable for family inpatient programmes to accept a high proportion of aggressive children at any one time.

Each of these contraindications would obviously need to be reviewed in the context of each family inpatient programme with its own theoretical orientation, and practical aims and objectives regarding the proposed assessment and/or treatment for any given family.

### 1.3.5 Overview of inpatient family programmes

Eight inpatient family programmes have been reported in the international English language literature over the past four decades. These services, which have spanned the United States of America, England, Canada, Norway, and Australia, are each distinctive. The features of each programme have been described as being underpinned by differing theoretical models and differing affiliations with a main service auspice. These features inform practical considerations such as the type of accommodation provided, the number of families admitted at any one time, and the average length of stay of the families. These characteristics are discussed in reference to each of the family admission programmes identified in the literature and are summarised in Table 1 on pages 37 and 38 below.

#### 1.3.5.1 Children's Psychiatric Research Institute, Ontario, Canada

Johnson and Savage (1967) provided one of the earliest reports of child-focussed family inpatient treatment in their description of the Children's Psychiatric Research Institute programme in Ontario, Canada. The programme admitted mother and child dyads, for observation and treatment of disturbance in the mother-child relationship, in the context of significant child emotional or behavioural disturbance, including sequelae linked to mental retardation. Depression experienced by the mothers was also recorded. The age range of the children was between three and ten years.

Table 1

*Summary Table of Inpatient Child Psychiatry Family Admission Programmes Reported in the Literature*

Researcher/s, Setting & Location	Theoretical Orientation	Length of Stay	No. of Families, Accommodation
<i>Johnson &amp; Savage (1967)</i> Children's Psychiatric Research Unit, Ontario, Canada	Therapeutic milieu focussed on education & individual counselling	3 weeks	Mother & child Semi-contained flat, attached to child psychiatric facility
<i>Nakhla et al. (1969)</i> <i>Kennedy et al (1987)</i> <i>Bandler (1987)</i> <i>Coombe (1996)</i> The Families Unit, Cassel Hospital * London, England	Psychoanalytic	9-14 months  5-day-week (home on weekends)	6-7 families Therapeutic community which includes two adult individual admission units
<i>Lynch et al (1975)</i> <i>Roberts (1978)</i> <i>Jones (1996, 1997)</i> <i>Byrne &amp; Jones (1998)</i> Residential Family Unit Park Hospital for Children Oxford, England	Developmental & ecological including psychoanalytic, child development, biopsychosocial & attachment theories	2 week assessment 4 week treatment	2 families  Attached to a major child psychiatry facility
<i>Ravnsborg (1982)</i> The Family Department Modum Bads Nervesantatorium# Vikersund, Norway	Eclectic including psychoanalytic, transgenerational, behavioural & systemic theories	10-12 weeks (initial stay) 1-3 weeks (readmission)	5 families & 6 couples Self-contained houses in village situation

Note: n/a: information not available

\*: any family member, but usually the adult is designated as the identified patient

#: either parent or child designated as identified patient

(Continued on the next page)

Table 1 (continued from previous page)

*Summary Table of Inpatient Child Psychiatry Family Admission Programmes  
Reported in the Literature*

Researcher/s, Setting & Location	Theoretical Orientation	Length of Stay	No. of Families, Accommodation
<i>Goren (1979)</i> <i>Brendler (1987)</i> <i>Brendler et al. (1986)</i> <i>Combrinck-Graham (1985)</i> <i>Combrinck-Graham et al. (1982)</i> The Family Apartments Philadelphia Child Guidance Clinic Pennsylvania, USA	Structural & systemic family therapy	6 weeks	2 single-parent families  Self-contained flats in child psychiatric unit
<i>Dydyk et al. (1982; 1989)</i> Intensive Family Therapy Unit Thistletown Centre for Children Toronto, Canada	Systemic MacGregor's multiple level impact therapy	2-4 days	1 family House on the campus
<i>Churven &amp; Cintio (1983)</i> <i>Churven &amp; Durrant (1983)</i> <i>Siegel &amp; Whitmont (1990)</i> Redbank House, Westmead Hospital, Sydney, Australia	Strategic family therapy (1983) Eclectic including self-psychology, social learning & systems (1990)	4-6 weeks  5-day-week (home on weekends)	3 families Interconnected cottages Attached to a major child psychiatry facility
<i>Bornstein et al. (1985)</i> Travancore Child & Family Centre, Melbourne, Australia	Psychodynamic & family systems	2 days– 3 months (2-3 weeks)	3 families  Attached to a major child psychiatry facility

Johnson and Savage (1967) described the Children's Psychiatric Research Institute programme as set in a planned therapeutic milieu based on the concept of education and individual counselling. Clarity of roles and co-operation of all staff members (kitchen personnel, cleaners, nurses, psychologists and social workers) was deemed essential. Regular channels of communication, usually through the social worker, were established. Importance was given to not taking over the mothering role. Overall, the average length of stay was three weeks, and outpatient treatment both preceded and followed admission.

#### 1.3.5.2 The Families Unit, Cassel Hospital, London, England

The work of The Families Unit at the Cassel Hospital in London was originally reported by Nakhla et al. (1969). It was observed that the many years of hospitalising mothers and children together (Main, 1958) and in treating disturbed mother-child couples (Folkart, 1964) had led to a growing awareness of the significance of dynamic forces within the family. Coupled with these observations and the then emerging literature on family therapy, in 1964 a psychoanalytically informed family-centred approach to treatment was adopted (Nakhla et al.), and has continued to present day (Chiesa et al., 1998; Coombe, 1996).

The Cassel Hospital, set in 'a large, rambling, but somehow 'homely' building' (Bandler, 1987, p.81) can admit six to seven families at any one time, with the average length of stay being between nine and fourteen months, with families returning home on the weekends. 'Families are referred when family functioning has broken down' (Bandler, 1987, p.81), and various forms of treatment prior to admission have been tried. Chiesa et al. (1998) described the families treated at the Cassel Hospital as 'borderline' families with multiple psychopathologies, which have not responded to previously employed conventional psychiatric, psychosocial, outpatient and/or inpatient intervention.

Although any family member may be the referred 'patient', the main concern most often centres on the parent or parents (Bandler, 1987). Families were referred when family functioning had broken down, such as in the cases of puerperal breakdown, severely neurotic or borderline disturbance in the parent/s which impacts significantly

on caring for the children, and reuniting families whose children have been in care due to physical or sexual abuse.

The hospital functions as a therapeutic community, with emphasis on families looking after their own children. The main professionals involved with each family include therapist/s for the parent/s (who are usually seen individually), child therapist/s treating the children, a nurse for the family (whose aim is to facilitate the family's capacity to carry out the everyday tasks of functioning). There is also a day unit for the children staffed by teachers and nurses (Kennedy, 1987; Kennedy, Heyman & Tischler, 1987).

#### 1.3.5.3 Park Hospital for Children, Oxford, England

The Residential Family Unit at the Park Hospital for Children in Oxford, England, specialises in providing psychiatric treatment for families in which there has been a severe breakdown in parenting. The unit's pioneering work with abusing families, established in 1967, was described by Lynch, Steinberg and Ousted (1975) and by Roberts (1978). Currently the unit is engaged in a programme of assessment risk, treatment and management of families in which severe abuse has occurred, or is likely to occur (Byrne & Jones, 1998). Two families can be accommodated at any one time. Whilst the assessment and treatment of a family with severe parenting breakdown begins before admission, and continues long past discharge, the inpatient treatment phase may last from two to six weeks (a two week assessment, followed, in selected cases, by a four week treatment phase).

The team's approach to assessment and treatment is grounded in an ecological/developmental perspective on severe parenting breakdown, including child abuse and neglect (Jones, 1996). This approach incorporates concepts from the psychoanalytic, child development and attachment fields. A biopsychosocial approach is used, which recognises the changing developmental and family propensities through time (Byrne & Jones, 1998).

As Byrne and Jones (1998) explained, the team follows the risk management process outlined by Jones (1997), in which the risk matrix is broken down into more

manageable components or domains which include parental, parent-child, child, family abuse acts, social setting and professional systems. The identification of both positive and negative features within each of these domains is viewed as crucial to risk assessment and treatment planning. This process enables the many factors to be weighed and counterbalanced during decision making and risk management, and has also proven to be a useful framework for communication and liaison with other professionals.

#### 1.3.5.4 Family Department, Modum Bads Nervesanatorium, Oslo, Norway

The Family Department, Modum Bads Nervesanatorium located in the country in Vikersund, near Oslo in Norway, began operation in the early 1970s and adopted an eclectic approach to family admission (Ravnsborg, 1982). In this programme, which served all of Norway and incorporated psychoanalytic, systemic, transgenerational and behavioural strategies, either the parents or the children could be the identified patient. Families were accommodated in self-contained houses in a village-like situation. The initial length of stay was reported as from ten to twelve weeks, with a possible further one to three weeks readmission with clearly defined goals (Ravnsborg).

#### 1.3.5.5 The Family Apartments, Philadelphia Child Guidance Clinic, Pennsylvania, United States of America

The Family Apartments set up through the Philadelphia Child Guidance Clinic in Pennsylvania in the United States of America by Salvador Minuchin began operating in 1974 (Brendler, 1987; Brendler & Combrinck-Graham, 1986; Combrinck-Graham, 1985; Combrinck-Graham et al., 1982; Goren, 1979). The Family Apartments programme involved admitting single-parent families, and used a structural and systemic approach which focussed on a more positive parenting style. Families received a combination of daily, formal or informal family therapy and individual therapy as indicated. Two families could be accommodated at any one time and were housed in self-contained flats in an inpatient unit linked with a child psychiatric unit. The average length of stay for this programme was six weeks.



#### 1.3.5.6 Intensive Family Therapy Unit, Thistletown Centre for Children, Toronto, Canada

The Intensive Family Therapy Unit (IFTU) located at the Thistletown Centre for Children in Toronto, Canada began operation in 1979 as a brief and intensive family assessment and treatment programme. One family at a time was accommodated in a house on campus of a large children's treatment centre for a two to four day period. The initiative for this service arose out of an interest in developing a more cost-effective way of working with families who otherwise consumed a disproportionately large slice of available resources (Dydyk et al., 1982; Dydyk, French, Gertsman, Morrison, & O'Neill, 1989).

The IFTU programme philosophy was systemically based and drew on assumptions of MacGregor's (1962) multiple impact therapy for families. These assumptions stated that families facing a crisis are stimulated to mobilise strengths and resources to meet the crisis, and are more likely to be flexible in attitude than at other times. Therefore, in any treatment it was viewed as probable that there would be more expedient and more notable change in the early stages, with later change being a deepening and strengthening of the initial changes (Dydyk et al., 1982).

Drawn from this philosophical base, the IFTU programme comprised three stages. The first stage focussed on pre-admission work where relevant information was obtained and the engagement process commenced. The second stage, admission, involved the family being inpatients for a pre-determined number of days. Treatment strategies utilised included family sessions, subsystem work, individual sessions, assigning of tasks, use of audio-visual feedback, observation and problem solving in instrumental areas such as bed-times, meals and the use of leisure time. Throughout the assessment and treatment stages close collaboration with the referring and other external agencies occurred. The third stage, follow-up, involved the inpatient treating team maintaining ongoing contact through consultation to the community agency that held responsibility for the family. This intensive service could be repeated at later stages for a 'booster' treatment, and intensive service was felt to provide the equivalent of an extended period of out-patient treatment if such was available (Dydyk et al., 1989).

#### 1.3.5.7 Redbank House, Westmead Hospital, Sydney, Australia

Redbank House family programme, located at Westmead Hospital in Sydney, Australia began operation in 1979 and is attached to major child psychiatric facility. It has continued operating over the last two-and-a-half decades. The programme is staffed by a multidisciplinary team, with three families, as well as individual children, may be admitted at any one time. Accommodation is set in interconnected, one-story cottages, with gardens and playground. The average length of stay is four to six weeks with families attending five-days-per-week, returning home on the weekends (Siegel & Whitmont, 1990).

In the early years, Redbank House employed a strategic family therapy approach (Churven & Cintio, 1983; Churven & Durrant, 1983), but later moved to an eclectic synthesis of systemic family therapy, social learning and self psychology theories. When documented by Siegel and Whitmont in 1990, this orientation included family therapy, group therapy, individual contact between case manager and child, and a psycho-educational programme. In addition, and considered central to the programme, was nursing staff management within a therapeutic community. In this setting, individualised treatment plans (which within a nurturant approach incorporates structured limits, rewards and consequences) were implemented and reviewed and revised as required (Siegel & Whitmont).

Admission policy for Redbank House family programme was to accept families when the child had a chronic 'internalised' problem, parents had severely limited parenting skills, and when outpatient treatment had failed. Exclusion criteria included risk of physical or sexual abuse in the absence of disturbed behaviour in the child, a need for temporary accommodation, and children with long-term delinquency or developmental delay. Moreover, the family programme did not accept a high proportion of violent or otherwise aggressive children at any one time (Siegel & Whitmont, 1990).

#### 1.3.5.8 Travancore Child and Family Centre, Melbourne, Australia

The Travancore Child and Family Centre in Melbourne, Australia began operation in 1982 as a family inpatient programme, and like Redbank House was associated with a major child psychiatric facility. The programme had the capacity to admit both families (range between 2 days to 3 months, usually for two to three weeks) and/or individual children up to the age of 16 years (for usually 3-9 months, with some children staying up to two years) for treatment (Bornstein et al., 1985).

Unlike Thistletown and Redbank House, Travancore did not focus on a particular model of family therapy as its core treatment philosophy, even though family assessment and family therapy were often utilised. Rather the programme adopted psychodynamic and general family systems principles in practice. The choice of therapy approach was matched to the particular needs of each given case. Moreover, thorough assessment prior to treatment was prioritised (Bornstein et al., 1985).

Travancore developed comprehensive and detailed admission criteria for the programme. These included first, serious problems being present in the emotional and social development and functioning of one or more children within the family, the pattern of psychological interactions between family members as a group, and/or in the family's ability to cope with its current interactional crisis with the support of other services and facilities. A second criterion was evaluation by the treating team that the child and family could be assisted through family admission. Third, admission of the family was deemed likely to significantly reduce treatment time over other treatment options. Fourth, other avenues and facilities for assessment or treatment had been inadequate or unsuitable. Fifth, admission of the family was preferable to admission of the child as the most appropriate form of intervention. The sixth criterion was that the family must agree to admission and could make arrangements in relation to care of their home and pets, work, school and other commitments. In addition, the resultant mix with other current inpatient families and individuals also required consideration, so as not to compromise others' ongoing management (Bornstein et al., 1985).

1.3.6 Other family-oriented child psychiatry day and inpatient programmes

Three other documented child psychiatry programmes that have adopted a dedicated family orientation are a Finnish inpatient programme, and day programmes operating in London and Sweden. These programmes are summarised in Table 2 on page 45 below.

Table 2:  
*Summary Table of Other Family-Oriented Child Psychiatry Day and Inpatient Programmes Reported in the Literature*

Researcher/s, Service, Setting & Location	Theoretical Orientation	Duration of Programme
<i>Cooklin et al. (1983)</i> <i>Asen (1988, 2002)</i> Day Programme Marlborough Family Day Unit, London, England	Eclectic  -family systems  -psychodynamic  -group work	3 months
<i>Sourander, Heikkila et al. (1995)</i> <i>Sourander &amp; Piha (1995; 1996)</i> Inpatient Programme Turku University Hospital Turku, Finland	Systemic  -psychodynamic  -behavioural	4 – 6 weeks
<i>Sundelin (1999)</i> <i>Sundelin &amp; Hansson (1999)</i> Day Programmes 5 Intensive Family Therapy Units Sweden	Systemic  -structural, strategic & systemic family therapy  - milieu therapy	3-4 weeks  plus 2-6 months follow-up

1.3.6.1 Marlborough Family Day Unit, London, England

The Marlborough Family Day Unit, London was set up in 1977 and operated as a multi-family group day programme servicing families with a background of emotional deprivation and social disadvantage (Cooklin, Miller, & McHugh, 1983). An eclectic practice was utilised, combining a family systems approach with psychodynamic

principles and group work. The programme ran a multi-family assessment and treatment programme for four six hour days each week. A maximum of thirty persons, adults and children could attend at any one time, which included up to ten families. While families initially stayed eighteen months, this time frame was reviewed in 1981 to around three months with attendance reviewed and negotiated at monthly intervals (Asen, 1988).

The aim of the programme was to provide more intensive assessment and treatment for children and families than could be provided on an outpatient basis (Asen, 1988). As Cooklin et al. (1983) described, the day unit was designed to intervene in the systems of families who present with severe or multiple problems to agencies attempting to help them, but who are difficult to engage in a therapeutic pact and unresponsive to attempts at outpatient work. The unit was described in terms of 'the creation of an artificial extended family, the intensification of sequence and patterns of interaction, and the making and transversing of boundaries' (Cooklin et al., p.453). A 'pressure cooker' analogy was used in reference to the demands of the programme. Changing contexts and groupings required families to be able to change their behaviour and expectations of each other, challenging usual ways of interacting and encouraging experimenting with new ways. Such differing demands generated stress, which in turn provided new data regarding the family (Asen). Moreover, particular attention was paid to the function of agency interventions and to redefining the relationship between family and agency (Cooklin et al.).

Over the years, new multiple family units based on the Marlborough model have been created elsewhere including The Netherlands, Germany, Scandinavia and Italy. The ideas for each family unit have been creatively transformed and adapted to specific cultural and work contexts (Asen, 2002).

#### 1.3.6.2 Intensive Family Therapy Units, Sweden

In Sweden, a number of day treatment programmes for families, described as Intensive Family Therapy Units (IFTUs) are in operation (Sundelin, 1999; Sundelin & Hansson, 1999). The IFTUs were inspired by the writings on the effectiveness of a multi-systemic perspective (Hallstrom, 1991; Hallstrom, 1992; Henggeler,

Schoenwald, & Pickrel, 1995; MacGregor, 1962), techniques drawn from earlier reports on therapeutic communities (Feldman, 1970, cited in Sundelin, 1999; Kennedy et al., 1987) as well as the work of Norwegian flying teams (Haugsgjerd, 1973, cited in Sundelin & Hansson, 1999).

The therapeutic models utilised in the IFTUs have been based on structural, strategic and systemic family therapy as well as milieu therapy. These systemic-oriented programmes consist of family and individual interviews as well as milieu work in close collaboration over a limited time period of three to four weeks. All therapeutic work is preceded by a planning and preparational period and followed by a period of outpatient contact (Sundelin, 1999; Sundelin & Hansson, 1999). The therapeutic work is planned and conducted by therapeutic teams (family members, family therapists, milieu therapists, teachers, and referral persons). Intervention with the IFTUs almost always begin from a crisis in the family or in the referring therapeutic system (Sundelin).

#### 1.3.6.3 Turku University Hospital, Turku, Finland

Operating in Turku, Finland, Sourander and Piha (1996) described the option of a short-term (four-week) systemically driven, 'family oriented' child and adolescent (age range 7 to 14 years) inpatient treatment programme within a longer term (9-18 month) treatment programme. The programme, which when reported had been operating for ten years, was staffed by a multidisciplinary team headed by a child psychiatrist. The main reasons for referral by agencies centred on a child's disruptive behaviour as well as difficulties in the school environment, combined with the family's difficulty to manage these problems. Many children come from multi-problem families with loose family structures, many major life changes, and hospitalisations, as well as changes in levels of subsistence (Sourander, Leijala, Lehtila, Kanerva, Helenius, & Piha, 1996; Sourander & Piha, 1995). Such child psychiatric hospitalisation was usually the last link in a chain of different treatment modes and agencies involving the family, the child, and often several educational, social, and psychiatric services.

Sourander and Piha (1996) outlined the inpatient treatment process as both an individual and family process, with the purpose of systemically integrating the different interventions in the child, his or her family and the outpatient professional network into the treatment process. Throughout treatment, the two systems to which the child belongs, the family system and the ward system, were in mutual interaction. The treatment philosophy consisted of psychodynamic understanding of the child's development, behavioural approaches to manage disruptive behaviour, and an overall family oriented approach. The principal treatment modes included milieu therapy and child-nurse dyadic relationship. Parental guidance or family therapy were also used in all cases, and for a limited number of cases individual psychotherapy and psychoactive medication were utilised (Sourander, Heikkila, Leijala, Heinisuo, Helenius, & Piha, 1995). In addition, all those involved with the presenting difficulties (for instance, family, other relatives, teacher, and other agencies) attended a network meeting prior to admission and prior to discharge (Sourander & Piha).

### 1.3.7 Staff experience and team dynamics in working with multi-problem families

As discussed in Section 1.2.6 above, transference and countertransference dynamics are invariably activated in working with troubled children and their families in an inpatient setting. These issues are further brought to the fore in the reports of working with whole families in child psychiatry inpatient settings.

Bandler (1987) noted in The Families Unit experience at the Cassel Hospital in London, that the family is observed to bring considerable emotional 'luggage' to the inpatient setting. The family's relationships and responses to staff included many feelings and reactions, which were considered transference reactions. For both the family and the referrer, inpatient family treatment is often regarded as a last opportunity for help. Past and present anxieties accompany the family into hospital, and often there are tremendous and unrealistic hopes, coupled with an equally strong conviction that nothing can help.

Individual workers could feel for example, burdened by the family's problems, overwhelmed with frustration and despair, or that it is solely up to them to make

everything all right. One worker might feel another is not doing enough, or alternatively doing too much. Moreover, with any family there is pressure to act; to make managerial decisions that will relieve patients of their inner struggle (Bandler, 1987).

In particular, parents who abuse their children were noted to arouse the strongest feelings and greatest anxiety in staff in a family inpatient setting (Bandler, 1987; Byrne & Jones, 1998). Observing, nursing and intervening on a daily basis in a grossly dysfunctional parent-child relationship, being a witness to emotional abuse or neglect can be extremely painful for team members (Byrne & Jones). Destructive forces in the parent are viewed at their most unrestrained, and children are recognised as helpless victims of situations they cannot comprehend or control. Such families test the staff's capacity of work together to the utmost (Bandler).

Byrne and Jones (1998) in their work with abusing families at the Residential Family Unit at the Parks Hospital for Children in Oxford, found that the families held the view that the unit represented their last hope for possible reunification with their children. Thus, some families are very keen to engage with the staff, and were likely to project their most hopeful and ideal selves into the team and individual team members, with someone else holding the split off 'bad' feelings. Other families came with considerable denial and underlying resistance. Beneath a superficial commitment they perceived the team as focussed on gathering evidence to facilitate the removal of their children. As Byrne and Jones explained, such projections can be located in one or more team members and the family may, unconsciously, seek to split the team.

In this work, it was therefore seen as critical that the team addressed the different perspectives and countertransference feelings of its members and demonstrated to the family a team capacity to overcome divisions. For families in the Parks Hospital programme, such work was seen to facilitate the vitally important process that enables the parents to move towards a full acknowledgement of their responsibility for the reality of the abuse and its impact upon the child, and accept back their split-off, 'bad' parts into their perceptions of themselves (Byrne & Jones, 1998).



If the feelings projected by such troubled families are taken in by the treating team but left to develop in an unprocessed manner, such as shown in team members through team dynamics unwittingly re-enacting or mirroring family relationships (Britton, 1981), then, as Bandler (1987) observed, strains and tensions can build to an intolerable extent, leaving workers feeling helpless, alone and unable to work together, thereby impacting on effective work with the families. However, as outlined in Section 1.2.4, if clear team structure is in operation and as reviewed in Section 1.2.7, if clinical supervision and staff sensitivity groups are integrated into clinical practice, then these strains can be understood, processed and managed, and the possibility of working effectively with the family remains open.

### 1.3.8 Summary regarding family inpatient and family-oriented day and inpatient programmes

In reviewing the eight family inpatient (presented in Section 1.3.5 and summarised in Table 1), and the three family-oriented day and inpatient (presented in Section 1.3.6 and summarised in Table 2) programmes documented in the literature, it is apparent that these programmes have held a unique place in child psychiatry treatment practice. The main similarities of all the programmes centred on their work with families experiencing multiple problems, often of a severe and longstanding nature, that have been resistant to outpatient treatment. Moreover, nearly all the programmes employed a multidisciplinary team and were set in a therapeutic type milieu or community that offered a combination of therapies.

However, distinctions in the programmes were noted in relation to their guiding theoretical orientations, length of stay and the number of families concurrently treated. For example, The Families Unit at the Cassel Hospital operating within psychoanalytic principles treated 6-7 families at one time, with admissions lasting up to eighteen months (Coombe, 1996; Kennedy, 1987). In marked contrast, Canada's Thistletown Centre for Children's IFTU programme, drew upon MacGregor's multiple level impact therapy, and worked with one family at a time over a set 2-4 day period (Dydyk et al., 1982; 1989). Most of the family inpatient and the three family-oriented day or inpatient programmes, however, fell within the short-term time frame (1-3 months) and utilised a multi-modal treatment approach in working with 2-3

families (in an inpatient setting) at a given time. Of note, the stated theoretical orientation of most of these programmes invariably included a systemic foundation, with many programmes incorporating psychodynamic principles as well.

The capacity to draw direct comparisons between the different programmes, however, is restricted, as none of the reports provided complete detailed information in reference to the relevant programme. Case examples were commonly presented to knit together the features of the programme for the given service. A number of programmes provided comprehensive information regarding their theoretical orientation linked with their practice (Siegel & Whitmont, 1990; Sourander & Piha, 1996; Sundelin, 1999), others gave more detailed information regarding their rationale for admission and attendant indications and contraindications (Bornstein et al., 1985), while others provided background information, such as with whom the program was or is affiliated, influences of practice and focussed detail on their overall treatment process (Byrne & Jones, 1998). Moreover, over time, in the context of changing clinical practices, as well as social and economic pressures, changes within the different programmes occurred. This was for example, documented in the length of stay in the Marlborough Family Day Programme from 18 months, reviewed down to three months (Asen, 1988), and in Redbank House changing from a dedicated strategic family therapy programme (Churven & Durrant, 1983) to a more eclectic operation incorporating self-psychology, social learning and systems theory (Siegel & Whitmont).

Comparisons can, however, be drawn between those programmes that provided detail regarding the structure of their programme, in particular, in reference to the phases of the programme (pre-admission, inpatient period and post discharge) and their involvement with external agencies, and those that did not. Such structure was most noted in the brief (Dydyk et al., 1989) and short-term family inpatient (Byrne & Jones, 1998) programmes, and the day programmes in Sweden (Sundelin & Hansson, 1999) and family oriented inpatient programme in Finland (Sourander & Piha, 1996). Structure related to service delivery was also observed in those programmes attached to a major child psychiatry facility which had access to their own outpatient and other inpatient services (Bornstein et al., 1985; Byrne & Jones; Siegel & Whitmont, 1990).

These programmes impressed as being viewed as systemically incorporated within a broader ongoing treatment context.

#### 1.3.9 Issues concerning an evidence base for treatment in child inpatient psychiatric settings

As noted at the outset of this thesis, a number of challenges currently face psychiatric inpatient treatment of children. Green and Jacobs (1998a) observed that the challenges are seen to come from many directions, from economic and political developments in many countries, from shifts in the social attitudes towards children and family life, and from within and between professional groups.

Health economist Knapp (1997) further elucidated these challenges by drawing on other literature to identify a range of latent and manifest factors considered to have contributed to the increased emphasis on the demonstration of the cost-effectiveness of child mental health care. Knapp's latent factors carry the common theme of limitation of resources and include (1) the growing prevalence of most types of childhood disorder, (2) the gap between need and service delivery capacity (Kurtz, Thornes & Wolkind, 1994), (3) cultural, social and economic changes which contribute to increased demands experienced by families (Diekstra, 1995), (4) changed social and family expectations, placing increased importance on the mental health of youth (Parry-Jones, 1995), and (5) market forces and pressures, with payers demanding better value for their money (Fuller, 1995).

The manifest factors outlined by Knapp (1997) centre on explicit demands in a range of contexts relevant to health care. These include (1) the demand by purchasers that they are receiving the best treatment for the price (Yates, 1994), (2) the sharp increase in the cost of mental health care falling to employers and other payers as a product of perverse incentives (Bickman, Guthrie, Foster, Lambert, Summerfelt, Breda & Heflinger, 1996), (3) the establishment of quasi-markets in the United Kingdom and the emergence of managed care (health maintenance organisations) in the United States (Subotsky, 1992), (4) the wish to develop policies that limit the damaging consequences of the fragmentation of children's mental health services (Hoagwood & Rupp, 1995; Jaffa, 1995), (5) the wish to evaluate new treatments, care settings, or new ways of organising

delivery, and (6) the wish to justify and promote the purchase of new pharmaceutical treatment products (Freemantle & Maynard, 1994).

The issue of an evidence base for the treatment of children in psychiatric settings is the common focus of each of these manifest challenges. Arguments supporting evidence-based medicine include that it makes more effective use of resources, enhances the clinician's knowledge, improves communication with patients, and assists the best-evaluated methods of health care to be identified, enabling patients and health professionals to make better informed decisions (Fonagy et al., 2002). These arguments also bring acceptance of greater accountability by professionals to the funders and purchasers of health care. Indeed, Fonagy et al. have taken up this challenge, as demonstrated in their recent work 'What works for whom: A critical review of treatment for children and adolescents'. Fonagy et al. crystalised issues regarding evidence-based medicine, its justifications and philosophical concerns arising, for the child and adolescent psychiatric field. 'Evidence-based medicine is founded on an ideal - that decisions about care of individual patients should involve the conscientious, explicit and judicious use of current best evidence' (Fonagy et al., p.1).

To date, outcome evaluation has held centre stage in the drive for evidence-based effective treatment. However, as Kazdin and Nock (2003) highlighted, addressing the processes involved in therapeutic interventions, the mechanisms of therapeutic change (understanding how psychotherapy works) are also required to maximise treatment effects and ensure that the critical features of therapy are generalised to clinical practice. To date, researchers have paid scant attention to processes involved in therapy that account for or contribute to therapeutic change (Kazdin, 2000). Within research design in child psychiatry, as commented by Kazdin and Nock, several questions need to be actively explored. What processes or characteristics within the child, parent or family can be mobilised to foster therapeutic change? What events, processes, activities, and tasks in treatment can foster therapeutic change?

It is in consideration of these above comments and questions that the need for rigorous outcome and process evaluation of child psychiatry treatment, including family inpatient treatment, must be met.

## CHAPTER 2

### EVALUATION OF INPATIENT CHILD PSYCHIATRY TREATMENT

The issues arising for both outcome and process evaluation research on inpatient family treatment programmes need to be considered in the context of issues for outcome and process evaluation research on child psychiatry inpatient units in general. To date, most reported evaluation research in this field has been focussed upon the effectiveness of outcomes.

This chapter first addresses the methodological issues and criteria for valid quantitative research in child psychiatry, the contributions of qualitative research in this area, and how quantitative and qualitative methodologies can be productively incorporated in research design. Attention then turns to concerns relating to the child psychiatry inpatient unit as a context for research, noting both the methodological and practical issues specific to this area.

Empirical findings from child psychiatry inpatient quantitative and qualitative outcome and process evaluation research are then reviewed, first for individual child inpatient units, and secondly for family inpatient and family-oriented day patient treatment programmes. The implications of reported past outcome research for effective evaluation are drawn out.

#### 2.1 Overview of quantitative and qualitative process and outcome evaluation

As noted at the end of Chapter 1, child and adolescent psychiatry, along with other health care fields, is faced with the need to consider its evidence base, and to justify its activities accordingly. The history of systematic efforts to identify empirically validated psychotherapy treatments for psychological disorders is a short one (Nathan & Gorman, 1998). The publication of Eysenck's (1952) article, 'The effects of psychotherapy: An evaluation', first introduced treatment research to methodological scrutiny. The place of psychotherapy treatment outcome studies has slowly become more recognised in determining the quantitative effectiveness of psychotherapy

techniques (Callias, 1992; Kazdin, 1995), in assisting in identifying factors which influence treatment effects (Kazdin), in helping to make comparisons of different treatments to determine that which is the more effective in quantitative terms (Callias), and in having a role in identifying and understanding the processes of change (Callias; Kazdin). Moreover, a number of practice guidelines reflecting more potent outcome methodology and more effective treatments have been proposed (Nathan & Gorman, 1988). Nevertheless, despite these gains, limited progress has been made in the field of inpatient child psychiatry process and outcome research. Outstanding methodological issues that have beset this area are discussed below.

### 2.1.1 Validity issues in quantitative outcome evaluation research in child psychiatry

Research on the effectiveness of psychotherapy interventions in child and adolescent mental health has lagged behind treatment outcome research for adults (Target & Fonagy, 1996; Barnes, Stein, & Rosenberg, 1999). Barnett, Docherty, and Frommelt (1991) reviewed 43 controlled outcome studies of individual child psychotherapy dating from 1963, and concluded that the magnitude of flaws in these studies made it impossible to draw reliable conclusions. This issue of methodological adequacy in child psychotherapy outcome research has continued to be discussed in the literature (Kazdin, 1995; Kovacs & Lohr, 1995, Peterson & Bell-Dolan, 1995; Weisz, Donberg, Han, & Weiss, 1995). Strengths and weaknesses of the research to date have been identified and a many major methodological problems have been recognised. Nevertheless, these methodological issues combined with considerations inherent to child and adolescent psychology, important to both conceptualising psychopathology and determining an appropriate treatment have not been routinely addressed in research reports themselves (Kazdin, 1993; Kazdin, 1995; Target & Fonagy). Most notable are the place of the randomised control trial, the need for a truly representative clinical group, dealing with issues of co-morbidity, dealing with the natural history of disorders, obtaining a sufficient sample size, attaining a detailed specification of therapy, ensuring the provision of pre-treatment, post-treatment and follow-up data, as well as valid and wide-ranging measurement practices.

### 2.1.1.1 The place of randomised controlled trial

In accord with positivist experimental reasoning, it has been accepted in the health field that a blind, randomised controlled trial (RCT) gives the clearest indication of the effectiveness of treatment (Roth & Fonagy, 1996). Random assignment of subjects to treatment and control or comparison groups requires, of course, group equivalence on all dimensions or variables considered likely to affect outcomes, thereby enabling identification of treatment effects (Kazdin, Seigel, & Bass, 1990; Peterson & Bell-Dolan, 1995; Weisz, Weiss, Alickes, & Klotz, 1987).

Historically, research on non-laboratory, real life psychosocial treatments for children rarely used the RCT procedure. Instead, the field was dominated by observational single-case reports without a systematic design, often using poorly validated measures and little definition of the treatment provided (Target & Fonagy, 1996). However, as Epstein (2004) had contended, the use of RCT design is problematic in child psychiatry. Ethical and practical objections to random allocation arise, since both the child and parent must be informed of the parameters of treatment. The choice of an appropriate control group is also difficult. Either an untreated (waiting-list) control group or an inert (placebo) treatment group raises the serious ethical problems of withholding treatment from disturbed (highly disorganised, suicidal or dangerous) children in the interest of research design (Blotcky, Dimperio, & Gossett, 1984; Epstein; Target & Fonagy).

In light of these ethical and design difficulties associated with RCTs, the usage of a variety of other, quasi-experimental designs has been mooted (Barnes et al., 1999; Curry, 1991), as well as consideration in the evaluation of efficacy to the findings from open trials (Target & Fonagy, 1996).

### 2.1.1.2 The need for a truly representative clinical group

The usage of a truly representative clinical group is also of prime importance to satisfy issues of external validity, and generalisability of treatment results to other settings and patients. Individuals included in a study should have a diagnostically consistent psychopathology (Kazdin, 1995; Peterson & Bell-Dolan, 1995), be referred rather than

recruited, and be treated in a clinical rather than non-clinical setting, with treatment being of similar duration (Kazdin, Bass, Ayers & Rodgers, 1990). Explicit inclusion and exclusion criteria are also necessary (Barnett et al, 1991). Until recently, inclusion and exclusion criteria were rarely comparable across studies because of the complexities involved in definition of psychiatric disorders in children. The latter situation has improved considerably since the subdivision of child psychiatric syndromes in the ICD-9 manual (World Health Organisation, 1978), and the DSM-III (American Psychiatric Association, 1980) (Target & Fonagy, 1996). It is also important for representativeness that the outcome study retain all clinical subjects for the entire trial, as the subjects remaining after considerable attrition may not accurately represent the population under study.

#### 2.1.1.3 Dealing with issues of co-morbidity

Complexities of diagnosis very evident in child and adolescent populations, are exacerbated by comorbidity. Kazdin (1995) reported that the presence of concurrent conditions is as high as 50% in community samples of childhood and adolescence disorders. Moreover, in clinical practice, a recently published Audit Commission in the United Kingdom found that 95% of more than 17,000 children whose attendances were studied had more than one diagnosis (Audit Commission, 1999, as cited in Graham, 2000). More specifically, children diagnosed with attention deficit hyperactivity disorder, up to 50% also have a conduct disorder, and 20 to 25% a specific learning disability (Barkley, 1996). Rates of comorbidity between other disorders, such as anxiety and depression have also been note to be high (Brady & Kendall, 1992). Caron and Rutter (1991) suggested shared risk factors, assortative mating, and the possibility that one disorder represents an earlier form of, or predisposes the child to a second disorder, as possible explanations for the high rates of comorbidity.

In the main, the issue of comoribity has not been addressed in psychotherapy treatment outcome research (Achenbach, 1995; Graham, 2000; Kazdin, 1995). The importance of addressing the issue of comorbidity is underscored in that children presenting with concurrent disorders show different developmental pathways as well as differential responses to a variety of treatments (Kendall et al., 1992, cited in



Target & Fonagy, 1996). This is, however, a complex area with many possible patterns, clearly requiring considerable empirical investigation.

As Mash and Krahn (2000) observed, comorbidity has direct implications for the selection of research participants and in the interpretations of results. Research samples from a clinic population are likely to have a disproportionately high rate of comorbidity, as referral for treatment is likely to be based on combined symptomatology for all disorders. To date, in some studies, children with additional diagnoses have been excluded. Whilst this may clarify the focus of any particular study, it also makes it much less clinically useful (Kazdin, 1990; Mash & Krahn). In other studies, the principal diagnosis of the child is used in selection for treatment, and the results are interpreted without regard to other coexisting disorders. As Target and Fonagy (1996) explained, this could obscure interpretation of treatment efficacy.

It has been suggested that in looking at outcome, the proportion of children with various types of comorbidity should be noted, and studies looking at children selected for lack of comorbidity (unrepresentative samples) should be treated with caution (Target & Fonagy, 1996). Research strategies that compare children showing single disorders with those showing comorbid disorders are indicated, to aid in disentangling the effects of comorbidity (Mash & Krahn, 2000).

#### 2.1.1.4 Dealing with the natural history of disorders

A further consideration in the assessment of treatment outcome is the natural history of disorders, in particular changing symptom patterns over the course of development. For children, follow-up after termination of treatment is of considerable importance, as there is evidence that treatment outcome varies considerably depending on the length of follow-up (Target & Fonagy, 1996). Kazdin (1990) noted that treatments that appeared effective or differentially effective in the short term might not actually surpass the impact of developmental changes. For example, girls who show disruptive behaviour before puberty may become anxious or depressed in adolescence, whereas boys show the reverse trend (Moffitt, Caspi, Dickson, Silva, & Stanton, 1996; White, Moffitt, Earls, Robins, & Silva, 1990).

It is essential to know about the context in which symptoms develop and the ways in which a young person's life may be influenced by both their difficulties as well as by clinical interventions. Open-ended qualitative interviews are likely to be an effective means of securing this type of information (Barnes et al., 1999) which can then be factored into the 'interpretation' of results.

#### 2.1.1.5 Obtaining sufficient sample size and sample attrition

A sufficient sample size including cell size must also be provided. As Mash and Krahn (2000) stated, small sample sizes reduce the likelihood that significant effects will be found, preclude multifactorial analysis of the results, and limit the generalisability of the findings. Of note, historically, very few child treatment outcome studies have begun with sufficient numbers of subjects to detect small effects in a traditional pretreatment-posttreatment design (Kazdin, 1995).

Providing an adequate sample size can be further challenged in the context of sample attrition. Sample attrition or drop out is a major problem in child psychopathology research, particularly in longitudinal studies of high-risk populations. As Mash and Krahn (2000) commented, attrition is not a randomly distributed event, because families who drop out of a research study are more likely to have characteristics such as multiple problems, low socio-economic status and single-parent status, when compared to those that remain in the study. Sample attrition results in reduced sample size, unequal group sizes, and once more difficulties in generalising because of a lack of sample representativeness.

This is a further issue remaining to be addressed.

#### 2.1.1.6 Attaining a detailed specification of the therapy

A detailed specification of the therapy undertaken is essential (Barnett et al., 1991) to be able to identify the treatment provided, to enable study replication, and to then make use of the results in practice and programme planning. As Kazdin (2003) has observed, the more recent use of treatment manuals in psychotherapeutic practice has aided the methodological rigour in outcome evaluation research. However, clear

difficulties do present in attempting to comprehensively manualise multi-modal therapy applied to complex, multi-layered presenting difficulties.

Nevertheless, in reviewing child inpatient treatment, in the context of 'less exclusively milieu-based therapy and more a tapestry of therapies' Epstein (2004, p.425) has called for a return to the more detailed description of the residential milieu to assist in discerning the therapeutic underpinnings of treatment.

#### 2.1.1.7 Ensuring pre-treatment, post-treatment and follow-up data

Close attention must also be given to pre-treatment, post-treatment and follow-up data in treatment outcome research design. Pre-treatment data provide baseline information in the case of single subject design and assist in demonstrating group equivalency (Peterson & Bell-Dolan, 1995) and the type and severity of problems under investigation (Durlak, Wells, Cotton, & Johnson, 1995). Post-treatment data are critical in determining the treatment effect which, depending on the complexity of the aims and process of the given intervention, may be immediate, interim and ultimate (Peterson & Bell-Dolan). This is of particular relevance in the case of multi-problem families, where the presenting concerns are often chronic and resistant to treatment in the past. In such cases, the ongoing effects of management and the wider issues of adjustment would be seen as more appropriate outcomes to measure, rather than outcomes of cure.

Finally, follow-up data is needed to provide evidence of maintenance of treatment effects, but can be difficult to establish. If effects fail to be maintained, the treatment may be viewed as unsuccessful even if immediate effects were promising (Peterson & Bell-Dolan, 1995). As Leichtmen and Leichtmen (2001a) observed, improvements made in treatment are often not sustained in the post discharge environment, and discharge status does not necessarily predict subsequent adjustment. For instance, a child-focussed treatment may succeed in altering the child's behaviour in the short term but the influence of adverse family, school, or peer group interactions may not have been adequately addressed in the treatment. Long-term follow-up can also be difficult to interpret due to the likelihood of further therapeutic input (Fonagy et al., 2002), or outcomes can be compromised due to lack of attention given to the importance of

transition from the inpatient setting back into the community (Cafferty & Leichtmen, 2001; Leichtmen, 2001; Leichtmen & Leichtmen, 2001b).

#### 2.1.1.8 The need for valid and wide-ranging measurement

Measurement is a further challenging issue in treatment outcome research design, with specific difficulties in assessing child psychotherapy outcome requiring attention. In all, attaining validity in this area has been notably difficult.

##### 2.1.1.8.1 Measurement instruments

Measures of childhood adjustment and symptomatology are less developed than they are for adults. It remains a difficulty partly because of the complexity of the interaction between development and psychopathology in childhood, such that the impact of psychological disorder often involves cognitive as well as socio-emotional capacities (Target & Fonagy, 1996). While for many years, most of the available measures were of symptomatic outcome, and were too few in number and insufficiently well standardised for children differing in age, gender, and socioeconomic background (Target & Fonagy), as Curry (2004) most recently observed, a range of assessment methods that are widely accepted and easily administered have become more available for use in child inpatient research.

##### 2.1.1.8.2 Use of multiple domains of functioning

It has been argued that the impact of psychotherapeutic intervention should not be studied simply in terms of the child's symptomatology, but in terms of the impact of that symptomatology on normal developmental processes, at critical phases of the child's psychological, social and educational development (Target & Fonagy, 1996). As Kazdin and Wassell (2000) suggested, there are potentially much broader effects of treatment, and these arguably may be as important as the changes achieved in the child. These also may have significant preventative value in the later psychological development of the child.

In addition, Kazdin and Wassell (2000) commented, demonstrations that there are reliable improvements in child, parent and family functioning over the course of treatment in parent and family domains have broad implications. First, the changes in the parent and family (for example in depression, stress, or relationship quality) reflect domains that often serve as targets of treatment for adults. Consequently, the changes effected with child therapy are clinically relevant for the parents.

Kazdin (2003) proposed a number of outcome criteria for evaluating treatment effectiveness, covering child functioning, parent and family functioning, and measures of social impact. Child functioning included symptomatology, impairment, prosocial competence, and academic functioning. Parent and family functioning incorporated dysfunction, contextual issues such as stress and quality of life, and conditions that promote adaptation such as family relations and organisation. Finally, criteria described as social impact measures related to systems such as school activities, attendance and truancy, and service usage, such as reduction in special services and hospitalisations (Kazdin). In the past, other authors have incorporated aspects of Kazdin's recent outcome criteria, but also include a specific consumer perspective as noted in client satisfaction feedback (Jensen, Hoagwood, & Petti, 1996; Jones, 1991).

#### 2.1.1.8.3 Delineating mechanisms of therapeutic change

As Kazdin and Nock (2003) highlighted, the study of specific mechanisms of therapeutic change should help understand how psychotherapy works, and thus serve to ensure that critical features of therapy are emphasised in clinical practice. To date, researchers have paid scant attention to processes involved in therapy that account for or contribute to therapeutic change (Kazdin, 2000). Within research design, several questions need to be actively explored. What processes or characteristics within the child, parent or family can be mobilised to foster therapeutic change? What events, processes, activities, and tasks in treatment can foster therapeutic change? Further, like a number of commentators, Frank and Frank (1991) drew attention to the role and importance of non-specific (or common) psychotherapeutic factors, which they identified as the intensive relationship between a patient and a therapist, the expectation of the patient to be cured, the ritual of the therapy, and the presentation of

a clear rationale with which the problems of the patient can be explained, as powerful vehicles for change in psychological therapies.

According to Kazdin (2000), ideas for evaluating the basis of therapeutic change can come from a range of sources, such as various learning models, information processing, or views of social cognition. Research on mechanisms of therapeutic change may help to bring order to the hundreds of treatments currently in use by delineating a much smaller set of mechanisms through which these treatments operate. However, there is not likely to be a single mechanism for a technique, and two children in the same treatment conceivably could respond for different reasons (Kazdin & Nock, 2003).

#### 2.1.1.8.4 Use of multiple informants

Given that clinical problems are multifaceted and a child's functioning in various domains of his or her life may be seen to be differentially influenced by treatment, multimodal measurement of treatment outcome is seen to be essential (Kazdin, 1993; Peterson & Bell-Dolan, 1995). The use of multiple informants (parent, teacher, child, clinician, and peers) providing parallel information is therefore viewed as desirable. Indeed, a recent study highlighted this point, finding the aggregated assessments from three informants (clinicians, parents and teachers) provided a comprehensive view of the child's psychopathology that could be used to predict measures of poor outcome after three years (Ferdinand, Hoogerheide, van der Ende, Visser, Koot, Kasius, & Verhulst, 2003).

Of note, however, the generally low rate of agreement among informants regarding a child's symptomatology or adaptation (Fonagy et al., 2002) does present as a practical consideration. Different informants with different relations to the child, and who see the child in different contexts, often view the presence and severity of emotional and behavioural difficulties quite differently (Achenbach, McConaughy, & Howell, 1987). For instance, Achenbach (1995) found that teachers, mothers and fathers shared little more than 10% of variance regarding the child's internalising symptoms.

Moreover, literature searches revealed a notable paucity of information comparing clinician and parent (Garcia, Joseph, Turk, & Basu, 2002; Rey, Plapp, & Simpson, 1999) and parent and child (Chesson, Harding, Hart, & O'Loughlin, 1997) perceptions of child outcomes. In addition, children's views regarding their own treatment has rarely been researched and little is known about children's understanding of mental health (Chesson et al.). As information from each of these sources is relevant to the assessment of referral problems and estimation of change during treatment, the overall outcome of therapy clearly demands a multi-faceted approach (Target & Fonagy, 1996), that so far has been difficult to achieve.

#### 2.1.1.8.5 Measurement bias

Finally, the issue of measurement bias also needs to be addressed. Researchers intent on proving the superiority of a given treatment may unwittingly bias the results (Fonagy & Target, 1996), whilst observers who are aware of the hypotheses under investigation can also influence the outcome (Peterson & Bell-Dolan, 1995).

#### 2.1.1.9 Summary regarding methodological issues and criteria for valid research in child psychiatry

As suggested by Fonagy et al. (2002), child mental health outcomes cannot be considered in absolute terms and the issues of outcome measurement are indeed complex. Barnes et al. (1999) observed that the complexity of children's lives requires imaginative approaches to research. Whilst it is generally agreed that the methodological challenges outlined above must be addressed, it is recognised that they place considerable constraints on outcome research. It has therefore been proposed that principles underlying these challenges be seen as representing a continuum of application (Goldfried & Wolfe, 1996; Peterson & Bell-Dolan, 1995).

Researchers and clinicians need to be able to draw from a range of different types of evaluation to make judgments and provisional conclusions regarding treatment. Whilst RCTs of treatment of specific disorders would be helpful if they could indeed be implemented, if the full picture is to be revealed, other research strategies are required (Barnes et al., 1999). The use of qualitative methods of enquiry, both in

situations where controlled trials are unlikely to be feasible, and as adjuncts to quantitative methods, should be considered seriously (Graham, 2000). This may assist in meeting the needs of research as well as the clinical domain (Goldfried & Wolfe, 1996; Peterson & Bell-Dolan, 1995), and provide a richness of contextual information which is unavailable from quantitative research alone.

### 2.1.2 The potential role and scope of qualitative methodology

Qualitative methods, both in data collection and data analysis, while not directly addressing the methodological difficulties discussed in Section 2.1.1 above, allow researchers to circumvent some of the practical impasses invited by RCTs in mental health treatment outcome research. They permit the researcher to ask and attempt to answer more complex questions, without needing to assume and claim research conditions that are difficult to meet. They can also be used to complement quantitative methods which may have limitations, in such a way that those limitations may be better taken into account in the overall interpretative findings.

Qualitative research, traditionally used in the fields of anthropology and sociology, and increasingly used in psychological and other health care settings, emphasises developing an understanding of the context of a phenomenon and its meaning to the persons being studied (Krahn, Hohn, & Kime, 1995). As Barker, Pistrang and Elliot (2002) further elucidated, qualitative research uses language as its raw material, and aims to study people's thoughts, experiences, feelings, or use of language in-depth and detail. The main advantage of qualitative data collection methods is that they allow a rich description of lived experience. According to Ertmer (1997), a range of data collection techniques including in-depth interviewing, participant observation, and written accounts of experience, can be utilised. The usual forms of qualitative data analysis entail content analysis of the resulting textual recordings of the data.

In in-depth interviewing, the researcher may talk with an individual, or members of a family or a group, over a period of several hours, days or years. The purpose of the interview is to gain a detailed understanding of each individual's perspective and capture the 'insider's' view of the situation (Bartunek & Louis, 1996). An example is provided by Cohen (1995), who through in-depth interviews with parents of children



with life-threatening, chronic illness, developed a theory about the process of parents' coping with sustained uncertainty.

Participant observation involves the researcher's immersion in the field of study. Participant observation is typically conceived of as existing along a continuum, with the role of 'complete observer' at one end, and the role of 'complete participant' at the other end (Ertmer, 1997). Classic historical examples of participant observation methodology in mental health research, albeit conducted by sociologists, were employed in Goffman's (1961) 'Asylums', and Rosenhan's (1973) 'On being sane in insane places' studies.

The ensuing textual analysis of transcripts of interviews and participant observations, as well as of archival data, can involve the identification of recurring themes in the content of the data (Fiese & Bickman, 1998). For example, Tannen and Wallerstein (1987) analysed video-taped and transcribed interactions between a parent and a paediatrician during the medical examination of an 8-year-old child with cerebral palsy. The analysis sought to describe how mismatches in the expectations and cognitive schemas of parents and paediatricians can decrease the efficiency of paediatric examinations and fail to alleviate parental concern.

Written or archival data may take the form of personal documents, such as letters, diaries or journals, and official documents including client, student or personnel files, and internal and external communications of an organisation (Ertmer, 1997). For example, Cohen (1995) utilised published autobiographies of parents' experiences with children with chronic illnesses to validate the findings derived from interviews with parents.

### 2.1.3 Overview of qualitative research frameworks

Ertmer (1997) distinguished four main qualitative approaches in research. Each framework may have applicability to the child and adolescent mental health area. These frameworks are case study, ethnography, phenomenology and grounded theory. Each may involve one or more aspects of the techniques outlined in Section 2.1.2

above. Therefore, while each displays a distinct combination of features, numerous overlaps are apparent (Ertmer).

#### 2.1.3.1 A case study framework

In a case study qualitative research design, the researcher ‘explores a single entity or phenomenon (‘the case’) bounded by time and activity (a programme, event, process, institution, or social group) and collects detailed information by using a variety of data collection procedures during a sustained time period’ (Creswell, 1994, p.12). In psychological research, methods of data collection can include interactive fieldwork, formal and informal interviews, as well as possible use of quantitative measures. Methods of data analysis centre on interpretational search for themes, structural search for patterns of discourse, and reflective portrayal of participants’ views. The form of the final report of a case study is that of a rich, descriptive narrative that attempts to reconstruct the participants’ lived reality. This may take the form of either an analytic (objective) narrative or a reflective (literary) narrative (Ertmer, 1997). Breuer and Freud’s (1895/1955) first case studies, along with Watson and Rayner’s (1920) study of Little Albert, provide very early examples of the usage of case study research design in the psychological arena.

#### 2.1.3.2 An ethnographic framework

Ethnography is defined as a type of qualitative inquiry in which ‘the researcher studies an intact cultural group in a natural setting during a prolonged period of time by collecting, primarily, observational data’ (Creswell, 1994, p.11). Ethnography was originally developed by anthropologists, but is now used by researchers in other disciplines, including psychology, sociology and education (Ertmer, 1997). It is distinguished from other forms of qualitative research by its focus on discovering cultural patterns in human behaviour, describing the perspective of members of the culture, and studying the natural settings in which the relevant culture is manifested (Gall, Borg, & Gall, 1996). Ethnography employs a unique set of data collection strategies, including participant observation, structured and less structured interviews with ‘informants’, and artifact collection, which may include personal or official documents. Methods of data analysis include structured indexing and coding of

events and experience recorded, and the use of constant comparative analysis. The findings of ethnographic studies are communicated through wholistic descriptions of everyday events, assertions, and analytical vignettes (Ertmer).

#### 2.1.3.3 A phenomenological framework

As Ertmer (1997) observed, phenomenological research design may be defined as a methodology that attempts to understand participants' perspectives and views of social realities. In phenomenological research, the investigator attempts to understand what a specific experience is like by describing it as it is found in concrete situations, and as it appears to the people who are living it. The phenomenon experienced and studied may be an event, a relationship, an emotion, or even a programme. Phenomenological data collection uses in-depth interviewing almost exclusively, and can involve purposeful sampling of 5-10 individuals. In contrast to the ethnographic interview, the phenomenological interview is not structured as a series of questions and answers, but rather presents more as a dialogue or conversation (Ertmer). The researcher and the participants work together to 'arrive at the heart of the matter' (Tesch, 1994, p.147). Moreover, phenomenological analysis of transcribed data focuses on 'meaning units', describing themes and patterns in the data, rather than focusing on 'events' and identifying categories. The data analysis adopts an open, tentative and intuitive approach. Phenomenological findings are typically reported in the form of a narrative that describes a theme or a pattern (Ertmer).

#### 2.1.3.4 A grounded theory framework

Grounded theory, developed by the sociologists Glaser and Strauss (1967), is probably the most common form of qualitative analysis currently in use (Barker et al., 2002). In grounded theory, the researcher 'attempts to derive a theory by using multiple stages of data collection and the refinement and interrelationships of categories of information' (Creswell, 1994, p.12). The term 'grounded theory' refers both to a method – a set of systematic procedures for analysing data – and also to the outcome of the analysis, which is theory 'grounded' in the data (Barker et al.). The theory is 'grounded' in that it is developed from the data, as opposed to being suggested by past literature. In this way, theory is an expected outcome from, rather

than a starting point for, the study. Grounded theorists start with broad research questions that provide the freedom and flexibility to explore a phenomenon in depth. The research questions identify the general focus for the study and tend to be action and process oriented. Grounded theorists typically draw from historical records, interviewing, and observational strategies to collect their data, generally utilising more than one source to maximise similarities and differences among the information obtained (Ertmer, 1997). Data analysis in a grounded theory approach is concept oriented, can adopt coding that is open, axial, and selective, as well as utilise constant comparative methodology. Findings are generally communicated through an analytic story (Ertmer). A grounded theory example is Charmaz's (1991) account of chronic illness experience. A theory was constructed from the data drawn from in-depth interviews, in relation to how the person's experience of time changes, and how this impacts on the sense of self.

#### 2.1.4 Complementing quantitative methodology with qualitative methodology

By using both qualitative and quantitative methods in pursuing a research question, researchers can maximise the strengths of each, while providing a mutually defined context for interpreting their results (Krahn et al., 1995). Qualitative approaches, with their potentially broad scope, are flexible and can scan a wide range of content areas that may have implications for understanding psychological phenomena. Quantitative approaches, requiring larger samples and precise measurement, can provide focussed and more generalisable findings. Both can inform child and adolescent mental health research, and when used together appropriately, the combination can facilitate the development of context-sensitive perspectives into the experience of children and their families.

Graham (2000) suggested that quantitative work could be more productive if it were more frequently preceded and inspired by good qualitative studies. For example, Skuse, Bentovim and Hodges (1998, cited in Graham, 2000), in a quantitative study identified family violence as an important predictor of later perpetrating behaviour in sexually abused boys. They were helped to formulate their hypotheses by systemically conducted qualitative assessments carried out by psychoanalytic psychotherapists. Qualitative work may also be used to help clarify areas where there

has been a substantial amount of controversy, for example in considering what are reasonable and unreasonable expectations of the effectiveness of child psychiatric services. As Graham proposed, exploration of the latter issue using qualitative methods with managers, mental health professionals and those working with other agencies (such as protective services and education), could be beneficial in reducing the dissonance and in assisting to make expectations more realistic. As Smith (1999, cited in Graham) noted, the best child and adolescent mental health service ‘...will not be the one that provides everything for everybody, but rather one that determines how much it wants to spend on such services, and then provides explicitly limited evidence services in a humane and open way without asking the impossible of its staff’ (Graham, p.417).

The inclusion of qualitative measures in all kinds of medical and other health research has been promoted as a way to close the gap between the sciences of discovery and implementation (Fitzpatrick & Boulton, 1994; Jones, 1995; Logan, 1997). It has been suggested that they are particularly appropriate for children and families, who can be treated as partners in evaluation (Ireland & Hollway, 1996; Weiss & Greene, 1992). Open ended methods, such as semi-structured individual interviews or focus groups, allow families to raise questions that might not otherwise have been contemplated, and should facilitate the discourse of answering those questions (Barnes et al., 1999).

Quantitative information, such as symptom levels, may need to be interpreted in the context of qualitative comments to understand discrepancies between informant views (Barnes et al., 1999). Therefore, it is suggested that in conjunction with quantitative research, the qualitative experiences of children and families, and of those providing a treatment or service, need to be examined. A creative mix of measures with an approach that incorporates the strengths of child, family and clinician perspectives could lessen the tension between internal and external validity. In this way, clinical practice and policy can be developed in a manner that takes account of the multiple and varied influences on children’s health and development (Barnes et al.).

Further, it has been suggested by Barnes et al. (1999) that in evaluation studies, the sharp distinction between audit and evaluation needs to be lessened. This would enable evaluation to be used constructively in a dynamic process of contributing to the

development of new services, and the refinement of existing ones, and to allow clinicians the opportunity to participate in the collection, documentation and utilisation of evidence, based on their own clinical practice.

#### 2.1.5 The child psychiatry inpatient unit as a context for outcome research

As Sourander and Leijala (2002) observed, and as outlined in Sections 1.2.2 and 1.2.8 of Chapter 1 above, whilst the importance of child psychiatric hospitalisation is noted, concerns regarding its usage have also been registered. Hospitalisation is the most expensive form of child psychiatric care, and inpatient management constitutes a sizeable proportion of child mental health expenditure. Given the potential benefits of, and concerns regarding, the use of child inpatient treatment, systems for the effective monitoring of hospital utilisation and follow-up of patients are needed.

Imrie and Green (1998) identified a number of different rationales linked to efficacy research in inpatient units. First, efficacy research can be undertaken to justify the existence of inpatient units by showing them to be effective. Secondly, it can be used to make a case for which additional resources are needed by inpatient units, to enable them to better meet clinical demands. Thirdly, efficacy research can highlight, through increased understanding of the inpatient care process, strengths and weaknesses in existing practice, so that services can be modified to become more effective.

##### 2.1.5.1 Methodological issues specific to child psychiatry inpatient research

In addition to the methodological challenges reviewed in Section 2.1.1 above, a number of significant difficulties encountered in conducting research in child psychiatry inpatient units have been documented. First, as discussed in Section 2.1.1.1., is the ethical objection to randomly assigning seriously disturbed children referred to an inpatient service to a no treatment control group or a comparison outpatient programme that has not been effective in the past (Sheerin, Maguire, & Robinson, 1999). As Epstein (2004) explains, it is unethical to deny a child in need of inpatient treatment a place due to research purposes, in the absence of adequate alternative treatment.

Secondly, as noted by Green and Jacobs (1998c), given the comparatively low incidence of major psychiatric disturbance within this age range, research strategies used in adult services, which involve greater numbers (throughput) of cases, are not applicable. Thirdly, the low throughput of patients in child psychiatric unit, means a slow accumulation of any series of patients, and consequently a small overall sample size. Fourthly, cases are typically heterogeneous displaying multiple comorbidity. Therefore, it is not possible to recruit samples manifesting a few isolated variables. In turn, this then leads to the need for a larger group to study (Green & Jacobs, 1998c). Fifthly, the inpatient unit culture is not necessarily stable, but, rather fluctuates and changes progressively over time (Green & Jacobs, 1998b; Shaw, 1998). Finally, as Sheerin et al. (1999) noted, each inpatient unit has 'its own unique admixture of history, philosophy of care, staff attitudes and perceptions, skills and training and will be situated within a wider organisational and ecological context' (p.97), and as such generalisation of findings from one inpatient setting to another cannot easily be made.

#### 2.1.5.2 Practical issues specific to child psychiatry inpatient research

In addition to the clear methodological issues affecting validity of research, certain practical issues in child psychiatry inpatient research have an initial influence on implementation. The inpatient unit is a dynamic structure around its own maintenance, with the clinical care of a very difficult caseload. To bring a research dimension into this balance can lead to a conflict of priorities and extra workload for staff (Green & Jacobs, 1998c). In addition, clinical staff can perceive research, especially efficacy research, as potentially threatening to their self confidence and unit culture, in an area where therapeutic change can be seen as slow and uncertain at the best of times. Given that efficacy research should implicitly lead to possible change in clinical practice, some unit cultures, biased to preserve sameness or at least some stability, may resist cooperation (Riddle, 1989).

Furthermore, inpatient units typically do not have enough resources, in terms of finances and personnel when engaging in evaluation research (Epstein, 2004). For instance, Green and Jacobs (1998c) described an attempt to mount a comparison of inpatient and outpatient treatment for six- to nine-year-old boys with severe mixed

disorders of conduct and emotion. Despite careful planning and the use of experienced clinicians, a number of difficulties arose. It was concluded that such research cannot be undertaken without substantial research funding, not only for the gathering of systematic data, but also for the payment of the additional clinical time necessary for such structured delivery of treatment.

In summary, these methodological and practical challenges linked to inpatient child psychiatry research may be seen to have contributed to the paucity of empirically sound outcome evaluation research conducted to date, the subject of Section 2.2 below.

## 2.2 Child psychiatry inpatient outcome research: Empirical findings

Not surprisingly, given the discussion above, while child and adolescent outpatient research has made some progress in the identification of evidence-based treatments (Kazdin, 2003; Kazdin & Wassell, 2000; McClellan & Werry, 2003), child and adolescent inpatient treatment evaluation remains at a relatively early stage of development (Green, Kroll, Imrie, Frances, Begum, Harrison, & Anson, 2001). Reviews reveal that before 1990, outcome research on child inpatient treatment was beset by profound methodological shortcomings (Blotcky et al., 1984; Pfeiffer & Strzelecki, 1990). Since 1990, some improvement has occurred, although to date, only a small number of studies display aspects of the methodological rigour needed to direct treatment in an informed manner.

### 2.2.1 Quantitative individual child psychiatry inpatient outcome evaluation

#### 2.2.1.1 Evaluation studies reported prior to 1988

Older outcome studies of child inpatient psychiatric treatment varied markedly in both scope and systematic methodology (Cornsweet, 1990). Blotcky et al. (1984), Pfeiffer (1989), and Curry (1991) have all commented critically on their methodological limitations. Only a few studies involved a comparison group, measures were often idiosyncratic to a given study, and little or no data regarding reliability and validity of measures were provided. Most studies were retrospective, relying on chart material



and follow-up of former patients. High rates of attrition were commonplace, and limited systematic information regarding diagnoses, symptoms or demographics was provided. Clinical settings varied widely and descriptions in reference to the patient population and treatment strategy were notably scarce. Moreover, few studies had a recognisable research design. Whilst most studies included some correlational analysis to try to identify predictors of outcome, at times these were confounded.

Pfeiffer and Strzelecki (1990) provided a review and meta-analysis of 34 child and adolescent psychiatry inpatient and residential outcome studies published between 1975 and 1987. From their analysis, it was concluded that inpatient treatment of children and adolescents is often likely to be beneficial, particularly if certain aspects of treatment are included. These were a good therapeutic alliance, treatment with a cognitive-based problem-solving skills training package, completion of the treatment programme, planned discharge, and availability of aftercare services. Aftercare was important to ensure the transfer and generalisation of treatment gains to the child's environment.

A further finding from Pfeiffer and Strzelecki's (1990) analysis was that children and adolescents displaying psychotic, aggressive, or acting out symptoms, or having psychosexual problems, or organicity indicated by CNS dysfunction, responded less favourably to inpatient psychiatric intervention. The review also revealed a relationship between different aspects of family functioning (level of family functioning, degree of marital conflict, frequency of separations or interrupted relationships with parents during early childhood, parental involvement with treatment) and the response to inpatient psychiatric treatment. Length of stay yielded only a modest relationship to patient outcome. Intelligence yielded a modestly strong positive relationship to outcome.

While Pfeiffer and Strzelecki's (1990) analysis has been considered to be one of the most useful in the field (Imrie & Green, 1998), by the authors own admission, held inherent limitations. These included the need to pool findings from child and adolescent studies from both inpatient and residential settings and covering varying lengths of follow-up (Pfeiffer & Strzelecki). Blotcky and Dimperio (1991) further underlined these concerns and drew attention also to the wide range of (and often non-

validated) outcome measures used in the studies. In addition, in the absence of referencing or explanation, concern was expressed in regarding the mathematical validity of the weighted predictive value used in the meta-analysis undertaken. Based on these concerns, Blotcky and Dimperio concluded that caution needed to be exercised in the interpretation of Pfeiffer and Strzelecki's findings, and called for more resources into developing and implementing more methodologically sound outcome evaluation projects.

A further child and adolescent inpatient unit efficacy review by Curry (1991), who drew on the results of a different set of studies than Pfeiffer and Strzelecki (1990), focussed primarily on methodological issues. Curry concluded that better outcomes were related to less severe psychopathology, average or above average IQ, reactive pattern of symptom onset, participation during hospitalisation, completing the goals of hospitalisation, and continuing therapy after discharge. These findings were viewed by Curry to be in agreement with those of Pfeiffer and Strzelecki. Whilst Curry also identified that a good proportion of inpatient children displayed improvements in functioning, functioning was seen to be variable during the immediate post-discharge period, such that improvement from admission to discharge did not necessarily predict adjustment at follow-up. Moreover, Curry also recognised the need for better planned future research and addressing methodological issues.

#### 2.2.1.2 Individual child psychiatry inpatient outcome evaluation studies reported between 1988 – 2003

Since the reviews by Pfeiffer and Strzelecki (1990) and Curry (1991), only a small number of inpatient child psychiatric treatment outcome studies have been reported in the literature. These are summarised in Table 3 on page 76, and are systematically reviewed below. The studies reviewed predominately focus on the 0-13 year age group. Only one group of studies (Sourander & Piha, 1996) includes an older population (4-15 years), but because the mean subject age (9.7 years) was noted to be comparable with that in the other studies, a decision regarding inclusion was made.

Table 3:

*Summary Table of Inpatient Child Psychiatry Quantitative Outcome Evaluation Studies Reported Between 1988 – 2003*

Researchers/s, Setting/s & Location	No. of Ss & Age Range	Length of Inpatient Stay	Evaluation Intervals	Respondents
<i>Kazdin &amp; Bass (1988)</i> 1 hospital Pittsburgh, USA	140 7-13 years (10.5 years)	1-4.5 months (2.6 months)	On admission At discharge Post discharge – 1 year	Parents Teachers Clinicians
<i>Ney et al. (1988)</i> 1 hospital Christchurch, New Zealand	112 0-12 years (n/a)	5 weeks	On admission Post follow-up – 1 year	Parents
<i>Gerardot et al. (1992)</i> 1 hospital Southeastern, USA	36 3-12 years (n/a)	56 days	On admission At discharge	Parents
<i>Kolko (1992)</i> 1 hospital Pennsylvania, USA	65 6-13 years (9.7 years)	3-101 days (49 days)	Post discharge - random assignment to 2, 4 or 6 Months	Parents Clinicians
<i>Sourander &amp; colleagues (1995; 1996; 1998; 2002)</i> 3 hospitals in Seinajoki, Satakunta & Turku Finland	46 4-15 years (9.7 years)	4-6 weeks	On admission At discharge Post discharge: - 5 months, 1 year & 3 years	Parents Teachers Clinicians
<i>Sheerin et al. (1999)</i> 1 hospital Drogheda, Ireland	26 3-13 years (8.7 years)	1-16 weeks (8 weeks)	On admission Post discharge – 3 & 15 Months	Parents Child
<i>Dickerson Mayes, Krecko et al. (2001)</i> 1 hospital Pennsylvania, USA	110 2-13 years (8.9 years)	4-80 days (14 days)	On admission At discharge Post discharge – 1 & 6 Months	Parents
<i>Gavidia-Payne et al. (2003)</i> 1 hospital Melbourne, Australia	29 0-12 years (9.3 years)	4-8 weeks	On admission At discharge Post Discharge– 4 months	Parents Teachers Referrers Child

Note: n/a: information not available

First, Kazdin and Bass (1988) conducted an outcome evaluation on 140 children, aged seven to thirteen years, admitted to a child inpatient psychiatric unit in Pittsburgh, United States of America. The children were admitted for acute disorders including highly aggressive and destructive behaviour, suicidal or homicidal ideation or behaviour, and deteriorating family relationships. The inpatient programme was short-term and designed for assessment and treatment. Primary forms of treatment included general routines of the ward (such as self-care activities, meals and class attendance), individual behavioural management programmes and medication. The length of stay ranged between one and four-and-one-half months (mean 2.6 months).

An evaluation of the children by the parents, teachers (community and hospital) and hospital care workers was conducted on admission, at discharge, and then again at one year follow-up. Parents completed the Achenbach Child Behaviour Checklist (CBCL) and teachers the School Behaviour Checklist (SBCL) at each time interval, while hospital care workers completed the CBCL on admission and at discharge. The study aimed to examine the relationship between parent, teacher and hospital staff evaluations of child functioning, and to evaluate the extent to which measures obtained on admission and at discharge could predict child adjustment at home and at school one year later (Kazdin & Bass, 1988).

Findings revealed that the parents and community teachers viewed the children, on admission and at discharge, to have significantly more difficulties, but to improve to a much greater extent over inpatient treatment, than did hospital staff (care workers and hospital teachers). These improvements, albeit still placing the majority of the children in the clinical range of functioning, were seen to be maintained by parents and community teachers at one year follow-up. Pre-treatment and post-treatment evaluations were found to reliably predict child functioning at home, and to a lesser extent, at school 12 months later (Kazdin & Bass, 1988).

The strengths of Kazdin and Bass's (1988) study centred on its prospective pre-post test design with a large sample size (N=140), multiple follow-up time intervals and use of multiple informants. In addition, the planned exploration of the relationship between different respondents, and whether predictions regarding future adjustment at home and at school could be made, were of clear merit. However, the study was

limited by being conducted in the one setting, only using checklist instruments, addressing child symptomatology alone, and by not exploring other domains of child functioning, as well as parent and family functioning. No control or comparison group was included in this study. Moreover, of note, the authors did not address the striking outcome, gleaned from summary table data, that the hospital staff (care workers and hospital teachers), based on their respective CBCL and SBCL evaluations, found little or no improvement from admission to discharge from the programme for the subject population. Clearly, such an outcome warrants discussion in its own right, rather than attention focussed predominately on the above noted favourable teacher and parent perceptions of outcome.

In the second relevant study, Ney, Adam, Hanton and Brindad (1988) conducted an outcome evaluation on 112 children (84% of an initial cohort of 133) aged up to twelve years old, who had been planned (as opposed to emergency) first admissions to a child inpatient unit in Christchurch, New Zealand, between 1983 and 1984. The sample included a wide range of presenting problems with a predominance of externalising disorders.

The programme was described as operating under a 'pragmatic philosophy' (Ney et al., 1988, p.793) which utilised varying combinations of up to 65 different therapeutic techniques, and included for each child, two weeks of pre-admission evaluations (made in the child's home and school where possible), five weeks hospitalisation (regardless of age, sex, diagnosis or severity of condition) and five weeks of follow-up. Prior to admission, child placement decisions were clarified, and the families were asked to commit themselves to being available for 12 hours each week. The parents attended weekly seminars, observed their child through one-way mirrors with the staff who taught them practical child management techniques, and were actively involved in working out guidelines for the discharge programme (Ney et al.).

Evaluation was conducted on admission, and then repeated 12 months after the follow-up period. Parents completed the Paterson-Quay Behaviour Problems Checklist, and questionnaires which assessed their functioning at the time admission, as well as their management and possible abuse of children. These measures provided (a) subjective evaluation, (b) checklist scores, and (c) counts of police, school,

community and the like involvement. Ney et al. (1988) concluded that the study revealed favourable outcomes to treatment of a wide range of child psychiatric conditions on the majority of indices used.

The main strengths of this study centred on the prospective, pre-post-test design, drawing on a large sample (N=112) with good subject retention (84% of the initial cohort), in a setting with clear programme planning incorporating the same length of stay parameters for all subjects, as well as detail regarding parent and family involvement throughout the inpatient phase. Such detail regarding the specification of therapy is of importance to assist in delineating mechanisms of change. The limitations of this study, however, are noted in the absence of a control or comparison group, the use of only one clinical setting and the notation that patients within this time structured programme could receive varying combinations of a range of 65 different therapies. These factors limit the generalisability of findings from this study to other settings.

Next, Gerardot, Thyer, Mabe and Poston (1992) evaluated the progress of 36 children aged from three to twelve years, who were admitted to a child psychiatric unit in the southeastern United States of America with a wide range of psychiatric disorders. The average length of stay was 56 days (range 25 to 85 days). The unit, staffed by a multidisciplinary team offered multi-modal treatment which included a milieu programme, individual psychotherapy, daily group work, daily school program, weekly family therapy and a weekly parents group. The children were evaluated by their parents on admission and at discharge, using the Achenbach Child Behaviour Checklist (CBCL). The CBCL Summary Problem Scales (Total, Internalising and Externalising) mean scores on this instrument were observed to fall highly significantly from admission to discharge.

While Gerardot et al.'s (1992) study was set in a prospective, pre-post test research design and used the standardised CBCL instrument for evaluation, a number of limitations regarding the study were noted. First, no control or comparison group was used. Secondly, only one outcome measure addressing part of one domain of functioning (child symptomatology) was drawn from only one informant. The multi-dimensional nature of outcome was not incorporated into this study. Moreover, the

low rate of subject retention (28% from the initial cohort) and resultant small sample size (N=36) drawn from the one clinical setting, further limits the generalisability of findings.

In the fourth study examined, Kolko (1992) evaluated the short-term outcome of 65 children, aged 6-13 years (mean 9.7 years) who were consecutively admitted to a child inpatient unit in Pennsylvania, United States of America. Children, with either internalising or externalising disorders were hospitalised for an average of 49 days (range 3 to 101 days). All children were exposed to a structured behaviourally oriented point system and group therapy, and occasional individualised medication regimes and family counselling. During the week of discharge the children were randomly assigned to one of three follow-up intervals (2, 4, or 6 months post discharge).

A range of measures were used in this evaluation. First, inpatient assessment measures were retrospectively drawn from chart reviews. These measures included demographic characteristics, child dysfunction (based on psychiatric and behavioural symptoms and problems related to abuse or neglect), marital or family dysfunction (addressing conflict, discipline, insularity and discontinuity of caretakers), and child and family treatment history (including before and during hospitalisation and recommended for aftercare). Second, at the designated follow-up period, parents were administered four complementary outcome assessment measures during a telephone interview. These included the Parent Daily Report and several in-house designed questionnaires addressing overall child improvement, child adjustment in critical roles or domains (involvement in child, parent and/or family aftercare services, school adjustment, peer or social adjustment, leisure activities, home relationships, parental discipline, and legal involvement) and parents' overall impressions regarding satisfaction with the service (Kolko, 1992).

Findings drawn from parents' follow-up reports, indicated that most children showed some significant change. A multivariate analysis using diagnostic and therapeutic variables revealed that attention deficit hyperactivity disorder, older age at admission, depression, neurologic or psychotic symptoms, limited involvement in aftercare, a history of physical abuse, and low intelligence predicted poor short-term outcome. A

favourable outcome was predicted by the relative absence of antisocial and disruptive behaviours. Length of stay and follow-up intervals were not related to outcome (Kolko, 1992).

The main strength of Kolko's (1992) study lay in the attempt, based on previous outcome research reviewed by Pfeiffer and Strzlecki (1990), to incorporate a range of variables potentially linked to outcome in the study. Moreover, the inclusion of a child adjustment scale, albeit non-standardised, was an important addition to the usual singular focus on child symptomatology as the treatment outcome measure. Similarly, the use of a consumer (parent) satisfaction measure also held merit. However, a number of methodological limitations were also noted in Kolko's study. These included the absence of a control or comparison group external to the programme, the lack of baseline on admission data that could be directly compared with the designated follow-up periods, the use of mostly non-standardised measures composed for two or three point scales, and the wide range in the length of stay (3-101 days) for subjects. While it appeared that Kolko had an extensive range of in-house inpatient information on which to draw for this evaluation, the failure to integrate this into a more methodologically sound research design has undermined his attempt to provide a comparison of varying lengths of follow-up and to delineate variables that predicted outcome.

Fifthly, in Finland, Sourander and colleagues (Sourander, Heikkila, et al., 1995; Sourander & Piha, 1996) conducted a comprehensive, multi-centre, prospective, follow-up evaluation study of three short-term (4-6 weeks) family-oriented child psychiatry inpatient programmes. The three child psychiatric hospitals were involved, and in each the treatment philosophy entailed psychodynamic understanding of the child's development, behavioural approaches to manage disruptive behaviour, and an overall family oriented approach. The principal treatment modes of each facility included milieu therapy and dyadic nurse relationship. In all cases, parental guidance or family therapy were used, and for a limited number of cases individual psychotherapy and psychoactive medication were also employed.

The evaluation, using standardised instruments and multiple informants was conducted on admission, at discharge, and then at five months, one year and finally



three years post discharge. Parents completed the Rutter Parent Questionnaire (RA2), and Achenbach Child Behaviour Checklist (CBCL), teachers completed the Rutter Teacher Questionnaire (RB2), and Achenbach Teacher Report Form (TRF), and clinicians completed the Children's Global Assessment Scale (CGAS). Utilising DSM-III-R diagnoses, the children were categorised into antisocial, mixed behavioural disorder, pure emotional disorder and organic or pervasive developmental disorder. While the research project primarily focussed on outcome evaluation, predictors of outcome were also explored (Sourander, Heikkila et al., 1995; Sourander & Piha, 1996).

Findings from this study and detail regarding the treatment programmes from the three hospital settings, are presented in at least 12 articles authored by Sourander and varying colleagues between 1995-2002. Of note, none of these papers include a complete detailed analysis of all of the above stated outcome measures (CGAS, CBCL, TRF, RA2, RB2) across the five designated time intervals. Instead, the papers have addressed varying combinations of the outcome measures, which have not always represented the stated three hospital sites, and at times (accounting for subject attrition across follow-up intervals) have drawn upon varying size populations. In addition, as noted in one of three year evaluations, different subject inclusion/exclusion criteria were used. To aid clarity and avoid unnecessary repetition, presented below are the findings drawn from several of the more informative articles.

First, Sourander, Heikkila et al. (1995), drawing on an initial cohort of 70 children from the three child psychiatric units, documented admission to five months follow-up findings, based on parent-ratings on the CBCL (N=43) and RA2 (N=59), and teacher-ratings on the TRF (N=39) and RB2 (N=50). Both parents and teachers reported significant improvements with internalising and externalising behavioural symptoms and overall severity of dysfunction and adaptive functioning. It was found, that the treatment programmes had a greater impact on externalising than on internalising behaviour problems. Of note, however, it was found that 65% of the patients were functioning outside the normal range at the five month follow-up period. In the main, these findings are comparable to Kazdin and Bass's (1988) parent- and teacher-reported outcome findings for children in their inpatient setting.

Another paper (Sourander, Helenius, & Piha, 1995) covering the same five month follow-up period, reviewed parent and teacher cross-informant correlations based on RA2 and RB2 findings drawn from a subject sample of 74 patients from the three child psychiatric unit settings. Findings revealed that both parents and teachers similarly viewed changes in children's emotional and behavioural problems from on admission to five months follow-up. A low to moderate correlation was noted between the parent and teacher ratings on admission. Males had higher cross-informant correlations than females on all behaviour scores. In addition, the consistency between raters was higher for 6 to 10-year-olds compared to an older population.

Secondly, findings at one year follow-up (incorporating on admission, at discharge, and five and 12 months follow-up), presented by Sourander, Helenius, and Piha (1996), were based on the CGAS, the RA2 and RB2, a subject sample of 50, drawn from one of the three originally stated sites, Turku University Hospital. In relation to parent (RA2) and teacher (RB2) reports for the children, findings revealed a significant improvement in behaviour from on admission to five months post discharge (N=43). However, teacher reports from five to 12 months post discharge (N=34) displayed limited improvement. Data was not available from the parents for the 12 month follow-up period. In reference to the CGAS measure, significant positive changes were reported from on admission to discharge (N=47), and from admission to five months post discharge (N=43). While a continued improvement in functioning was observed from five months to 12 months post discharge (N=34), this did not reach statistical significance. In all, the CGAS rating on admission was found to be the strongest predictor of the child's functioning at follow-up. However, a large number of children continued to display an impairment in global functioning at follow-up. In reference to the different diagnostic groups, children with emotional disorders or disruptive behavioural problems (without severe antisocial tendencies) showed further improvement post discharge. In contrast, children with severe antisocial problems showed a decline in functioning after discharge.

Sourander and Piha (1998) reported on findings for the three year follow-up period drawing from on admission, five-month and three-year follow-up data based on each of the five outcome measures (CGAS, CBCL, TRF, RA2, & RB2) utilised in the

original study. The findings for this initial cohort of 80 subjects, drawn from the three child psychiatric units, revealed that the majority of patients improved in functioning over the three year period. A significant improvement in functioning was observed between the five-month and three year follow-up periods, although the findings were less significant than during the first follow-up period. However, while improvement was noted, at the three-year follow-up period nearly 25% of children remained within the clinical range of functioning at both home and at school, with less than 50% functioning within the normal range. Pure anxiety or affective disorders were associated with a favourable outcome. A less favourable outcome was predicted by disruptive behavioural disorder, severity of initial dysfunction, high antisocial and hyperkinetic symptoms, adoptive household and post-discharge institutional care.

Another three-year follow-up review of this project, which drew on a more select population (excluding patients who had been admitted for long-term hospital treatment) was conducted by Sourander and Leijala (2002). The findings from this cohort (N=46) revealed, once more, that while the majority of the children improved in functioning over the course of the three-years, they also continued to display a high level of symptoms at follow-up. In addition, the children with conduct problems had the highest stability and predicted the poorest outcome. Moreover, the 3-year stability of parent, teacher and clinical ratings of the child was very high.

Several studies from this research group reviewed predictors of outcome. First, Sourander, Helenius, Leijala, Heikkila, Bergroth and Piha (1996) explored child, family and treatment variables that may predict the child's normal functioning at follow-up, and to identify variables predicting improvement in total behaviour problems. Data was drawn from the three child psychiatric unit settings, based on RA2 (N=59) reports on admission and five months post discharge. Findings revealed that a child's more frequent individual behaviour problems, antisocial behaviour and disengaged family interaction on admission predicted both functioning outside the normal range and less improvement at five months follow-up. Previous treatment due to developmental or behavioural problems and hyperkinetic symptoms on admission also predicted functioning outside the normal range. Parent's previous psychiatric hospital treatment was negatively associated with improvement. Pure emotional disorder predicted normal range of functioning at follow-up. Finally, the child's age,

gender, place of treatment, and length of stay were not related to outcome. Second, Sourander, Leijala et al. (1996) using place of residence as a one year outcome measure, it was found that children's antisocial behaviour on admission was the strongest predictor of long-term treatment or placement at follow-up.

A number of strengths and limitations are noted in reference to this Finnish research. Overall, this research demonstrated outcome evaluation strengths in the prospective, pre-post test design, the use of multiple informants and multiple outcome measures. Further strengths included the longer term follow-up, and the study sample comprising in most of the reviews subjects from three hospital units, which increases the generalisability of findings. Limitations centre on the absence of a control or comparison group and the predominant use of questionnaires. Also, as noted above, none of the 12 papers produced by Sourander and colleagues provided a complete review of the five outcome measures used across the designated time intervals. In addition, no discharge RA2 or RB2 data, nor 12-month follow-up RA2 data, was available. Instead, the papers addressed varying combinations of the outcome measures and at times used varying size populations (making it difficult to gauge subject attrition rates) and varying exclusion criteria. Finally, despite the systemic family-focus of the reported programmes, the outcome measures centred on the child domain of functioning, to the exclusion of parent and family domains of functioning. Focus upon these other domains of functioning may have provided important information reflective of family systems thinking practices.

Sixthly, Sheerin et al. (1999) reported on 15 month prospective follow-up study of child inpatient unit in Drogheda in Ireland. This study followed a cohort of 26 children (age range 3-13 years, mean 8.64 years) consecutively admitted to a child inpatient unit over a 12 month period. The unit operated within a milieu setting which incorporated concepts of group, occupational and educational, recreational and behavioural therapies, to create a multimodal therapeutic life experience. A core emphasis within the milieu was on play therapy. Assessments were conducted on admission, three months post-discharge and 15 months post-discharge, using the Rutter Parent Interview, the Birleson Depression Scale and the Harter Self Perception Profile for Children.

Findings revealed that inpatient treatment was linked with a significant reduction in overall symptomatology. This was most notable for emotion-type symptoms at both the three and fifteen month follow-up points, and for hyperactive-inattentive patterns at 15 month follow-up. Conduct symptoms did not reduce at either follow up period, nor did self-esteem change significantly following inpatient treatment. Children with depressive symptoms, in particular, appeared to benefit at both follow-up periods (Sheerin et al., 1999).

Strengths of this study focus on the longer (15 month) follow-up period, and as in Kolko's (1992) study, the inclusion of an outcome measure, this time child self-perception, other than child symptomatology alone. Limitations centre on the absence of a control or comparison group, the sole use of questionnaires and the small sample size (N=26).

In the seventh piece of research to be documented in this area, Dickerson Mayes, Calhoun, Krecko, Vesell and Hu (2001) evaluated 110 children (89% of the initial cohort) consecutively admitted to a child psychiatric unit in Pennsylvania, United States of America. The age range was from two to thirteen years with an average age of 8.9 years. The unit was staffed by a multidisciplinary team. Components of the treatment programme daily individual and group psychotherapy, family therapy twice per week, daily attendance in the school programme, daily recreational therapy, and a parent support group twice per week. Each child had an individualised behaviour and treatment programme. Medication was often also used. The length of inpatient stay ranged from 4 to 80 days, with an average of 14 days.

Evaluation was conducted on admission, at discharge and then at one month and six months post discharge. The child's primary caretaker completed the parent version of the Columbia Impairment Scale (CIS) for their child on each occasion. Findings revealed that children improved significantly in psychological functioning on the CIS from admission to discharge. However, follow-up (post discharge) scores were higher than discharge scores, indicating that progress made during admission was not fully maintained. Of note, children were significantly less impaired at one and six month follow-up than at admission, with a nonsignificant difference between one- and six-month follow up scores (Dickerson Mayes, Calhoun et al., 2001).

A further analysis of the data conducted by Dickerson Mayes, Krecko, Calhoun, Vessell, Stuch and Toole (2001) considered a number of variables that may be related to admission progress and follow-up outcome. It was found that children who were more impaired at admission made more progress during admission, but were more impaired at follow up than children who had milder symptoms on admission. Children without a behaviour disorder had a better outcome than children with a behaviour disorder. None of the other variables alone or in combination, was significantly related to admission progress or follow up outcome, including specific diagnoses, gender, race, age, IQ, family functioning, negative life events, parent education and employment, biological family history, length of stay, parent involvement during admission and follow up services.

The main strengths of Dickerson Mayes, Calhoun et al. (2001) study were the prospective pre-post test design, large sample size (N=110) with excellent subject retention (86%), and the use of multiple follow-up points. In addition, the complementary study (Dickerson Mayes, Krecko et al., 2001), which explored a range of variables to assess whether these were related to admission progress and follow-up outcome, was of merit. Limitations were, however, noted in the absence of a control or comparison group, the use of only one clinical setting, and the use of only one respondent for a single measure of outcome which focussed on child symptomatology alone. In addition, the length of stay was highly variable ranging from 4 to 80 days. As discussed in other studies, all these factors limit the generalisability of findings.

Finally, the most recently reported outcome evaluation study in the literature was conducted by the Statewide Child Inpatient Mental Health Service (SCIMHS) in Melbourne, Australia (Gavidia-Payne, Littlefield, Hallgren, Jenkins, & Coventry, 2003). The SCIMHS is a 12-bed inpatient facility operating a multi-modal programme for children up to 12 years of age. Most of the admissions to the service are individual child admissions, however, accommodation is available for whole families, which is typically reserved for parents with younger children. The programme duration is 4-8 weeks.

Data for 29 children (35% of an initial cohort of 84 children), with a mean age 9.34 years, was collected on admission, at discharge and at four months follow-up from multiple informants, including parents, teachers, referrers and the child. A range of standardised measures to address child functioning (The Strengths & Difficulties Questionnaire, The Health of the Nation Outcome Scales for Children & Adolescents, The Piers-Harris Children's Self Concept Scale), parent functioning (The Parenting Scale, The Parent Sense of Competence Scale, Centre for Epidemiological Studies Depression Scale) and family functioning (McMaster Family Assessment Device) were utilised (Gavidia-Payne et al., 2003).

As shown in a number of other studies reported above, findings from this study revealed significant improvements in child behaviour and functioning, as reported by both parents and teachers over time. Changes in the child's self concept, however, were not significant (Gavidia-Payne et al., 2003). Of note, this latter finding was similar observed in Sheerin et al.'s (1999) study in reference to the child's self esteem. Regarding the parent domain of functioning, improvement in parent competency and efficacy, parenting practices, as well as reduced parental depression were reported. Finally, regarding the family domain of functioning, changes were not found to be significant (Gavidia-Payne et al.).

In review, Gavidia-Payne et al.'s (2003) study, like the above reported Finnish studies, demonstrated a marked improvement in outcome evaluation design, in the use of prospective, pre-post test data, and the use of multiple informants. A further strength of Gavidia-Payne et al.'s study was the inclusion of multiple outcome measures covering child, parent and family domains of functioning. Moreover, a range of measures were used in each domain, not symptomatology alone. Limitations, however, were also noted. These included the absence of a control or comparison group, the use of only one clinical setting, the sole use of a questionnaire format, as well as the small sample size (N=29), and the concerning large subject attrition rate (only 35% subject retention). These factors reduce the generalisability of the findings.

In addition, two other child psychiatry evaluation studies of community and partial hospitalisation programmes warrant mentioning, although the programmes catered for

an older population (up to the age of 18 years) than those in the studies outlined in Table 3. First, Kiser, Millsap, Hickerson, Heston, Nunn, Pruitt, and Rohr (1996) described an outcome evaluation across two child and adolescent partial hospitalisation programmes in Memphis, United States of America. Second, also drawn from the United States of America, Henggeler et al. (1999) compared very brief inpatient psychiatric admission and assertive community treatment based on a modified version of multisystemic therapy (MST) for youths presenting with psychiatric emergencies. These two studies are mentioned in view of their respective research designs which moved beyond the usual single sample and child symptomatology alone outcome measure designs reported in the majority of studies reviewed above. Kiser et al. and Henggeler et al. both used large population samples, and included two settings to assess outcome along multiple domains of functioning (including family functioning, social outcome and consumer satisfaction) using multiple outcome measures, drawing on the reports of multiple informants.

#### 2.2.1.3 Summary and conclusions regarding quantitative evaluation for individual child psychiatry inpatient programmes

As reviewed above and outlined in Table 3 on page 76, only eight quantitative studies in reference to outcome evaluation of child psychiatry inpatient treatment were identified in the literature published between 1988 - 2003. When comparing these findings with those reported on between 1975 and 1987 several points require consideration.

First, the pre 1988 reviews (Curry, 1991; Pfeiffer & Strzlecki, 1990) included studies of both child and adolescent psychiatry inpatient populations in their analyses, and few exclusion criteria regarding the subject population had been employed in these studies. The current review has drawn on an exclusive child inpatient population (focussed mainly on the age group up to 13 years) and in most of the reported studies exclusion criteria (such as mental retardation, presence of neurological symptoms) were employed. Secondly, as outlined in Chapter 1, in Sections 1.2.1 and 1.3.9, in the last two decades, in the context of a range of social, political and economic developments, significant changes to child psychiatry inpatient practice have occurred (Green & Jacobs, 1998a). The most notable changes have been observed in the push for short-term treatment (Epstein, 2004), delivered within a multi-modal framework (Fahlberg,



1990). Therefore, in summarising and drawing conclusions in reference to the current review of child inpatient evaluation studies, it is not possible to make meaningful comparisons with the earlier reviews.

In all, the studies reported from 1988 to the present, while displaying marked improvements in research design, indicate that further developments in this area continue to be required. A noted strength in seven of the eight studies reported between 1988 and 2003, lay in their prospective, pre-post test design. The same seven studies provided admission baseline data, and follow-up measurement, ranging from at discharge alone (Gerardot et al., 1992), to at discharge and then again several months post discharge (Dickerson Mayes, Calhoun et al., 2001; Gavidia-Payne et al., 2003; Sourander et al., 1995), to one year post discharge (Kazdin & Bass, 1988; Ney et al., 1988; Sourander et al., 1996), to 15-months post discharge (Sheerin et al., 1999), and finally, to three-years post discharge (Sourander & Piha, 1998; Sourander & Leijala, 2002). This can be viewed as a vast improvement on the pre 1988 studies where few studies utilised such basic design features.

All the relevant studies described a notably heterogeneous population typical of inpatient child psychiatry settings, with a predominance of disruptive disorders. The treatment modalities, in the main focused on multi-modal intervention. Given this, it is not possible to determine which, if any, of the treatment components were therapeutic. This is especially so since a detailed description of the therapeutic underpinnings of the respective programmes, was generally not provided. The Sourander and Piha (1996) report, was an exception providing more details in reference to their programmes.

In addition, the studies encompassed by the current review predominately used questionnaires to measure outcome. Most of these were well-validated standardised instruments, which is of importance to enable easy integration into future studies for the purpose of meta-analysis. Of note, however, in assessing child symptomatology, only two instruments (the Achenbach CBCL and the Rutter Parent Questionnaire) out of the nine different instruments used in these eight studies were used in more than one study. Clearly, there has been limited consensus regarding the best measure of child symptomatology.

Indeed, most studies restricted the outcome evaluation to child symptomatology alone. Two studies did, however, also include a measure of child self concept/self perception (Gavidia-Payne et al., 2003; Sheerin et al., 1999) while two other studies added a child social or community adjustment measure (Kolko, 1992; Ney et al., 1988). Only one study (Gavidia-Payne et al.) broadened the outcome evaluation scope to include parent and family functioning measures as well. All of the studies used the parents as the respondent (with most drawing on mother-reporting), with only half of the studies incorporating the use of multiple informants (such as child, clinician, referrer and/or teacher) to provide parallel and/or complementary information.

While several studies had sample sizes in excess of 100 subjects (Dickerson Mayes, Calhoun et al., 2001; Kazdin & Bass, 1988; Ney et al., 1988), the samples of most of the remaining studies were notably small. Subject retention rates (yielded from the initially available cohort) varied between Dickerson Mayes, Calhoun et al.'s excellent rate of 89%, to the low 35% retention rate in Gavidia-Payne et al.'s (2003) study and the mere 28% retention in the study conducted by Gerardot et al. (1992). Such a degree of subject attrition noted in the latter studies clearly raises questions regarding population skewing in the sample and challenges the external validity of findings.

In addition, only one study (Sourander et al., 1995) used a sample from more than one setting. The remaining studies all drew their data from a single inpatient setting, which, due to the idiosyncrasies of each programme, limits the generalisability of findings. None of the reported studies included a control or comparison group in their evaluation. While once more acknowledging the ethical dilemmas inherent in engaging in such a practice in child psychiatry, the absence of a control or comparison group does cloud the identification of treatment effects.

In reference to treatment outcomes, in the main, these studies displayed findings comparable to the earlier studies, but only fledgling attempts to delineate mechanisms of therapeutic change were noted. The main finding from the studies reported between 1988 and 2003, was that children with a disruptive behavioural disorder were seen to respond less favourably to child inpatient treatment (Dickerson Mayes, Calhoun et al., 2001; Kolko, 1992; Sheerin et al., 1999; Sourander & Piha, 1998; Sourander & Leijala, 2002). In contrast, children with pure anxiety or affective disorders (Sheerin et al.;

Sourander et al., 1995), or in the relative absence of antisocial and disruptive behaviour (Dickerson Mayes, Calhoun et al.; Kolko) appeared to secure more favourable outcomes. Poorer outcomes were also noted by Sourander and Piha in their three-year follow-up study in the context of severity of the initial dysfunction, adoptive household and post-discharge institutional care.

The poor outcomes for children with externalising difficulties, particularly in the context of antisocial behaviour, as Sourander, Helenius and Piha (1996) contended, do not necessarily represent an argument against short-term hospitalisation. Inpatient admission for this group of children may serve important purposes in reference to diagnostic investigations, and to crisis and family interventions.

Nevertheless, in the context of the observed limitations in the research designs of this most recent review of outcome evaluation studies, coupled with Salzer's (1996) remarks regarding the potential to overstate or make inferences beyond the capacity of a given research design, caution does, however, need to be exercised in the interpretation of the findings. In short-term programmes (4-6weeks), due to this limited time frame, improvements in behaviour problems from admission to discharge may reflect a natural progression to a more normative level of functioning, or as suggested by Sourander, Heikkila et al. (1995) could be seen to be more clearly related to the inpatient treatment, particularly in the case of planned, non-crisis admissions. With longer term follow-up periods, other factors, such as resilience, the natural recovery (or maturational) processes (Salzer), possible sleeper effects (Sheerin et al., 1999; Sourander & Leijala. 2002), as well as range of other specific treatment and individual and family variables, coined 'mechanisms of therapeutic change' (Kazdin & Nock, 2003, p.1116), may account for some of the improvements seen over time. These points may be seen to be particularly relevant when considering results of longer-term post discharge follow-up periods.

In reference to the natural recovery or maturational process, it has been noted that parents may seek inpatient treatment for their child when a behavioural disorder reaches a peak. If this is the case, then as Gerardot et al. (1992) suggested, the improvements on outcome measures may actually represent a natural progression to a more normative level of functioning. This may be seen to be more an issue in respect

to parent and community teacher reports of the children, and seen as a product of help-seeking behaviour, a crisis situation, or an acute exacerbation of chronic longstanding difficulties. As many of the studies found, while improvement in functioning was usually observed from on admission to discharge, further improvements beyond discharge were rarely attained. Some studies observed a maintenance in the reported discharge level of functioning, others a decline in the level of functioning. Nevertheless, post discharge, based on clinical symptomatology, large percentages of patients remained functioning outside the normal range.

The possibility that there may be sleeper effects, described as benefits accrued to the child and family that manifest much later in symptom improvement, is also important to consider here (Sherrin et al., 1999). In the context of longer term follow-up studies, the pathways through which sleeper effects may operate require close consideration. From the inpatient experience, the child and family may have gained an internalised model of psychological functioning incorporating the importance of containment and understanding, or honed skills useful for future conflict resolution. In addition, in preparation for outpatient work, future professionals may be provided with an in-depth understanding of the child and the family (Sherrin et al.). Finally, the actual input from aftercare treatment, or at least monitoring or contacts with psychosocial services post discharge may also have an impact on reported improvements (Sourander and Leijala, 2002). Therefore, it is important to explore the possible avenues via which sleeper effects may be activated, to assist in disentangling inpatient treatment effects from aftercare effects, and/or acknowledge the invariable overlap in the continuum of care spanning inpatient and outpatient work (including prior to inpatient treatment).

Finally, the issue of other variables, 'mechanisms of therapeutic change' (Kazdin & Nock, 2003, p.1116) that may also have a role in positive outcomes requires attention. These may be specific treatment variables, or other individual or family factors. While some studies (Dickerson Mayes, Krecko et al., 2001; Kolko, 1992; Sourander, Helenius et al., 1996) attempted to determine variables or predictors related to outcome, focused attempts to delineate the same clearly remain in their infancy (Green et al., 2001). As Kazdin and Nock (2003) posited, within research design in child psychiatry, several questions need to be actively explored. What processes or characteristics within

the child, parent or family can be mobilised to foster therapeutic change? What events, processes, activities, and tasks in treatment can foster therapeutic change?

### 2.2.2 Qualitative individual child psychiatry inpatient outcome evaluation

Despite the recommendations and noted value of a qualitative research approach, very few qualitative evaluation studies based on inpatient child psychiatry treatment have been reported in the literature to date. A summary of child psychiatry inpatient qualitative process and/or outcome evaluation studies reported since 1993 is provided in Table 4 on page 95 below. For each study, the subject respondents (children, parents, families, nurses, clinicians) are identified, the research design and method of evaluation noted and the area of investigation briefly described. Critique of each study addressing the respective strengths and limitations follows. As will be noted, several of the reported studies also include a quantitative component. Moreover, given the limited number of studies specifically related to inpatient child psychiatry, at the end of the following review and critique of inpatient child psychiatry qualitative studies, a relevant qualitative study which draws on an adolescent inpatient population is also reviewed.

First, in Canada, Bradley and Clark (1993) conducted a retrospective quantitative and qualitative study regarding patient characteristics and family satisfaction in a 10 bed child psychiatric inpatient unit in Halifax, Nova Scotia. This tertiary referral unit was described as being best equipped for children who can benefit from intensive assessment and/or management from a multidisciplinary team, and who demonstrate complex difficulties that include dysfunction in at least two of the following areas – psychological, medical and socio-familial. Treatment options included individual, group and/or family-based interventions, as well as the use of psychoactive medications where appropriate.

Table 4:

*Summary Table of Inpatient Child Psychiatry Qualitative Process and/or Outcome Evaluation Studies Reported Between 1993-2002*

Researcher/s, Setting & Locataion	Subjects	Area of Investigation	Research Design & Method of Evaluation
<i>Bradley &amp; Clark (1993)*</i> Child inpatient setting Nova Scotia, Canada	42 families 34 clinicians	Patient characteristics and consumer (family & referring or follow-up clinicians) satisfaction with the child inpatient service	Retrospective study using -chart review -questionnaires & interview re programme evaluation and consumer satisfaction
<i>Chesson (1996)</i> Child inpatient setting Aberdeen, Scotland	29 clinicians	How staff attitudes, education, training, philosophies & values might affect therapeutic relationships	Ethnographic study using -questionnaire survey -semi-structured interview -observations of ward routines -content analysis of unit documents
<i>Chesson et al. (1997)*</i> Child inpatient setting Aberdeen, Scotland	19 parents 19 children	Parent and child perceptions regarding admission, treatment and outcome	Semi-structured interviews conducted on 3 occasions (prior to admission, six weeks post admission & 2-4 weeks post discharge) Rutter Child Behaviour Questionnaire
<i>Scharer (1999; 2000)*</i> 1 child inpatient setting & 1 partial hospitalisation programme South Carolina, USA	12 parents 13 nurses	The relationships that develop between parents and nurses	Grounded theory study using -semi-structured interviews -participant observation
<i>Puotinemi et al. (2001; 2002)*</i> 19 child inpatient settings Finland	79 parents	Parental resources and coping factors associated with a child in psychiatric care	Questionnaire – likert scale and open-ended

Note: \* Studies that also included a quantatative component also

Drawn from a designated 12 month period, 42 families (68% of the initial cohort) and 34 (76%) referring or follow-up clinicians participated in the study. The mean length of inpatient stay was 42 days, and the child's age range was between 4.6 to 16.6 years (mean 12.1 years). The length of time between discharge and evaluation ranged between 4.1 to 17.7 months (mean 11.5 months) (Bradley & Clark, 1993).

Several specifically designed measures were used. A chart review form was developed to collect information regarding demographic characteristics of the children and their families, the nature and extent of the presenting difficulties, DSM-III-R diagnoses, inpatient assessment and treatment provided, and discharge plans and recommendations. Two questionnaires - programme evaluation and consumer satisfaction - for parents and clinicians using likert-type seven point scales were also developed. The parents and clinicians rated the quality of the unit's treatment and follow-up services, discharge recommendations and the overall respect given to their opinions. Parents and clinicians also rated the child's current level of functioning (same, better, or worse). In addition, parents were interviewed concerning the specific problems at home, at school and in the community which they wanted to address during the inpatient period. For each problem stated they were asked: were their concerns answered; did they learn new ways to deal with the problem; are they still using the new strategies; and how is the problem now (same, better or worse)? Finally, parents were asked open-ended questions regarding their opinions concerning the strengths and weaknesses of the unit programme. The parents were interviewed by telephone and the clinicians were contacted by mail and asked to complete and return the questionnaire (Bradley & Clark, 1993).

Findings revealed that most parents rated the service positively. For those who expressed dissatisfaction, poor communication from staff was a primary concern, along with poor ratings of respect shown by some staff, and minimal help and follow-up post discharge. Features of the inpatient service found to be most helpful were the behaviour-management strategies, support and consistency of the ward staff and other professionals, educational advice and family therapy (Bradley & Clark, 1993).

Clear strengths in Bradley and Clark's (1993) study focussed on the use of multiple respondents (referring and follow-up clinicians, as well as parents) and the use of a

detailed questionnaire which identified and categorised the presenting concerns across settings and tracked strategies used and any changes that occurred. In addition, the use of open-ended questions concerning the strengths and weaknesses of the unit programme, was beneficial in drawing out further important process information. However, limitations of this study were noted in the retrospective nature of the investigation, along with an absence of a detailed specification of the interventions, as well as the highly variable length of time (4.1 months to 17.7 months) between discharge and follow-up evaluation.

Next, in Scotland, Chesson (1996) conducted a comprehensive qualitative study at the Lowit Unit in the Royal Aberdeen Children's Hospital, a 10 bed unit which catered for up to sixteen patients (including day patients) at any one time. The study focussed on how staff attitudes, education, training, values and philosophies might affect therapeutic relationships in a child psychiatric unit. The author, a sociologist, collected data over a 12 month period from April 1992. Four main elements of the research were identified. First, a written questionnaire survey of all staff was undertaken. The survey covered staff input into the Unit, training qualifications and previous experience, views of the Unit philosophy and child management techniques, and influences on professional practice. Second, a semi-structured interview survey of 29 staff which expanded on written questionnaire comments as well as gathering information regarding multidisciplinary teamwork, characteristics of treatment, functions and roles, factors facilitating and inhibiting relationships, effects of hospitalisation on children and their families, and features of the ward environment was conducted. Third, observations of ward routines were employed. These involved staff meetings, ad hoc observation of the Unit, maintenance of ward logs regarding ward traffic, shadowing of the Unit Charge Nurse, and attendance at one-off events such as in-service days. Finally, content analysis of unit documents which covered reports on the ward, minutes of meetings, and policy statements was also employed.

The findings of this study (Chesson, 1996) were comprehensively documented in the book, 'Child Psychiatric Units at the Crossroads' (Chesson & Chisholm, 1996). First, the most commonly cited theoretical approach in the Unit was eclectic, although many clinicians favoured an overarching systems orientation. While behavioural programmes were frequently mentioned, there was little evidence to suggest that this



was the main theoretical base for the Unit. Secondly, in reference to staff role, overall a lack of clarity emerged. A marked difference was, however, noted between full-time nurses and teachers, whose work was based exclusively on the Unit, and other staff whose ward commitments were part of a wider set of responsibilities. The role of nursing staff in particular was highlighted and described as important and demanding, but many team members thought that nurses may undervalue their role. Thirdly, with regard to multidisciplinary team work, factors seen to facilitate relationships between team members centred on meetings and in-service days. Factors seen to inhibit team relationships were varied. Many noted the team members' (other than nurses and teachers) office accommodation being widely dispersed in relation to the ward setting created difficulties in that ward-based staff felt 'left with the situation' while other 'people visit(ed)' (Chesson, p.212). In addition, staff from a range of disciplines saw differences in hours worked, status and pay creating resentment among team members. Other differences perceived between professions appeared to relate to the amount of direct contact with children and the nature of therapeutic input. Difficulties in maintaining relationships when situations were demanding or challenging were also noted. Fourthly, while confusion was noted in reference to the concept of the therapeutic milieu, when staff were questioned regarding what constituted a structured environment, three main elements were identified. These included the daily routine, clear guidelines, and consistency between parents and ward staff, as well as between staff members. Fifthly, in reference to treatment outcomes, while most staff considered positive outcomes for the children were achieved, some others reflected that outcomes were variable. Finally, a degree of complexity and confusion over leadership and management issues emerged in the study. Some of the complexity was seen to be due to a multiplicity of management pathways and differing patterns of professional organisation, relating to the different professions involved.

The main strength of Chesson's (1996) study was the multifaceted ethnographic approach adopted. In the researcher utilising a range of data collection methods, embracing the perspectives of all clinical disciplines within the staff, and employing the necessary in-depth analysis, a rarely found detailed empirical review of the complexities that constitute the practice and function of a child psychiatry inpatient unit was provided. A further strength to the study involved the researcher's

independent status from the programme, both in employment and in professional orientation. By the researcher not being 'in-house', an important objectivity could be retained and a freedom from bias claimed. Limitations of the reported study, however, are noted in the scant outline of the data analysis methodology that was employed, and the absence of input from the inpatient children and their families regarding their experience of the programme. Moreover, it would have been useful to tie these qualitative findings to quantitative outcome data drawn from multiple (child, parent, teacher and clinician) perspectives across multiple domains of functioning.

Indeed, a further study conducted at the Lowit Unit at the Royal Aberdeen Children's Hospital, again headed by Chesson (Chesson et al., 1997), did combine quantitative and qualitative outcome evaluation, albeit in a limited manner. In this study, undertaken in 1993 and 1994, both the parent (N=19) and child (N=19) from the same family via semi-structured interviews were asked their perceptions regarding admission, treatment and outcome. The interviews were conducted on three occasions - prior to admission, six weeks after admission, and two to four weeks post discharge. A quantitative outcome measure, the Rutter Child Behavioural Questionnaire (RA2), was also completed by the parents prior to admission and post discharge.

The main findings revealed that a third of the children had not been informed by their parents regarding admission (this view was supported by parental comments), only two children viewed the Unit as a hospital, and that parents and children were not able to provide a clear reason for admission. Limited understanding of treatment and the work of the multidisciplinary team was evident, and parents rarely sought professional help themselves. A graduation emerged from younger/less intelligent children having a less accurate perception of reasons for inpatient stay to older/more intelligent having a better understanding. Children's satisfaction appeared related to outcome as measured by parental perception, but not scores on the RA2. Parents' and children's views on several issues were incongruent, and it is suggested that this has significant implications for treatment (Chesson et al., 1997). Of note, findings from the RA2 quantitative outcome measure were not reported on in their own right.

In review, a clear strength of Chesson et al.'s (1997) study centred on the research design that utilised both quantitative and qualitative methodology to bring to life both

outcome findings as well as both child and parent perceptions regarding the processes of the inpatient programme. This is important information, that to date has had scant reference in the literature. Limitations were, however, also evident. In the quantitative component, only one respondent (parent), for one outcome measure (RA2) drawing on only one domain of functioning (child symptomatology) was used. This does not satisfy the call for measurement to be multidimensional in the use of multiple informants, multiple measures and multiple domains of functioning. Moreover, as stated above, the RA2 findings were not reported on in their own right. In addition, in the qualitative component of the study, again it would have been useful to include clinicians' perceptions as well in the programme evaluation. As Chesson et al. reflected it is essential to establish perceptions of admission, treatment and outcome since meanings, particularly shared meanings, are likely to influence outcomes. Therefore, it is contended that future outcome evaluation studies would ideally seek out parallel quantitative and qualitative information from the treating clinicians, as well as from the parents and children involved, regarding these factors.

In the fourth study of relevance here, Scharer (1999; 2000) conducted a grounded theory investigation involving two child psychiatric sites (an inpatient unit and partial hospitalisation programme) in South Carolina in the United States of America. The average length of stay in both units was approximately 10 days. The study was undertaken to learn not so much about the outcomes, as about the processes of relationship building between nurses and parents on these units. Subjects included 12 parents and 13 nurses, making for 21 nurse-patient interactions. Data collection methods involved individual interviews with the parents and nursing staff, and participant observation at both sites on numerous occasions.

As Scharer (1999; 2000) observed, the findings underscored the crucial nature of the admission process. It was noted that parents often came to the Unit expecting to be blamed for their child's problems. It was found that when nurses responded with reassurance and caring, the parents' engagement was enhanced. Throughout the admission, it was found that expectations of parents and nurses influenced the relationship. Moreover, the study also displayed ways in which nursing routines influence the relationship during the admission period (Scharer).

A major strength of Scharer's (1999; 2000) study, as documented in the relevant paper, lay in the articulation of the methodology used. Both detail and clarity were evident. However, limitations of this study may be perceived in the subject selection process. It was described that subjects were selected to represent variation on characteristics such as race, sex, age, ethnic background and marital status. Moreover, attempts were also made in the selection process to include parent-staff pairs that had different types of interactions. The manipulation of subject choice may have skewed the representativeness in such a small sample size. While in general this is not an issue for qualitative research, it is possible that Scharer ended up restricting the sample selection to the point that important interactions between other nurse-patient dyads were not represented in the results.

The fifth study of interest here, conducted in Finland by Puotiniemi, Kyngas and Nikkonen (2001; 2002), explored parental resources and coping factors associated with having a child in psychiatric inpatient care. The study, undertaken between December 1997 and May 1998, drew on the perceptions of 79 parents (30% of an initial cohort of 268) in reference to their children (age range 6-15 years, mean 10.7 years) from 19 child psychiatric units in Finland. Quantative and qualitative measures were used via likert scale and open-ended questionnaire format. The questionnaire consisted of 93 items covering background data, coping demands, coping strategies, availability of social support and the need for professional support.

Findings revealed that parents received more emotional than instrumental support, primarily from their spouses, families, friends, fellow workers and health care personnel. Almost half of the respondents wanted more support from health care personnel. The parents expected the health care staff to value and respect them as parents. They wanted to discuss matters openly with the staff and hoped for more cooperation between the family and the staff. Of the range of types of social support, emotional support, support in the care and rearing of the child in inpatient care, and love and acceptance correlated most strongly with parental coping (Puotiniemi et al., 2001; 2002).

A main strength of Puotiniemi et al.'s (2001; 2002) study centred on the little explored area of factors associated with coping of parents with a child in psychiatric

inpatient care. This is of particular importance given the increasingly noted inter-relationship between the functioning of parents and child functioning (Kazdin & Whitely, 2003). A further strength lies in the utilisation of multiple inpatient centres, which increases the potential subject numbers and generalisability of findings. Unfortunately, however, the response rate at 30% was notably poor, and father data was limited.

A further qualitative study, conducted by Demmitt and Joanning (1998) in midwest United States of America, also addressed parents' perceptions of the process of inpatient treatment. Drawing on an adolescent population, and therefore not listed in Table 4, it involved an ethnographic account of 17 parent-informants who were divided into four focus groups to discuss their experience. An initial lead question was asked by the researcher, followed by other specific questions as necessary. According to the parents interviewed, they wanted to be more involved in goal setting and decision making for their child, found family therapy to be useful in addressing family issues and family-staff conflicts, and underscored that regular communication was essential between the staff and parents, but felt most communication had to be initiated by the parents. Data from the study also suggested that families with divorce had more and/or different issues than intact families, and therefore required extra consideration regarding their management.

While Demmitt and Joanning's (1998) study was conducted on a small scale and from the one setting, it has provided important information into this under-explored area of parents' perceptions regarding the process of inpatient treatment. The method of such an investigation could also be readily and usefully applied with parents from a child inpatient setting. Similar future studies could also include the child's perspective, and could be further benefited by the complete confidentiality afforded by an individual interviews rather than focus groups.

### 2.2.2.1 Summary and conclusions regarding qualitative evaluation of individual child psychiatry inpatient programmes

It is clear that qualitative child psychiatry inpatient studies have begun to develop greater scope, as noted in their usage across professional disciplines, from their predominance in psychiatric nursing (Puotiniemi et al., 2001; Puotiniemi et al., 2002; Scharer, 1999; Scharer, 2000) to their inclusion in clinical psychology (Chesson et al., 1997), psychiatry (Bradley & Clark, 1993) and family therapy (Demmitt & Joanning, 1998). However, the field of literature has remained unintegrated, as none of the above documented child inpatient qualitative studies mention the other studies reported in the literature. The exception being Chesson et al. (1997) citing Chesson (1996).

Collectively, the documented studies covered the process of treatment, from pre-admission (Chesson et al., 1997), to on admission (Scharer, 1999; Scharer, 2000), to throughout the treatment period (Bradley & Clark, 1993; Chesson, 1996; Demmitt & Joanning, 1998; Puotinemi et al., 2001; Puotinemi et al., 2002; Scharer, 1999; Scharer, 2000) and finally, to outcomes post discharge (Bradley & Clarke; Chesson et al.).

All of the studies gave due recognition to the importance of the parents' experience and perception in relation to the inpatient treatment of their child. This was observed in Puotinemi et al.'s (2001; 2002) exploration of parent resources and coping factors associated with a child in inpatient care; Scharer's (1999; 2000) analysis of the relationship that develops between the parents and the nurses; Demmitt and Joanning's (1998) overall review of the parents' experience of the inpatient process; and the perceived outcomes by the parents of their child's inpatient experience as noted by Bradley and Clarke (1993) and Chesson et al. (1997). These noted issues of relationship and parental involvement, may provide useful starting points for future research regarding the exploration of mechanisms of therapeutic change in inpatient child psychiatric research.

## 2.2.3 Quantitative and qualitative child psychiatry family inpatient and day patient programmes evaluation

### 2.2.3.1 Evaluation studies regarding child psychiatry family inpatient treatment programmes

As outlined above in Section 1.3.8 of Chapter 1, all the child psychiatry family inpatient programmes documented in the literature provided varying degrees of descriptive information regarding the manner in which their programmes operated. However, despite the general call and increasing mandate in psychology and psychiatry for process and outcome evaluation research, in the nearly forty-year history of family inpatient treatment, few programmes have engaged in such research. The research activities of the family inpatient programmes are reviewed below and the completed family inpatient treatment evaluation studies that have been documented in the literature are summarised below in Table 5 on page 105.

The first family inpatient programme evaluation study to appear in the literature was conducted by the Children's Psychiatric Research Institute family admission programme in Ontario, Canada, nearly 40 years ago (Johnson & Savage, 1967). Using a case study format and a likert-type questionnaire for parents and clinicians, as well as open-ended questions for the parents, this retrospective, essentially qualitative follow-up study explored the perceived outcome and experience of the family admission programme.

Eight families (47% of an initial cohort of 17) responded to the questionnaire. Six families rated their stay as 'very helpful', one 'of some help' and one 'not much help'. Individual psychotherapy sessions were rated positively. Counselling within the milieu received most negative comments, although replies were positive from parents who attended the programme after this aspect of the programme had been reviewed. All parents who assisted in the school or volunteer programme rated these experiences as helpful. Staff ratings agreed with those of the eight families who had replied. It was concluded that joint mother and child admission offered 'an excellent opportunity for meaningful intervention', particularly for the 'child with unresolved symbiotic attachments to the mother' (Johnson & Savage, 1967, p.411).

Table 5

*Summary Table of Child Psychiatry Family Inpatient Programme Evaluation Studies Reported in the Literature*

Researcher, Setting & Locataion	Subjects	Area of Investigation	Research Design & Method of Evaluation
<i>Johnson &amp; Savage (1967)</i> Children's Psychiatric Research Unit, Ontario, Canada	8 families	Outcome of family admission	Case study using -retrospective follow-up -questionnaire (clinicians & families)
<i>Churven &amp; Durrant (1983)</i> Redbank House Sydney, Australia	40 families	Outcome of family admission	Case study using -retrospective follow-up questionnaire (clinicians) -semi-structured questionnaire via telephone (families)
<i>Dydyk et al. (1989)</i> Intensive Family Therapy Unit Thistle town Centre for Children Toronto, Canada	20 families & 22 comparison familes	Viability of inpatient family programme as determined by cost comparison based on reduced need for subsequent individual child admission .	Case study using - chart reviews
<i>Healy et al. (1991)</i> The Families Unit Cassel Hospital London, England	27 families	Change in family functioning as determined by quality of mothers' 'internal object relationships'	Case study using -chart review -questionnaire (clinician)
<i>Healy &amp; Kennedy (1993)</i> The Families Unit Cassel Hospital London, England	28 families	Assessing which families benefit from inpatient work	Case study using -chart review -questionnaire (clinician)



A number of limitations are clearly apparent in Johnson and Savage's (1967) reported evaluation of family inpatient treatment. Data collection was retrospective, the research design and questionnaire components were not clearly articulated, aspects of the programme changed over the course of the evaluation, and the resultant sample size was notably small (N=8) such that statistical analyses could not be employed. In addition, a control or comparison group was not used. A strength of this study was in the use of multiple informants, parents and clinicians. Of note, as a product of this evaluation, improvements in programme delivery were made.

The second evaluation of a child psychiatry family inpatient programme documented in the literature was conducted 16 years later at Redbank House in Sydney, Australia. Churven and Durrant (1983), in another retrospective follow-up study, incorporating basic quantitative and qualitative methodologies, reported on 40 families consecutively admitted to the family admission programme. Information was drawn from recollections independently made by the clinicians and parents. Clinicians were asked to rate the outcome of therapy at last contact with the family on a five point scale (1-2 deteriorated, 3 unchanged, 4 significantly improved, 5 resolved). Post discharge, families were contacted by telephone and asked to respond to a semi-structured interview in reference to their three main presenting problems, continuing concerns, and whether they required further treatment. Outcomes were rated as either 'resolved' (if all three problems were satisfactorily overcome and no continuing problems), 'significantly improved' (if two of the three main problems were overcome, and continuing concerns did not require treatment) or 'unimproved' (if one or no problems had been overcome or major concerns persisted).

Churven and Durrant (1983) described a significant improvement in 80% of the cases, based on both the clinician and family report. A better than 90% congruence between these independent assessments was found. Based on the 'improved' families' opinions, parents believed that the children's problems resolved as a result of improved child management, gaining a better understanding of, and ability to meet their child's emotional needs, and improvements in marital relationships. They perceived the main instrument of change as the 24 hour support and guidance offered by the nursing staff through milieu treatment. Criticisms regarding the programme from both 'improved'

and 'unimproved' families centred on the lack of privacy and the nursing staff being too directive.

In review, the limitations of Churven and Durrant's (1983) study centred on it being retrospective, employing non-standardised instruments, and in the wide range of follow-up periods (for the families, four to 18 months post discharge, and for the clinicians 'at last contact with the family'). Moreover, a control or comparison group was not used. The strengths of the study are drawn from the qualitative information provided regarding the parents perception about the programme's attributes, as well as criticisms in reference to the programme's practice. Such information could provide useful leads regarding process variables or mechanisms of therapeutic change enacted in child psychiatry family inpatient treatment.

The next family inpatient evaluation study to appear in the literature was conducted by Dydyk et al. (1989) at Toronto's Thistletown Centre for Children's Intensive Family Therapy Unit (IFTU) in Canada. The aim of this quantitative study was to test the viability of the family admission treatment approach, in terms of whether admission of the family and child to IFTU would eliminate the need for individual residential treatment of the child, whether those families admitted to the IFTU would display a reduction in the length of subsequent inpatient treatment of the referred child, and how the costs of individual child admission for the referred child compared with IFTU treatment costs.

Utilising chart reviews for a case sample of 20 IFTU families and 22 families from a comparison group from the same service, Dydyk et al. (1989) stated that findings revealed that 50% of IFTU children originally recommended for individual inpatient treatment upon discharge from the programme, successfully avoided inpatient treatment for six months. For this same group of children, a reduction of 35% of total time in residence occurred when compared to a comparison group. A cost savings was therefore realised as a result of IFTU admission compared with individual child inpatient admission.

Whilst the purpose behind this study was of, and remains of clear merit, research design and consequent methodological rigour were limited. The study, whilst including a

comparison group, lacked a truly randomised design, the experimental and comparison group were not consistently matched across variables, and outcome 'measures' were restricted to counting of bed-days and length of time from family admission to subsequent individual admission.

Finally, London's Cassel Hospital, which has described their Families Unit programme in several articles (Bandler, 1987; Coombe, 1996; Kennedy, 1987; Kennedy et al., 1986), has also reported two case study investigations of families treated during the 18 month period from May 1986 to October 1987 (Healy & Kennedy, 1993; Healy, Kennedy & Sinclair, 1991).

First, Healy et al. (1991) conducted a quantitative comparison of features of 14 families with a history of child physical abuse, with 13 families with no such history, over the course of intensive inpatient treatment. A 129-item in-house designed questionnaire was completed for each family by the clinician. Ten questions related to problems identified by professionals involved with the family, 25 questions concerned current family circumstances, 30 questions reviewed the histories of the parents, 40 questions examined the qualities of life-time relationships established by family members, and finally 24 questions explored changes made by the family during treatment. Information was also collected from various sources including the family therapist, family nurse, staff meetings, teachers and nurses working with the children in the day unit, observations by the day/night nurses, meetings with referrers and other professionals involved with the family, and observations from other families living in close proximity within the hospital.

Findings revealed a significant difference between the two groups in terms of current circumstances and background histories. In terms of treatment outcomes, families where abuse was admitted benefited more from treatment than families where abuse was suspected but not admitted. The ability of mothers to remember good relationships from childhood (that is good internal object relations), and to establish good relationships during treatment emerged as important prognostic factors for successful treatment (Healy et al., 1991).

The second study conducted by Healy and Kennedy (1993), utilised the same cohort with one additional family, to focus on the measurement of change in family functioning during admission. It compared 14 families who were seen to make beneficial changes with 14 families who were not seen to make such changes during treatment. The same 129-item in-house designed questionnaire was employed in this quantitative study. The current family circumstances, the background history of mothers, the quality of the mother's relationships remembered, observed and established during admission, and other independent measures of change, were found to be significantly different between the two groups. The quality of internal object relationships was again identified as an important indicator of a capacity to benefit from treatment in the Cassel Hospital Families Unit setting.

In addressing the question regarding which families benefit from inpatient psychotherapeutic work at the Cassel Hospital, a number of patterns were seen to emerge. It was found that families who were more established (older parents, older children), who could rely more on internal family supports (presence of partner, fewer agencies involved, intrapsychic strength in mother as shown by history of affective or neurotic disturbance) were more likely to have a capacity to benefit from treatment. Moreover, the quality of the internal object relationships (as evinced by maternal good relationships remembered from childhood, observed currently, and developed during treatment) was viewed to greatly enhance the capacity of individuals to engage in treatment (Healy & Kennedy, 1993).

In reference to these two studies (Healy & Kennedy, 1993; Healy et al., 1991), the main strengths were found in the quality and detail of the information collected and the relevance of this to the lives and daily functioning of the families involved. However, limitations were also noted. First, while the information collected for both studies was extensive and informative, the questionnaire utilised was a non-standardised in-house item. Moreover, the clinicians collecting the information were also the researchers, thereby setting up the potential for bias. On the other hand, such dual role involvement ensured a detailed understanding of the families and therapeutic processes. The small sample sizes were a further concern and this contributed to the omission of father data in both studies. Finally, the dedicated psychoanalytic theoretical orientation of the Cassel Hospital programme, may limit generalisability of

findings to other shorter term multi-modal family oriented programmes. In all, however, important information was gathered which awaits verification on a larger population using standardised measures.

Two Australian projects planned in this area, although not eligible to be included in Table 5, are worthy of mention here. In 1985, in Melbourne, an evaluation of the Travancore Child and Family Centre incorporating quantitative and qualitative outcome data was mooted by Bornstein et al. (1985). Bornstein et al. recognised that family inpatient treatment was not a panacea for all individuals with serious psychiatric problems, and were keen to analyse which patient groups benefit from individual admission, family admission or a combination of individual and family admission. In a preliminary review of the first 34 families admitted to the Child and Family Centre, one third were family admissions only. In this group nearly all of the referred children had a diagnosis of behavioural or anxiety disorder. In the second two groups, nearly two thirds of the referred children had a diagnosis of borderline syndrome, psychosis or antisocial conduct disorder. The planned evaluation did not, however, come to fruition. No follow up outcome data has been reported in the literature to date.

Similarly, Siegel and Whitmont (1990) in reference to the Redbank House programme in Sydney also recognised the need for more robust family admission outcome evaluation. Acknowledging earlier research at Redbank House (Churven & Durrant, 1983), Siegel and Whitmont noted the need to establish treatment efficacy of family inpatient treatment beyond retrospective clinician and parent follow up. A systematic, prospective group comparison research design utilising multiple measures (standardised psychological inventories, and blind-rated videos of family sessions) across three time periods (on admission, at discharge and at nine months follow up) was planned. Again, however, this study was not carried through. It was revealed that restrictions on resources and what was described as varying levels of commitment for outcome evaluation from team members impeded the same (Whitmont, 2001, personal communication).

To the current researchers knowledge, no other child psychiatry family inpatient treatment process or outcome evaluation studies have been reported in the internationally available English language literature since 1993.

#### 2.2.3.2 Evaluation studies regarding child psychiatry family day patient treatment programmes

Along with the family inpatient programmes reviewed above, a further two child psychiatry programmes with a family focus, operating within a day programme format, have also reported evaluation research in the literature.

First, Cooklin et al. (1983) in reference to the Marlborough Family Day Unit in London, conducted a survey with families admitted to the Unit along with outside professionals (family doctors, social workers, school staff) involved in working with them. In this basic qualitative study utilising rudimentary quantitative analyses, a range of questions were asked about the presenting problem, and aspects of family life, satisfaction with their stay on the unit, and attitudes towards the programme. Preliminary findings revealed that 72% in both the parent and professional groups interviewed claimed the presenting problem improved. Moreover, it was found that the families utilised professional supports less post discharge leading the team to hypothesise that both the families and professionals had learnt to redefine the presenting difficulties so that new solutions could be found. However, once more like several of the planned family inpatient programme evaluations, the planned detailed analysis of this survey was not, however, identified in future literature.

Next, in marked contrast to the family inpatient or day patient evaluation studies described above with their considerable methodological limitations, in Sweden, Sundelin and Hansson (1999) conducted a methodologically robust multi-centre study. Within a prospective pre-post test outcome design using standardised measures, 86 families (79% of an initial cohort of 109 families) from five Swedish intensive family therapy units (IFTU) were assessed between 1993 and 1994. As outlined in Section 1.3.6.2 of Chapter 1, the IFTUs were established systemically-oriented programmes, based on structural, strategic and systemic family therapy as well as milieu work.

Each programme offered a full-day multi-impact family treatment programme over a three to four week period, which was preceded by a period of extensive planning, and also involved an intensive follow-up period with the unit of between two to six months. The therapeutic work was planned and conducted by therapeutic teams which included family members, family therapists, milieu therapists, teachers, and referral persons. The families under treatment were referred from outpatient units, where most had received family-oriented therapy on an outpatient basis without satisfactory results. The presenting concern for 60% of the children was conduct disorder, while the remaining 40% were distributed equally among internalised problems and other concerns such as attention and social problems. The average age of the children was 10.8 years (Sundelin & Hansson, 1999).

In this quantitative study, two evaluation intervals – pre-treatment and six months post admission - were used. Instruments utilised included the self-rated The Family Climate Test and Family Relations Scale (FARS), and the observer-rated Clinical Rating Scale-Turbo (CRS-Turbo) and Beavers' Observational System Scale. In addition, family tasks involving an interview about the family's life and a structured problem-solving task 'the Puzzle' were videotaped (Sundelin & Hansson, 1999). Findings revealed significant changes in the direction towards better family climate and a higher family functioning. Given the very difficult circumstances of these multi-problem families, the results were considered to be very encouraging. Sundelin and Hansson concluded that the intensive family therapy treatment assessed in this study, demonstrated improvement in half of the families.

The strengths of Sundelin and Hansson's (1999) study centered on the pre-post test design, size of the subject population ( $n=86$ ), reasonable subject retention (79% of the initial cohort), and the use of multiple standardised measures of family functioning drawing on both self-rating and observer-ratings. Sundelin and Hansson described this study as the first to incorporate these measures in the evaluation of intensive multi-impact therapy. In addition, the fact that the research was drawn from five different centres, fielding similar results, added to the generalisability of the findings.

However, limitations in this study were also noted. No control or comparison group was utilised, and while standardised measures were employed, these measures centred exclusively on facets of family functioning, and did not incorporate measures of individual child or parent functioning. Moreover, process variables, possible mechanisms of therapeutic change were not explored in this study. Finally, a further evaluation interval, possibly at the end of the three to four week day patient period would have been useful for comparison with the pre-treatment and six months post admission evaluation intervals. The inclusion of these components in the study may have pathed the way for more detailed findings reflective of the highly detailed systems-oriented theoretical model described by Sundelin (1999) as the basis of their work.

#### 2.2.3.3 Summary and conclusions regarding quantitative and qualitative evaluation of family inpatient and family day patient child psychiatry treatment programmes

Foremost, there has been a notable paucity of outcome and/or process evaluation studies regarding child psychiatry family inpatient and family day patient treatment programmes reported in the literature. In the forty year history of family inpatient treatment, research concerning only four programmes, comprising five discrete studies (Churven & Durrant, 1983; Dydyk et al., 1989; Healy & Kennedy, 1993; Healy et al., 1991; Johnson & Savage, 1967) have been published. In addition, a pattern emerged of research that was planned but not followed through in a number of programmes (Bornstein et al., 1985; Cooklin et al., 1983; Siegel & Whitmont, 1990).

Among the family inpatient studies that were completed, the foregoing critiques revealed that the overall quality of research was seriously lacking, with limitations largely outweighing strengths in each given study. The range of methodological limitations were viewed to be similar to those noted in inpatient child psychiatry research pre 1990s. Each of the reported studies adopted a simple case study format and rudimentary data collection methods. Nearly all of the studies drew on retrospective data employing a chart review and/or in-house non-standardised questionnaires, with most questionnaires being completed by clinicians alone. In marked contrast, the more recently reported, Swedish family oriented IFTUs day programme evaluation conducted by Sundelin and



Hansson (1999) displayed methodologically robust prospective, pre-post test design using standardised instruments and multiple informants, although measures were made of family functioning only. Of note, the quality of this research design could be seen as comparable to some of the individual inpatient and family oriented day programmes research designs developed in recent years.

Nevertheless, in each of these (completed, partially conducted, preliminary or planned) family inpatient and family oriented day patient programme evaluations, important seeding information regarding process and outcome evaluation design, and data, has been provided. In all, the findings were suggestive of the value of family inpatient or family oriented day patient treatment. Ideally, future research in reference to child psychiatry family inpatient or day patient treatment would draw upon aspects of Sundelin and Hansson's (1999) research design, but extend this to include information on child, parent and family measures of functioning, and address issues of both process and outcome evaluation, utilising complementary quantitative and qualitative methodologies.

#### 2.2.4 Future directions regarding child psychiatry inpatient research

The body of literature reviewed in Chapters 1 and 2 above, reveals that the inpatient treatment of individual children, inpatient treatment of children involving a family admission, and family oriented day patient treatment, are likely to be of value to certain troubled children and their families. However, in the main, the research that suggests this has remained lacking in methodological rigour necessary for evidence-based frameworks desirable in the socio-economic climate of the twenty-first century. Indeed, as Shirk (2001) observed, from a service perspective, one of the major challenges of our time involves the implementation of empirically supported treatment in clinical settings. Based on much of the research conducted to date, Salzer's (1996) caution regarding making interpretations beyond the capacity of given research designs has remained important to heed.

In this context, and acknowledging the range of methodological and practical issues tied to child psychiatric inpatient research (Green & Jacobs, 1998c; Riddle, 1989), a number of recommendations regarding future research design and direction have been

made. First, as Moore and O'Connor (1991) recommended, it is important that a standardised component of evaluative research be built into normal clinical practice. As many inpatient units use standardised assessment as part of their work-up and unit staff generally know much of the information needed to rate such measures, it is possible to facilitate making outcome assessment routine within an inpatient setting. Moreover, as Blanz and Schmidt (2000) suggested, low subject numbers can be addressed by pooling of data from units.

In reference to the research design, the necessity for ensuring design is longitudinal (including pre-test, post-test and follow up intervals) and multidimensional has been repeatedly emphasised. This includes using a range of measurement instruments (assessing symptom reduction, social competence and functioning, academic functioning, change in treatment consumption patterns, consumer satisfaction) (Sundelin & Hansson, 1999), engaging a number of informants (child, parent, clinician, and teacher) to assess across multiple domains of functioning (child, parent and family) (Kazdin, 2003). To assist in increasing sample sizes, the use of multi-centre studies, where possible, as utilised in the reported Finnish (Sourander & Piha, 1996) and Swedish (Sundelin & Hansson) studies is also recommended. Thirdly, in recognition of inpatient programmes now incorporating a range of therapies, a fully detailed specification of the treatment undertaken within the therapeutic milieu and its theoretical underpinnings is required (Epstein, 2004).

Regarding directions for future research areas, the exploration of mechanism of therapeutic change – understanding how psychotherapy works - has been suggested to assist in maximising treatment effects and to ensure critical features of therapy are integrated into clinical practice (Kazdin & Nock, 2003). Possible areas to be investigated could be components of the ward environment and milieu functioning (Imrie & Green, 1998), the therapeutic alliance between the patient (child, parents, and family) and the treating team (Kroll & Green, 1997), the impact of programme planning and structure (including aftercare planning and follow-up management), and the inter-relationship between child, parent and family functioning (Crowley & Kazdin, 1998; Kazdin & Wassell, 2000; Kazdin & Whitley, 2003).

Finally, in reference to future research directions – both in methodology and suggested areas of exploration, the use of both qualitative and quantitative methodologies is strongly put forward, to assist in yielding the most comprehensive findings in the much needed area of inpatient child psychiatry outcome and process treatment evaluation (Graham, 2000; Krahn et al., 1995).

These above issues were given due consideration in the design of the present study as outlined in the following chapters.

## **CHAPTER 3**

### **RATIONALE AND DESIGN OF THE PRESENT STUDY**

In the context of the burgeoning need for evidence-based outcome effectiveness in the current social and economic climate, an opportunity arose to conduct outcome and process evaluation of inpatient family treatment at the Austin and Repatriation Medical Centre's, Child and Adolescent Mental Health Service Child and Family Residential Unit programme, located in Melbourne, Australia, in 1995. The ensuing research has been able to take advantage of the methodological lessons derived from the evaluation research reviewed in Chapter 2 above.

This chapter outlines the rationale and the context of an outcome evaluation study as it was originally planned. A description of the Austin Child and Family Residential Unit (AC&FRU) including the setting, the philosophy of the Unit, the operating framework, patient population, referral and admission procedure, as well as the assessment and treatment phases and follow-up plans is outlined. An overview of the planning and progress of the originally designed outcome evaluation then follows. Attention then turns to the design of the present evaluation study. The original study was carried out to a certain point, but then formed an archival basis for the present study. The present study then involved Stage 1 which analysed the archival data gathered by the original study, and Stage 2 entailing qualitative interview methodology exploring process issues arising in the archival study. The two stages, their aims and hypotheses are presented.

#### **3.1 Rationale and design of the originally planned outcome evaluation**

##### **3.1.1 Description of the Austin Child and Family Residential Unit**

The information presented here concerning the AC&FRU programme, authored by former AC&FRU clinicians, is derived from several documents. The first reported a systems approach analysis of parents' and clinicians' perceptions of children's behaviour, drawing on 37 families referred to the AC&FRU (Volk, 1993). The second document (McLoughlin, 1996) reviewed the distinguishing features of 34 families consecutively admitted (1994-1996) to the AC&FRU programme. Both of these

sources, which satisfied postgraduate studies, also provided descriptions regarding the programme. The third document, in the form of a conference presentation, provided a more detailed overview regarding the AC&FRU programme, with a particular emphasis on the role of the nursing team (Volk, 1996). The final source was the original research project proposal document (Jenkins, McLoughlin, Evans, Volk, & Littlefield, 1995), which formed the basis for Stage 1 of this current project. The information from these four documents, is supplemented, where applicable, by reference to other family admission programmes and child psychiatry and psychology literature in general.

#### 3.1.1.1 Setting of the Unit

The Austin Child and Family Residential Unit (AC&FRU), a dedicated family residential mental health programme of the Austin Child and Adolescent Mental Health Service in Melbourne, operated for an eleven-year period, between 1986 and 1997.

The Unit was housed within a renovated two-storey home set in aesthetically pleasing leafy surroundings, separate from the main hospital buildings. The AC&FRU functioned as a ward setting, but had the feel of a large house. Two family suites, individual bedrooms, a communal kitchen, living and dining areas, indoor and outdoor play areas, laundry and additional bathroom facilities were provided (Volk, 1993; 1996).

#### 3.1.1.2 Philosophy of the programme

The philosophy guiding the operation of the AC&FRU programme is drawn from several sources. First, a commitment to the concept of family systems theory was observed by Volk (1993), with most clinicians ranking this as their main theoretical orientation, and all clinicians placing this orientation within the first three models from which they worked. In further reviewing these findings, it was noted that a psychodynamic orientation also held a prominent position, and to a lesser extent, cognitive behavioural theory. In addition, theoretical models, specific to a given clinician's background discipline were noted. For instance, the social worker cited the social casework model, and the model of human occupation was noted by the occupational therapist.

Of interest, the later reports of the AC&FRU programme focussed more on general principles of operation and promoted a multi-modal framework documenting the types of therapies provided, rather than tying the same to specific theoretical orientations. As Jenkins et al. (1995) and Volk (1996) described, the AC&FRU aimed to improve the fit between the child and the child's interpersonal environment and, similarly, between the family and the family's interpersonal environment. It was stated that no one particular, set theory governed the operation of the programme. Assessment and treatment were described as multi-modal, and encompassed a range of individual, family, social, and biological therapies chosen according to the clinical needs of the child and family. The range of assessments and therapies available included family, individual, parent/marital, group, behavioural, developmental and educational approaches. Pharmacology was not a major focus of intervention. If a child was admitted on psychoactive medication, this would be reviewed by the child psychiatrist, and as deemed appropriate would be maintained, altered or phased out.

#### 3.1.1.3 Operating framework

The AC&FRU programme provided intensive, short-term assessment and intervention, together with recommendations for follow-up, to two families at any one time, each including a referred child aged 0-13 years who was experiencing serious emotional, behavioural, relationship and/or psychiatric difficulties. Referrals to the programme were usually of a tertiary nature. The programme operated throughout the year on a five-day-a-week basis (Monday morning to Friday afternoon), with families returning to their own homes and community on the weekends (Volk, 1996).

A multidisciplinary team with specialist skills in child and family psychiatry staffed the AC&FRU programme. The team included a consultant child psychiatrist (who held the team leader position), a child psychiatry registrar, three clinical psychologists, seven psychiatric nurses (who were rostered on a 24-hour basis), a social worker, an occupational therapist and two special education teachers. A paediatric registrar was attached to the team and access to neurology services and speech pathology were also available. Support staff, cook and ward clerk, were also attached to the AC&FRU. Not all staff were employed full-time, and many staff held responsibilities outside the AC&FRU (Volk, 1996).

Each family was allocated a case management team, comprising a case manager and a primary nurse. The case manager could be a child psychiatrist, child psychiatry registrar, clinical psychologist, social worker or occupational therapist. Nursing staff, working during the day, four or five days per week, occupied the role of the primary nurse. Both the case manager and primary nurse roles were rotated between team members. The case management team co-ordinated the family's management throughout their involvement in the AC&FRU programme. Case management meetings with the family occurred two to three times per week, and provided a forum to discuss the events of the intervening days and in the treatment phase, to explore management options in anticipation of difficulties. The primary nurse and the parents met formally on a daily or second daily basis, and along with other nursing staff had ongoing informal contact and general interactions within the ward setting. The primary nurse was seen as main contact person for the family at a ward level. The case manager and primary nurse also met on a daily basis, in team handover meetings, following these meetings, or at another designated time, to discuss the family's progress and to consider issues which arise as the admission progressed. This ensured ongoing and detailed communication in relation to the family and their presenting concerns and progress in the programme (McLoughlin, 1996; Volk, 1996)

The comprehensive programme was based within a therapeutic milieu and focussed on daily routines, behaviours, and interactions. The structured environment of the therapeutic milieu was viewed as the core of the AC&FRU programme. This structure was reflected in (a) the formal agreement made between the family and the treating team regarding the admission, (b) house rules, (c) team members being clear about their designated roles; and (d) the expectation that parents retain responsibility for their children during the course of the admission (Volk, 1996). Such structure was deemed crucial as the Unit (encompassing the milieu and the team) could be viewed as the 'parent' to the family, in providing a safe, supportive and non-judgemental environment with clear expectations and consistency in management. This was often found to be a powerful experience, as many of the families (adults and children alike) may not have had this experience of being supported within a firm, safe setting (Volk).

The average length of stay for each family was about six weeks, comprising a clearly demarcated two-week assessment period and a four-week treatment phase. Working parents were required to take time off work to be available during the initial two-week assessment period, with partial return to regular activities encouraged in the subsequent treatment phase (Volk, 1996).

#### 3.1.1.4 Patient population

##### 3.1.1.4.1 Overall features of the families

The patient population of the AC&FRU was heterogenous in terms of presenting problems. In all cases the referred child was considered to be experiencing severe emotional and behavioural problems, and formed the focus of the referral (Volk, 1996). In addition, individual difficulties in these families often crossed generational boundaries, with both the parent and the referred child, and, at times, other siblings presenting with psychiatric disturbance (Jenkins et al., 1995; Volk). McLoughlin (1996) recalled the preponderance of parental reports of their own experiences of childhood sexual and physical abuse and abandonment.

Furthermore, the complexity of the presenting family difficulties also often led to the involvement of multiple agencies (Jenkins et al., 1995). As McLoughlin (1996) reported, based on a review of 34 families consecutively admitted to the AC&FRU programme between 1994-1996, involvement with other agencies, such as the education system and child protective services, was frequently observed. In the cohort described by McLoughlin, protective concerns were identified in over 73% of the families, with 50% of the total number of families admitted having formal involvement with statutory child protection services. In addition, 91% of the families reported school and educational difficulties for their children, and in 62% of the families, the child's continued participation in the school state system was considered to be under threat.

In the context of such multiple problems, as Brendler (1987) observed, inpatient families typically have reached a therapeutic impasse, in that the family has not responded to outpatient intervention. The families were often at crisis point, having depleted their own, as well as other community resources, and presented as



overwhelmed in the face of severe, recurring problems. They tended to be chaotic and disorganised, with a background of disadvantage across generations. With such families, every professional involved in working with the family can feel stuck and the family is likely to have been viewed as unworkable or resistant to therapy (Brendler).

#### 3.1.1.4.2 Child characteristics

The referred child (identified patient) usually had long-standing difficulties and had been labelled 'the problem'. These difficulties may have generalised over time and across home, school and playground settings. The child may have also been excluded from school, playgroup, kindergarten or social club, and may have been facing placement outside of the family (Volk, 1993; 1996).

The siblings of the referred child often also presented with difficulties in their own right (Volk, 1993; 1996). Research over the years has clearly shown the importance of sibling relationships in shaping child development (Dunn, 1983; 1992). Positive sibling interactions can enhance children's prosocial behaviours, while negative sibling interactions can increase childhood behaviour problems (Fagan & Najman, 2003). Such negative interactions may be seen to be further heightened in the context of a dysfunctional family.

#### 3.1.1.4.3 Parent characteristics

The parents often presented with severely restricted parenting skills, many with their own individual psychiatric disorders or personality difficulties, as well as serious marital conflicts. Frequently, their limited parenting skills were seen to clearly impacted on and influence the child's presenting difficulties (Volk, 1996).

### 3.1.1.5 Referral, screening procedure and admission policy

Families were referred to the AC&FRU programme by a range of mental health providers (from within the Austin and Repatriation Medical Centre's Child and Adolescent Mental Health Service, community mental health agencies, or by private child psychologists and psychiatrists) or could be self-referred.

Reasons for referral included the following situations (Volk, 1996):

- a) outpatient intervention had proven difficult or had been unsuccessful;
- b) a second opinion was sought by the referrer;
- c) the severity of the disturbance required inpatient assessment and management; and/or
- d) local resources were lacking as with families from rural areas.

Admission was not offered to families with (Volk, 1996):

- a) parents with current substance abuse problems;
- b) a family member who was acutely psychotic;
- c) currently changing family membership and/or
- d) problems related to the need for temporary accommodation.

Given that two families could be admitted to the AC&FRU programme at any one time, the compatibility of families on the ward, in terms of presenting problems, the ages of the children and the number of family members was taken into consideration. For instance, the proportion of aggressive children admitted to the Unit was monitored, two families with pre-school age children during school term time would not ensure the best use of the schooling facilities available, and adequate staff coverage throughout both the assessment and treatment phases were important (Volk, 1996).

A thorough screening process was employed by the team prior to offering admission to the programme. This process involved, first, receiving information regarding the family from the referrer. Such information included basic demographic details, family constellation details, history regarding the difficulties, past and current agencies involved with the family including involvement with or notification to Protection Services. This information was presented and discussed at the weekly multidisciplinary team meeting. At this meeting, a decision was made by the team as to whether to offer the family a

screening interview to further assess the appropriateness of admission, to request further information from the referrer, or to suggest referral elsewhere (McLoughlin, 1996).

The screening interview, which involved the whole family (all current household members), was conducted. This was for the team to gain a better understanding of the family and the presenting difficulties, and for the family to gain a more detailed understanding of how the team worked. One non-nursing team member conducted the interview, whilst other team members, representing each professional discipline, observed the interviewer and family from behind a one-way mirror (Volk, 1993).

Whilst a family admission was the most likely outcome of this interview, it was not the only possible outcome. Not all families interviewed were offered family admission, not all families accepted an offer; and some families were referred elsewhere. At the end of the interview, the presenting difficulties were reframed in family terms. If admission was offered, the initial requirements were set (Volk, 1993). These were that:

- a) the whole family (all current household members) would be admitted for an initial two week assessment period;
- b) the parents would retain responsibility for their children over the course of the admission;
- c) school-age children would attend the Austin Hospital Special School over the course of the admission;
- d) work and extra curricula commitments would be suspended during the initial two week assessment period; and
- e) active participation by all family members in the programme would be required.

If the team considered admission may assist, the family was then asked to decide whether intervention would be useful for them and to re-contact the interviewer with their decision within a week. All admissions were voluntary, although strong recommendations from the Victorian State Government Child Protection Services and other agencies were sometimes involved (Volk, 1996).

### 3.1.1.6 Assessment phase

Within the AC&FRU programme, the family system as a whole and each member of the family were considered a patient in his or her own right. All families admitted to the programme engaged in an initial two-week assessment period during which the family came and lived in the Unit from Monday morning to Friday afternoon, returning home on the weekends. Work and extra-curricular activities were suspended during this time and all school age children attended the Austin Hospital Special School located in the hospital grounds in close proximity to the Unit. The families were encouraged to use the space in the Unit provided and to 'do as they would at home' within the confines of the Unit and hospital policies, and within the structure of the appointments set out in the family's assessment timetable (Volk, 1996).

As stated above, each family was allocated a case management team, who for each family, and for individuals in the family, co-ordinated a series of appointments and commitments (such as school attendance). A timetable of these appointments and commitments was given to each family member for the forthcoming week. During the assessment phase, in particular, there were often several meetings held on the same day (McLoughlin, 1996). The team and the family worked together, and together assessed the family's situation and explored future directions. The AC&FRU clinicians provided a range of assessments tailored to the needs of each family. These could include family, individual, parent, marital, group, behavioural, developmental and educational assessments. The importance of including all family members in the assessment and viewing the family as the unit of greatest focus, as well as ensuring this was a collaborative process with active participation from the family, was emphasised (Volk, 1996).

As described, the programme itself was grounded in a therapeutic milieu, and attended closely to daily routines, behaviours, and interactions. The nursing team members' main role in the assessment period was observation within the milieu. In the position of participant-observer, the nursing team observed the family's behaviour and interactions within the family, with other patients and with team members. It was important for the team to gain as clear as possible understanding of the difficulties facing the family, and the manner in which they managed those difficulties and also

identify contributing, precipitating and maintaining factors in the family dynamics. In the assessment phase, staff only intervened if there was a safety issue, and in their intervention aimed to respect the family's attempts at handling the problem (Volk, 1996).

Parents retained responsibility for their children throughout the course of the programme. All team members routinely put issues back to the parents, and this constant handing back aimed to reinforce the concept of the family as a unit and encouraged the parents to take charge (Volk, 1996).

At the end of the two-week assessment period an assessment review meeting regarding the family was held. This meeting was attended by all AC&FRU team members who had involvement with the family, and whenever possible the referrer/s and/or other professionals who had significant contact with the family in the context of the referral of the family for admission (Volk, 1996). As McLoughlin (1996) noted, the task of this meeting was to develop a working hypothesis regarding the family's difficulties and to formulate a treatment plan, which may involve ongoing inpatient treatment or outpatient management.

A review feedback meeting with the family was then held. In this session, the outcome and recommendations of the review meeting were summarised for the family, with a request that they consider proposals made and if an extended admission was offered, to decide whether they wish to take this up. A further meeting was then scheduled for the following day to meet with the family regarding their decision, and to respond further to any queries regarding the information provided at the review feedback meeting (McLoughlin, 1996). As McLoughlin noted, in most cases offers of an extended admission, beyond the two week assessment period, were accepted. Sometimes requests for certain conditions were made. These could include deferring the second part of the admission due to other family commitments, allowing siblings to return to their base school, and arrangements related to work commitments. When families chose not to remain beyond the assessment period, the remaining time was devoted to post discharge arrangements.

### 3.1.1.7 Treatment phase

If recommended by the team and accepted by the family, the admission could extend into a four-week treatment period. During this period, the family and individual family members often continued with therapy sessions commenced in the assessment phase and worked on goals mutually established between the family and the case management team, carried through in the ward-based family programme (Volk, 1996). As indicated in Section 3.1.1.2 above, medication was not a major focus for most families.

The case management team would ask the parents to identify areas of family life they wanted to work on in the programme. Emphasis was placed on the parents identifying, discussing and thereby owning their family's own programme. The primary nurse worked closely with the parents during the first few days of the treatment period and facilitated the development of the programme, drawing on the parent's knowledge of their family, and on the team's knowledge of the family, as well as the team's collective experience of working with families (Volk, 1996).

Aims for each family were individually negotiated, but some common themes amongst the families presented (Volk, 1996). Several components that were often built into the ward-based programmes included the following:

- a) Positive reinforcement of desirable interactions was used, such as verbally encouraging the parents to 'catch' the child behaving well and to use star charts as a reward.
- b) Limit setting and consequences for unacceptable behaviour was used, with general guidelines regarding limit setting being provided.
- c) Therapeutic physical holding of the child by the parents and the nursing staff was used if the child became a danger to him/herself or to others in the Unit. As explained by Sourander, Ellila, Valimaki and Piha (2002) therapeutic physical holding involves holding the child in a sitting position or holding the child down when the child is on the floor, while providing verbal reassurance and comfort as needed.
- d) Routines throughout the day, such as getting up and getting organised in the morning, settling to bed and routines around meal-times such as eating together as a family, were encouraged.

- e) Regular activities or outings were planned into the weekly family timetable, and involved parent-child dyads as well as the whole family.
- f) A weekly parent's night out was integrated into the programme. During this time the nursing staff would care for the children on the Unit, requesting specific instructions from the parents regarding the child's settling routine.
- g) Individual relaxation or personal activity time was encouraged for each family member.

The programme was built up over the first three weeks of the treatment phase, to ensure that the family members experienced success along the way (Volk, 1996). Emphasis was placed on harnessing and further developing the resources within the family in terms of improving relationships between all family members, re-establishing parent-child boundaries, building self-esteem and assisting the parents to understand their children from an individual, developmental and emotional perspectives.

In the treatment phase, the primary nurse and other members of the nursing team shifted from an observation role to a more active role in modelling interventions and generally supporting and backing up the parents (Volk, 1996). The relationship that developed over the assessment period facilitated ready acceptance of staff working in such a role with the family. The programme was formally written up and discussed with all nursing team members. The 24-hour coverage Monday to Friday enabled nursing staff to work alongside the parents to ensure consistent implementation of the programme which in itself was intended to afford important modelling regarding parenting practice. The primary nurse met with the parents on a daily basis to monitor how the programme was progressing.

In the fourth and final week of the treatment phase (sixth week of admission), discharge planning was implemented to assist in the transition back to home (Volk, 1996). This included reintegration of the children into their base schools, making a 'going home chart' or counting down calendar, talking about leaving both formally in sessions and informally within the milieu, and having a family farewell party held in the final days of admission, which all team members involved with the family as well as the other family on the Unit would attend.

#### 3.1.1.8 Follow-up plans

Follow-up plans for the family were diverse and depended on a number of considerations. These included the needs of the family, where the family was geographically located and the resources available both within the team and in the family's locality. The team was mindful of the strength of engagement usually achieved over the six-week period and the importance of the process and issues surrounding separation. Discharge planning was therefore carefully addressed throughout the course of the admission (Volk, 1996).

#### 3.1.2 Place of the Austin Child and Family Residential Unit among other family admission programmes internationally

The AC&FRU family inpatient programme, along with the eight other family admission programmes reported in the English language literature (as outlined in Section 1.3.5 of Chapter 1), held a unique place in the treatment options for inpatient child psychiatry. The AC&FRU programme, when compared to these other programmes, impressed as most similar to those operating through the Park Hospital for Children (Byrne & Jones, 1998), Philadelphia Child Guidance Clinic (Brendler, 1987; Combrinck-Graham et al., 1982), Redbank House (Siegel & Whitmont, 1990) and Travancore Child and Family Centre (Bornstein et al., 1985). Each of these programmes worked with either two or three families at a given time, in an inpatient setting affiliated with a major child psychiatry facility, drawing on multi-modal practice frameworks, with a programme delivered within a short-term (1-3 months) time frame.

However, distinctions between reports of the AC&FRU programme and these other family inpatient programmes, are also evident. In several of the other programmes, the option of individual admission was also routinely available. The AC&FRU was a dedicated family admission programme and did not run a parallel individual child admission programme. In addition, all the AC&FRU admissions were planned, and crisis admissions were not an option. Also, in reference to theoretical orientation, while reports of several of the other programmes clearly articulated their ongoing, underlying stance, the AC&FRU programme did not consistently document an overall guiding theoretical orientation, as indicated in Section 3.1.1.2 above.



Finally, in contrast to what has been documented for other programmes, the AC&FRU had clear guidelines as to what constituted the assessment and treatment phases for each family. While similar structuring was noted in Oxford's Park Hospital for Children's family inpatient programme (Byrne & Jones, 1998), and may have been in operation in other family treatment programmes, this was not clearly detailed in the relevant literature.

In reference to the other family-oriented child psychiatry day and inpatient programmes reviewed in Section 1.3.6 of Chapter 1, the Finnish family-oriented child inpatient programmes (Sourander & Piha, 1996) and the IFTUs in Sweden (Sundelin, 1999; Sundelin & Hansson, 1999) can be viewed to be similar to the AC&FRU programme, with regard to the intake population, programme planning, the multi-modal treatment approach as well as the short-term length of stay. Differences are apparent in terms of the more intense post discharge work and more integrated involvement with the wider family treatment system in the Finnish and Swedish programmes, in comparison to the AC&FRU programme.

### 3.1.3 The aim to evaluate the Austin Child and Family Residential Unit programme

#### 3.1.3.1 Context of the planned outcome evaluation

As revealed in Section 2.2. of Chapter 2, in 1995, when the outcome evaluation of the AC&FRU programme was originally conceptualised, a paucity of methodologically sound research had been documented internationally in the family inpatient, as well as individual child inpatient area. In the light of this situation, and given the uniqueness of the AC&FRU programme and expertise that had developed over the years by clinicians in the programme, a pressing need for formal outcome evaluation presented.

It was considered that the proposed research would provide valuable information regarding relevant underlying theory, and practice, as well as regarding outcomes for the families admitted to this dedicated family admission programme. Such information was of prime importance in the environment of escalating health care costs and recognised need for accountability in clinical practice. It was anticipated that the project would

contribute to the much-needed empirical evaluation of family intervention treatment models, and contribute to improved treatment planning and service delivery in these areas.

The resources available to conduct research of AC&FRU programme were limited to the clinical resources already allocated to the AC&FRU team. According to policy within the broader medical centre, all senior clinicians were expected to be involved in research, and such activities were factored into their job descriptions and workloads.

#### 3.1.4 Original design of the outcome evaluation

The AC&FRU had been operating for over seven years at the point at which a formal research team for the Unit was established. As stated above, resources for the research team were drawn from the then allocated clinical staff for the AC&FRU team. No additional funding was allocated for research. The research team, established in 1994, comprised four AC&FRU team members representing the disciplines of psychiatry, psychiatric nursing, social work and occupational therapy. The present researcher was a member of this team, in her role as Nurse Unit Manager. The research team met on a regular consultative basis with a clinical research psychologist who was allocated to the Austin & Repatriation Medical Centre's Child & Adolescent Mental Health Service. The aim of the research team was to identify research needs of the Unit, then with consultative input to formulate and conduct research evaluation studies in relation to work undertaken in the Unit.

In this context, in 1995 it was planned to conduct an overall empirical evaluation of the outcomes of the programme. The use of empirically validated measures, comparing pre- and post-test evaluations, and the incorporation of several domains of functioning (child, parent and family), in the research design would ensure that the hypotheses of the study could be tested in a targeted, objective way. In other words, focused, standardised measures (detailed in Section 4.2 of Chapter 4 below), used systematically with all participants in the programme, would allow for the possibility of identifying positive, negative or neutral outcomes for the children and families participating in the programme.

This current research design was thus planned to take account of the significant shortcomings of previous child psychiatry family inpatient outcome evaluation research as detailed in Section 2.2.3.

#### 3.1.4.1 Evaluation of the effects of the programme on child functioning

Child functioning (of both the identified patient and the sibling closest in age) was planned to be assessed using (a) the Achenbach Child Behaviour Checklist (CBCL, Achenbach, 1991a), a parent-report measure of behaviour problems and social competence in children, (b) the Achenbach Youth Self Report (YSR, Achenbach, 1991b), a self-report for older children and adolescents which parallels the CBCL, (c) the Teacher Report-Form (TRF, Achenbach, 1991c), which again parallels the CBCL, (d) the Harter Self-Perception Profile (Harter, 1982), a self-report instrument used to assess the child's sense of competence, and (e) the Teacher's Rating Scale of Child's Actual Competence and Social Acceptance (Harter & Pike, 1981) which parallels the Harter Self-Perception Profile.

#### 3.1.4.2 Evaluation of the effects of the programme on parent functioning

Parent functioning was planned to be assessed using the 28-item General Health Questionnaire (GHQ-28, Goldberg & Hillier, 1979), a self-administered screening questionnaire aimed at detecting psychiatric disorders in adults.

#### 3.1.4.3 Evaluation of the effects of the programme on family functioning

Family functioning was planned to be assessed using two main measures. The first was the Family Adaptability and Cohesion Scale III (FACES III, Olson, 1986), a self-report scale measuring family adaptability and cohesion. The second, based on the McMaster Model of Family Functioning was the parent self-report instrument, the McMaster Family Assessment Device (FAD) (Epstein, Baldwin, & Bishop, 1983), and the clinician rated McMaster Clinical Rating Scale (MCRS, Miller, Kabacoff, Epstein, Bishop, Keitner, Baldwin, & van der Spuy, 1994). These measures assess family problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functioning.

3.1.4.4 Overview of planned evaluation

Table 6 below, presents the planned comprehensive, multiple informant prospective outcome evaluation study, showing when individual and family functioning questionnaires would be administered, and who would be reporting on these measures at certain time points. Where family included two parents, both parents would be asked to respond to the questionnaires, and where one parent was included, that one parent would be asked to respond. Two clinicians would also be asked to complete questionnaires. These were the case manager and the primary nurse allocated for each family. If aged eleven or older, the identified patient and the sibling closest in age would be asked to complete questionnaires. The Austin Hospital Special School teacher would also be included. The evaluation was planned to be implemented with respect to all families admitted from July 1995, with a pilot period from February to June 1995. It was envisaged that the project would continue for two years.

Table 6:  
*Summary Table of the Planned Outcome Evaluation Regarding Child, Parent and Family Functioning for Families Admitted to the Austin Child & Family Residential Unit Programme*

Area of Functioning	Questionnaire	Person/s Completing	Time Points
1. Child - identified patient (IP) - sibling closest in age to IP	Achenbach Child Behaviour Checklist	Parents Clinicians	1, 2, & 3 1 & 2
	Achenbach Youth Self-Report	Children aged 11 or older	1, 2, & 3
	Achenbach Teacher Report Form	Teachers	1 & 2
	Harter Self-Perception Profile	Children	1, 2, & 3
	Harter – Teacher’s Rating Scale of Child’s Actual Competence & Social Acceptance	Teachers	1 & 2
2. Parents	28-Item General Health Questionnaire	Parents	1, 2, & 3
3. Family	McMaster Family Assessment Device	Parents	1, 2, & 3
	McMaster Clinical Rating Scale	Clinicians	1 & 2
	Family Adaptability & Cohesion Scale	Parents	1, 2, & 3

Key:  
Time Points = Time of questionnaire administration:  
Time 1: on admission to the programme,  
Time 2: on discharge from the programme,  
Time 3: six months post discharge from the programme.  
Clinicians: primary nurse and case manager allocated to the family

#### 3.1.4.5 Implementation of study and data collected

The comprehensive evaluation plan could not be conducted in its entirety. As indicated in Section 3.1.4 the resources to conduct research were limited, and it eventuated that the clinicians available were not able to administer and follow-up all of the questionnaires originally deemed appropriate to clinical functioning. After pilot use, the Family Adaptability & Cohesion Scale, the Achenbach Youth Self-Report and Achenbach Teacher Report Form and Harter – Teacher's Rating Scale of Child's Actual Behaviour were not used. Moreover, the validity of the Harter Self-Perception Profile was deemed questionable when compared with clinical observation and interview in the Unit. This instrument was therefore also not included in the battery of questionnaires used with the families admitted.

#### 3.1.5 Progress of the outcome evaluation originally designed

The schedule of questionnaires actually administered is outlined in Table 7 on page 135 below. The study actually conducted, then, focussed on child functioning as reported by the parents on the Achenbach Child Behaviour Checklist Problem and Competency Scales, and by clinicians on the Achenbach Child Behaviour Checklist Problem Scale only, parent functioning with the parents' self-report on the 28-item General Health Questionnaire and family functioning as reported by the parents on the McMaster Family Assessment Device.

Table 7

*Summary Table of the Actual Outcome Evaluation Performed Regarding Child, Parent and Family Functioning for Families Admitted to the Austin Child & Family Residential Unit Programme*

Area of Functioning	Questionnaire	Person/s Completing	Time Points
1. Identified patient (IP)	Achenbach Child Behaviour Checklist - Problem & Competency Scales	Parents	1, 2, & 3
	Achenbach Child Behaviour Checklist - Problem Scales only	Clinicians	1 & 2
2. Sibling closest in age to the IP	Achenbach Child Behaviour Checklist - Problem & Competency Scales	Parents	1, 2, & 3
	Achenbach Child Behaviour Checklist - Problem Scales only	Clinicians	1 & 2
2. Parent	28-Item General Health Questionnaire	Parents	1, 2, & 3
3. Family	McMaster Family Assessment Device	Parents	1, 2, & 3

Key:  
Time Points = Time of questionnaire administration:  
Time 1: on admission to the programme, Time 2: on discharge from the programme,  
Time 3: six months post discharge from the programme.  
Clinicians: primary nurse and case manager allocated to the family.

3.1.5.1 Context of the present study

The AC&FRU programme ceased operation in July 1997 and changed to a twelve bed Statewide Child Mental Health Service which focussed primarily on individual child admissions. This different focus was the result of overall changes to government funding in child and adolescent mental health in the state of Victoria.

On closure of the AC&FRU programme, the collected data sat dormant in hard copy form, with considerable six month follow up data still to be collected. Given that the programme was unique and valued by the A&RMC Child and Adolescent Mental Health Service, and as noted in Section 2.2.3.1 of Chapter 2, was the only known programme of this type to have undertaken formal outcome evaluation, it was considered important to complete and indeed extend the study.

The researcher, who had co-ordinated much of the overall data collection as a member of the original AC&FRU research team that devised the project, was able to complete this evaluation and further extend the project as a Doctor of Psychology research study, commencing on this work approximately six months after closure of the programme.

The extension to the project, described as Stage 2 of the study, was planned to involve retrospective follow up interviews with former AC&FRU team members, who would be invited to reflect on the theory and practice of the programme, as well as on perceived outcomes for the families admitted to the programme.

### 3.2 Rationale and design of the present evaluation study

#### 3.2.1 Overall aims of the present study

Against the background described above, the aims of the study presently reported were twofold.

Firstly, the study carried forward the aim of the originally planned study to evaluate the outcome effectiveness of a short-term family in-patient psychiatric intervention. This would be done by analysing the archival data collected during the period of operation of the programme, with considerable follow-up data to be collected after the programme closure. Secondly, it was aimed to explore retrospectively, in a qualitative way, the experiences of the clinicians of the AC&FRU in relation to theory, practice and perceived outcomes for the families.

#### 3.2.2 Stages of evaluation of the present study

In relation to the stated aims of the present study, the project can be conceptualised as having been conducted in two complementary stages. The first stage was an archival study evaluating the effectiveness of the inpatient family psychiatric intervention, using quantitative questionnaire data collected when the AC&FRU programme was in operation, with a proportion of follow-up data collected after its closure. The second stage, following on from the first stage, would reflect through qualitative means on the theory, practice and outcomes of the intervention as perceived by the clinicians who had

been involved in the programme. Stage 1 was to constitute a quantitative study, drawing upon parent and clinician evaluations of outcome which were archived during the operation of the programme, Stage 2 was to be a retrospective qualitative study of clinician experiences of the processes as well as the outcomes of the programme.

### 3.2.3 Stage 1 evaluation: Archival study of outcomes

#### 3.2.3.1 Aims and expectations of Stage 1

The aim of Stage 1 was to evaluate the effectiveness of the family inpatient intervention in terms of both the functioning of the family as a whole and the functioning of individual family members (the referred child or identified patient, the sibling closest in age to the identified patient, and the parents). Effectiveness would be evaluated by comparing pre-intervention measures (on admission to the family inpatient programme) with post-intervention measures at two points (at discharge from the programme, and then six months later). Measures would involve perceptions at each point in time, reported by parents and clinicians working with each family.

First, it was expected that significant improvement in the identified patient's functioning would be reported as perceived by the parents and clinicians from admission to at discharge from the programme and this improvement would be perceived as maintained at the six months follow up by the parents. Identification of the areas of difficulty for the identified patient and the family as a whole, and implementation of a programme tailored to address these was expected to result in improvement in the identified patient's functioning.

Secondly, it was expected that psychopathology in the identified patient would be perceived by parents to be greater than that perceived by the clinicians both on admission and at discharge from the programme. Parents ratings would reflect less familiarity of psychopathology than the clinicians who would be placing the child's presenting difficulties in the context of the full range of extremes of behaviours observed in a child inpatient psychiatric setting,



Thirdly, it was expected that, as the parents became increasingly aware of the family dynamics and inter-relationships, they would more clearly identify difficulties for individual family members and rate the sibling with more problems at discharge than on admission to the programme. A significant improvement in functioning for the sibling would then be expected to be perceived by the parents between discharge and later stages as the family integrated an increased understanding of their inter-relationship with each other, and implemented ongoing strategies employed during their family inpatient admission and ongoing outpatient work. Clinicians, in contrast, having identified difficulties for the siblings on admission, were expected to report a significant improvement in the sibling's functioning from on admission to the programme to that at discharge.

Fourthly, it was expected that a significant improvement in parents' functioning would be self-reported from admission to discharge and this improvement would be perceived to be at least maintained at six months follow up. These improvements would be seen in the context of the parents becoming increasing more competent in managing the presenting family difficulties as well as addressing their own needs.

Finally, it was expected that there would be a significant improvement in family functioning as reported by the parents from admission to discharge, and that this improvement would be perceived to be at least maintained at the six months post discharge follow up. Again these improvements would be seen in the context of the parents becoming increasing more competent in managing the presenting family concerns.

No major improvements for the family or individual members from discharge to the six-month post discharge follow up period were expected, given the multi-problem and severe nature of the family's presenting difficulties. The period between discharge and the six-month follow up would be seen as a period of transition and consolidation. This would involve consolidation of the gains achieved during their admission and putting these into operation in everyday functioning and tasks. Families would be focussed on reintegration back into their home, school and general community, as well as transition from the AC&FRU treating team back to the initial referring team or onto other community services and supports.

### 3.2.3.2 Specific hypotheses of Stage 1

A series of hypotheses were generated concerning changes in child, parent and family functioning, as reported by participants in the study, on the basis of the expectations outlined above.

#### 3.2.3.2.1 Hypotheses concerning identified patient functioning

Hypothesis 1a:

Psychopathology in the identified patient would be perceived by parents and clinicians as less at the time of discharge than at the time of admission to the AC&FRU programme, as indicated by scores at each of these times on the Achenbach Child Behaviour Checklist Summary Problem Scales (parents and clinicians) and Competency Scales (parents only).

Hypothesis 1b:

Psychopathology in the identified patient would be perceived as greater by parents than by clinicians at both the time of admission and the time of discharge from the AC&FRU programme, as indicated by scores at each of these times on the Achenbach Child Behaviour Checklist Summary Problem Scales.

Hypothesis 1c:

Psychopathology in the identified patient would be perceived by the parents as no different at the six month post discharge follow-up time than at the time of discharge from the AC&FRU programme, as indicated by scores at each of these times on the Achenbach Child Behaviour Checklist Summary Problem and Competency Scales.

#### 3.2.3.2.2 Hypotheses concerning sibling functioning

Hypothesis 2a:

Psychopathology in the sibling would be perceived by the parents as greater at the time of discharge than at the time of admission to the AC&FRU programme, as indicated by

scores at each of these times on the Achenbach Child Behaviour Checklist Summary Problem and Competency Scales.

#### Hypothesis 2b:

Psychopathology in the sibling would be perceived by clinicians as less at the time of discharge than at the time of admission to the AC&FRU programme, as indicated by scores at each of these times on the Achenbach Child Behaviour Checklist Summary Problem Scales.

#### Hypothesis 2c:

Psychopathology in the sibling would be perceived by the parents as less at the six month post discharge follow-up time than at discharge, as indicated by scores at each of these times on the Achenbach Child Behaviour Checklist Summary Problem and Competency Scales.

### 3.2.3.2.3 Hypotheses concerning parent functioning

#### Hypothesis 3a:

Parents' self reports of mental health difficulties would be less at the time of discharge than at the time of admission to the AC&FRU programme, as indicated by scores at each of these times on the General Health Questionnaire – 28.

#### Hypothesis 3b:

Parents' self-report of mental health difficulties would be no different at the six month post discharge follow-up time than at the time of discharge, as indicated by scores at each of these times on the General Health Questionnaire – 28.

### 3.2.3.2.4 Hypotheses concerning family functioning

#### Hypothesis 4a:

Parents would identify fewer difficulties for the family at the time of discharge than at the time of admission to the AC&FRU programme, as indicated by scores at each of these times on the McMaster Family Assessment Device.

#### Hypothesis 4b:

Parents would identify the difficulties for the family as no different at the six month post discharge follow-up time than at the time of discharge, as indicated by scores at each of these times on the McMaster Family Assessment Device.

#### 3.2.4 Stage 2 evaluation: Interview study of clinicians views of theory, process and outcomes

To complement Stage 1 of the project, the aim of Stage 2 was to explore, through qualitative means, the nature of the service delivered by the AC&FRU programme, from the perspective of those delivering the service. Clinicians involved in working with the families admitted to the programme between July 1995 and June 1997 were to be asked to reflect retrospectively upon their conceptualisations of the underlying theory and practice of the programme, as well as the perceived outcomes for the families and themselves, through the medium of a semi-structured interview. The interview was to be devised by the researcher on the basis of her lived experience of working on the programme.

Expectations of Stage 2 findings were formulated very broadly, in terms of perceived theory, practice and outcomes of the programme.

First, it was expected, because the programme was in principle grounded in a range of theoretical conceptualisations (as outlined in Section 3.1.1.2, primarily family systems, psychodynamic and cognitive-behavioural orientations delivered within a multi-modal treatment context from a multidisciplinary team approach), there would be a wide range of themes emerging in the experience of the participating clinicians in their interview responses. The manner in which these varying theoretical orientations inter-related would be explored.

Secondly, in reference to the practice of the programme, clinicians would be asked to provide detail regarding the actual processes of the programme. This would involve content about how the programme addressed problems at both family and individual levels, as well as team roles and general team functioning. Clinicians would be invited to frankly express their experiences of the processes of the programme, so that new

information could be discovered. In the spirit of exploration, expectations were not formulated concerning their experiences.

Thirdly, regarding the outcomes, assuming that the clinicians did perceive positive quantitative effects for the identified patients, siblings and families engaged in the programme, what was of particular interest was the manner in which they perceived these came about. It was expected that, through exploratory questioning, a broad range of factors perceived as contributing to these outcomes, the barriers, difficulties and challenges experienced, would be identified.

## **CHAPTER 4**

### **METHOD OF STAGE 1: ARCHIVAL QUESTIONNAIRE STUDY**

In this chapter, the methodology relating to Stage 1 of the project, the archival quantitative questionnaire component, is outlined. First, the method of recruitment and the sample population (parents and clinicians) are identified. Next, details of the three questionnaire instruments used (Achenbach Child Behaviour Checklist, General Health Questionnaire-28 and McMaster's Family Assessment Device) are presented. Finally, the procedural details of Stage 1, incorporating ethics approval, data collection and planned data analysis, are outlined.

As noted in Chapter 3, Section 3.1.5, after the pilot period, the project was scaled back considerably from the original plan.

#### **4.1 Sampling**

##### **4.1.1 Method of recruitment**

Recruitment of both the family and the clinician participants occurred directly through their respective involvement with the Austin and Repatriation Medical Centre's (A&RMC) Child and Adolescent Mental Health Service's (CAMHS) Child and Family Residential Unit programme. First, the families in this study were to be recruited at the time of their admission to the Austin Child and Family Residential Unit (AC&FRU) programme. Acceptance to the programme was not contingent upon the families participating in this study. Each of the 29 families consecutively admitted to the programme between July 1995 and June 1997 voluntarily agreed to be participants.

Second, the clinician population was recruited to this study in the context of their work with the families in the AC&FRU programme. Their involvement in this study was viewed as a compulsory aspect of their work profile. Given this, no formal consent was enlisted from the clinicians in this stage of the project.

## 4.1.2 Participants in the study

### 4.1.2.1 Parents

The first set of respondents in Stage 1 of the project were the parents of the 29 families who were admitted to the AC&FRU programme from July 1995 to June 1997.

### 4.1.2.2 Austin Child and Family Residential Unit Team Members (Clinicians)

The second set of respondents were the clinicians working with the families in the AC&FRU programme. The clinicians nominated to act as respondents reporting on the children's (the identified patient and the sibling of the identified patient) functioning at Time 1 and Time 2 were the case manager and primary nurse allocated to the family for the duration of their admission. A total of 12 clinicians were involved in Stage 1 of the project. Six of these clinicians were case managers (one consultant child psychiatrist, two trainee child psychiatrists, one clinical child psychologist, one social worker and one occupational therapist) and six were primary nurses (all registered psychiatric nurses).

## 4.2 Questionnaire Instruments

After the pilot study, three instruments were used in Stage 1 of the evaluation. As shown in Table 7 on page 135 above, these were the Achenbach Child Behaviour Checklist (CBCL), the 28-item General Health Questionnaire (GHQ-28), and McMaster's Family Assessment Device (FAD).

### 4.2.1 Achenbach Child Behaviour Checklist (CBCL)

#### 4.2.1.1 Overview of the CBCL

The Achenbach Child Behaviour Checklist (CBCL) was selected for this evaluation because of its reputation as a very carefully developed, standardised and adaptive instrument for assessing children's problem behaviours (Verhulst & Koot, 1992). The CBCL (Achenbach, 1991a) is a standardised questionnaire for parents and caretakers of children aged four to 18. The CBCL was originally developed by Achenbach and

Edelbrock (1983), and has provided mental health professionals with a reliable means of assessing the behaviour problems and social competencies of children referred for treatment. It does not provide a specific diagnosis. The CBCL is presented in Appendix I.

#### 4.2.1.2 Composition and Competency and Problem Scales

The CBCL is presented in two parts and takes about 20 minutes to complete. The child's behaviour is rated on a 3-point-scale for each item. The first part comprises 20 social competence items designed to measure children's adaptive functioning, based on detailed knowledge of the child's use of free time and participation in community activities. The total competence score comprises the sum of the three scaled scores: activities, social and school. The competence scales are not scored for 4-5 year olds, because children of this age are seldom in school and the other competence items were not found to discriminate well between referred and non-referred 4- and 5-year old children (Achenbach, 1991a). In the current study, as the clinicians observations were restricted to the inpatient setting, completion of the CBCL Competency Scale was restricted to the parents.

The second part of the CBCL is made up of 118 items relating to a broad range of behaviour problems that may have been observed over the past six months. Ratings of these 118 items are summed to provide scores on three Summary Problem Scales - Total, Internalising and Externalising scales, and eight or nine Syndrome Problem Scales, dependent on the age of the child. The Syndrome scales include Withdrawn (9 items), Somatic Complaints (9 items), and Anxious/Depressed (14 items) which comprise the Internalising Summary Problem Scale; Delinquent Behaviour (13 items) and Aggressive Behaviour (20 items) which comprise the Externalising Summary Problem Scale; and Social Problems (8 items), Thought Problems (7 items), Attention Problems (11 items) and Sex Problems (6 items) (Achenbach, 1991a).

#### 4.2.1.3 Scoring

Scale raw scores are transformed to T scores which are then used to develop a Behaviour Problem profile (see Appendix II for a sample profile). Norms provide a tripartite division into normal, borderline and clinical ranges for the scales.



With regard to the Summary Problem Scale scores (Total, Internalising and Externalising scales) the normal range falls below a T score of 60, borderline from 60 to 63, and the clinical range above 63.

T scores for the Syndrome scales have a different normal and clinical range. T scores less than 67 are classed within the normal range, T scores 67, 68 and 69 are within the borderline clinical range, and T scores 70 and above are designated within the clinical range.

T scores for the Competency scales are different again. T scores less than 30 fall within the clinical range, T scores 30-33 are considered borderline, and above 33 are classified within the normal range (Achenbach, 1991a).

#### 4.2.1.4 Reliability and validity

The CBCL has been documented to have acceptable reliability and validity. The inter-interviewer and test-retest reliabilities of the CBCL item scores were supported by intra-class correlations in the .90s for the mean item scores obtained by different interviewers and for reports by parents on two occasions seven days apart. The test-retest reliability for the CBCL scale scores was supported by a mean test-retest  $r=.87$  for the Competence scales and .89 for the Problem scales over a seven day period (Achenbach, 1991a).

#### 4.2.1.5 Norms

The CBCL has been normed and used widely in the United States. It has been employed with clinical and non-clinical populations to determine whether a child exhibits usual or excessive behaviour in relation to same-age peers who are functioning adequately at home and at school (Achenbach, 1991a). The CBCL has been found to discriminate between clinical outpatient and inpatient populations (Achenbach, 1978; Edelbrock & Achenbach, 1980; Jones, Latkowski, Kircher & McMahon, 1988; Massey & Murphy, 1991), has been applied to archival data (Towle & Scharz, 1987) and has also been used as a screening instrument for case definition (Bird, Canino, Rubio-Stipec, Gould, Ribera, Sesman, Woodbury, Hueretas-Goldman, Pagan, Sanchez-Lacy & Moscoso, 1988).

Australian norms for non-referred children have recently been established (Crijnen, Achenbach, & Verhulst, 1999). These were drawn from a population of 1,372 four to 16-year-olds selected through random sampling of households in Western Australia (Silburn, Zubrick, Garton, Gurrin, Burton, Dalby, Carlton, Shepherd, & Lawrence, 1996; Zubrick, Silburn, Garton, Burton, Dalby, Carlton, Shepherd, & Lawrence, 1995; Zubrick, Silburn, Gurrin, Teoh, Shepherd, Carlton, & Lawrence, 1997). This research was piloted in 1995 (Garton, Zubrick, & Silburn, 1995), and has been the source of Australian information for the most recent CBCL cross-cultural comparison of problems reported for children (Crijnen et al., 1999).

Prior to these results, findings for a non-referred population within Australia had been mixed with no verified norms. Hensely and colleagues (Achenbach, Hensley, Phares, & Grayson, 1990; Hensely, 1988) had reported on a Sydney non-referred population, and found that parents reported children in this population significantly higher on problem scales compared with the norms of their North American counterparts. In contrast, a Melbourne study of non-referred children found children in this population to be more like the American norms (Bond, Nolan, Adler, & Robertson, 1994). In this latter study, however, the age range was largely restricted to seven-year-olds.

In reference to a clinically referred population in Australia, Nolan, Bond, Adler, Littlefield, Birleson, Marriage, Mawdsley, Salo and Tonge (1996) analysed data for 1342 children newly referred to six major child and adolescent mental health centres in Melbourne. The mean total problem T score was above the clinical range for all age groups and range between 64.5 for 4-11-year-old girls to 66.9 for 4-11-year-old boys. While more clinically referred children in Melbourne scored above the clinical cut-off than American children, overall, this study provided support for the usefulness and applicability of the recommended CBCL cut-off scores in an Australian population (Nolan et al.). To the present researcher's knowledge, no Australian inpatient norms are available to date.

#### 4.2.1.6 Choice of instrument in the study

In the absence of empirically sound quantitative measures being used in the family inpatient outcome evaluation field previously, the CBCL was selected as the measure of child psychopathology because it is viewed to be the most carefully designed, standardised and adaptive instrument for assessing childrens' problem behaviours (Verhulst & Koot, 1992). Moreover, the CBCL has been used extensively in child psychiatry generally, and in particular in several of the individual inpatient programmes as reviewed in Section 2.2.1.2 of Chapter 2 above (Gerardot et al., 1992; Kazdin & Bass, 1988; Sourander & Piha, 1996).

### 4.2.2 28-Item General Health Questionnaire (GHQ-28)

#### 4.2.2.1 Overview of the GHQ-28

The 28-item General Health Questionnaire or GHQ-28 (Goldberg & Hillier, 1979), a scaled version of the lengthier GHQ versions (Goldberg, 1972), is a self-administered mental health questionnaire designed for use in consulting settings aimed at detecting individuals with a diagnosable psychiatric disorder. It focuses on two major classes of phenomena, namely the inability to carry out one's normal 'healthy' functions, and the appearance of new phenomena of a distressing nature (Goldberg & Williams, 1988). It thus detects psychological components of ill-health associated with breaks in normal function rather than lifelong traits (Graetz, 1991). Whilst the lengthier versions of the GHQ has been used as a screening device to detect psychiatric cases, or to estimate the prevalence of psychiatric disorder within various samples or sub-samples, the shorter versions such as GHQ-28 have been used as a more general measure of psychiatric well-being. The GHQ-28 is presented in Appendix III.

#### 4.2.2.2 Composition and problem scales

The GHQ-28, based on 28 items derived from a factor analysis of the GHQ-60, consists of a range of 28 questions about social activities, psychological symptoms, and some physical symptoms experienced 'over the last few weeks'. The respondent answers either 'not at all', 'not more than usual', 'rather more than usual' or 'much more than

usual' to each question. Responses to the questions are recorded on four component scales, namely Scale A: somatic symptoms, Scale B; anxiety and insomnia, Scale C: social dysfunction and Scale D: severe depression.

#### 4.2.2.3 Scoring

The GHQ may be scored in two ways. First is the binary scoring method, predominately used in longer versions of the questionnaire and when the GHQ has been used as a screening device to detect psychiatric cases, or to estimate the prevalence of psychiatric disorder within various samples or sub-samples (Graetz, 1991). Two answers ('not at all' and 'not more than usual') are considered normal responses, and score 0, while the other two answers ('rather more than usual' and 'much more than usual') are considered pathological and score 1. The design of the instrument in conjunction with this scoring method is such as to eliminate most of the bias attributable to various response sets. The total score is the sum of the individual items, and is the generally the reported score. A GHQ score of five or more (out of 28) is designated to be of clinical importance (Goldberg & Hillier, 1979).

Second is the Likert scoring method. This method is generally used for shorter versions of the GHQ as a more general measure of well-being. An overall GHQ score is calculated for each subject by assigning separate scores (0-3) to each response and summing across items. The response category 'not at all' is scored as 0, 'not more than usual' is scored as 1, 'rather more than usual' is scored as 2 and 'more than usual' is scored as 3 (Goldberg & Williams, 1988). Banks, Clegg, Jackson, Kemp, Stafford, & Wall (1980) demonstrated that this Likert scoring method produced a more acceptable distribution of the scores for parametric analysis (with less skew and kurtosis). The Likert scoring method was applied in this study to provide more detailed information .

#### 4.2.2.4 Reliability and validity

The reliability and validity of the GHQ has been thoroughly investigated. Most recently, Goldberg and colleagues (Goldberg, Gater, Sartorius, Unstun, Piccinelli, Gureje, & Rutter, 1997) investigated the validity of GHQ-28 and GHQ-12 in a World Health Organisation study of psychological disorders in general health. Findings revealed there

was no tendency for the GHQ to work less efficiently in developing countries, and age, gender and educational level were shown to have no significant effect on the validity of the GHQ (Goldberg et al.).

In addition, Werneke, Goldberg, Yalcin & Ustun (2000) recently compared the factor structures of the GHQ-28 and GHQ-12. In relation to the GHQ-28, the original C scale (social dysfunction) and D scale (severe depression) were found to be more stable than the scale A (somatic symptoms) and scale B (anxiety). It was considered that the cross-correlation between scales A and B, probably reflected the strength of relationship between anxiety and somatic symptoms. Whilst the variance in factor structure was not seen to affect validity as measured by sensitivity and specificity previously reported by Goldberg et al. (1997), Werneke et al. highlighted the importance of investigators wishing to explore the scaled scores being mindful of the inter-correlation between scales, particularly between scales A and B.

Whilst not affecting the validity as a case detector, the four subscales comprising the GHQ-28 have inter-correlations ranging from 0.33 to 0.61 (average 0.51) (Goldberg & Hillier, 1979), and 0.35 to 0.65 (average 0.50) (Banks, 1983).

#### 4.2.2.5 Norms

Tenant (1977) found the GHQ to be an efficient, reliable and valid measure of psychological disturbance in Australian populations. This landmark work has continued to be regarded as the basis for the use of the GHQ in Australia (Goldberg & Williams, 1988; Taylor, Wilson, Dal Grande, Ben-Tovim, Elzinga, Goldney, MacFarlane, Cheok & Kirke, 2000).

#### 4.2.2.6 Choice of instrument in the study

Goldberg et al. (1997) and Werneke et al. (2000) recommended that the GHQ-28 be used if the researcher wishes to have scaled scores in addition to a total score. As more detailed information was required in this study, the GHQ-28 version was administered. Again, this choice was made in the absence of previous use of standardised measures of parent functioning in the family inpatient admission field.

## 4.2.3 The McMaster's Family Assessment Device (FAD)

### 4.2.3.1 Overview

The McMaster's Family Assessment Device or FAD (Epstein et al. 1983) is a 60-item Likert scale self-report questionnaire, designed to measure family functioning based on the McMaster Model of Family Functioning (MMFF), a clinically oriented conceptualisation of families. The model describes structural and organisational properties of the family group and the patterns of transactions among family members which have been found to distinguish between healthy and unhealthy families. The FAD is presented in Appendix IV.

### 4.2.3.2 Composition and problem scales

The FAD was designed to assess six dimensions of the MMFF, as well as overall level of family functioning. The seven subscales of the FAD are Problem Solving (PS), Communication (CM), Roles (RL), Affective Responsiveness (AR), Affective Involvement (AI), Behaviour Control (BC), and General Functioning (GF).

Problem Solving refers to the family's ability to resolve problems to a level that maintains effective family functioning. The Communication scale assesses whether communication is clear or masked with respect to content, and direct and indirect in the sense that the person spoken to is the person for whom the message is intended. The Roles scale focuses on whether the family has established patterns of behaviour for handling family tasks. Affective Responsiveness assesses the extent to which individual family members are able to experience appropriate affect over a range of situations. Affective Involvement is concerned with the extent to which family members are interested in and place value on each other's activities and concerns. Behaviour Control assesses the way in which a family expresses and maintains standards for the behaviour of its members. Lastly, the General Functioning scale provides an overall assessment of the level of family functioning (Epstein et al., 1983).

#### 4.2.3.3 Scoring

The instrument asks the participant to respond to statements about their family on a four-point scale ranging from 'strongly agree' and 'agree' to 'disagree' and 'strongly disagree'. The responses for each dimension of family functioning are summed and divided by the total number of items resulting in one score for each dimension of family functioning for each respondent. Scores range from a low of 1.00, reflecting optimal family functioning, to 4.00, reflecting the most severe level of disturbance in family functioning (Miller, Epstein, Bishop, & Keitner, 1985).

#### 4.2.3.4 Reliability and validity

The reliability and validity for the FAD have been well investigated. Studies have reported that the FAD has adequate levels of internal consistency (coefficient alpha = .72 to .92), test-retest reliability (.66 to .76), moderate correlations with other measures of family functioning and discriminates significantly between families rated by experienced clinicians as healthy and unhealthy (Epstein et al., 1983; Miller et al., 1985).

It has been found to show good concurrent validity and protection against social desirability factors (Miller et al., 1985). The seven individual FAD scales were designed to be different conceptually and statistically, and thereby satisfy internal consistency (Miller et al., 1985).

#### 4.2.3.5 Norms

Miller et al. (1985) established clinical cut-off scores for each of the six dimensions of family functioning and for the general functioning scale. These scores, which were based on clinician ratings, can be used to differentiate between healthy and unhealthy family functioning. Norms for an Australian population are drawn from Sawyer, Sarris, Baghurst, Cross and Kalucy's (1988) Adelaide based study which compared mother, father and adolescent reports from 94 clinic referred families with 94 community families. Overall, this study provided additional support for the usefulness and applicability of the FAD in identifying family psychopathology in an Australian population. However, in Sawyer et al.'s (1988) study it was noted that adolescents in

both groups rated their families significantly less healthy than their parents, and differences between fathers reports in the two groups failed to reach significance. The higher adolescent rated scores were also observed in a further Australian study (Martin, Rozanes, Pearce & Allison, 1995), as well as in Kline's (1995) study based in Massachusetts, United States of America. The need to consider, separately, self-reports on family functioning obtained from different members of the same family was highlighted (Sawyer et al., 1988).

#### 4.2.3.6 Choice of instrument in the study

Again, the choice of this instrument was made in the absence of previous use of standardised measures of family functioning in the family inpatient treatment field. The McMaster FAD was chosen in this study as it appeared to be one of the more carefully developed family assessment instruments available. First, the FAD was based on a well-developed theoretical model of family functioning (Epstein & Bishop, 1981). Second, a parallel clinician scale, the McMaster Clinical Rating Scale (Miller, et al., 1994) was also available and had been planned to be utilised in the originally devised study. Moreover, other child psychiatry programmes (Gavidia-Payne et al., 2003; Kiser et al., 1996; Kline, 1995) had utilised the FAD as a measure of family outcome.

### 4.3 Procedure

#### 4.3.1 Ethics approval

The Austin and Repatriation Medical Centre's (A&RMC) (then the Austin Hospital) Human Research Ethics Committee provided approval for Stage 1 of the present study, that is the evaluation study originally planned, in 1995 (see Appendix V). Members of the AC&FRU research team who instigated this project (which included the current researcher), as well as the Director of the Child and Adolescent Mental Health Service at the A&RMC, gave permission for the now archival data to be formally analysed by the researcher in 1997.

A&RMC Human Research Ethics Committee also approved a protocol amendment to the 1995 originally planned study, in 1997. The amendments as outlined in Chapter 3,



Section 3.1.5 and summarised in the letter to the A&RMC Human Research Ethics Committee in Appendix VI, involved the inclusion of the current researcher as project investigator and Dr Suzanne Dean as project co-investigator, and the noted withdrawal of several instruments in the study. The letter of approval for this protocol amendment is provided in Appendix VII. It then became possible for the research to be carried forward as a Doctor of Psychology degree research project.

#### 4.3.2 Data collection

##### 4.3.2.1 Parent questionnaires

On the day of the family's admission to the AC&FRU, the researcher would meet with the family, to explain the aims and purpose of the study. Appendix VIII provides a copy of the Adult Patient Information Sheet, and Appendix IX, a copy of the Child Patient Information Sheet in the form of a covering letter. Formal consent from the parents and children, who were of an appropriate age was then attained. Appendix X provides a copy of the Consent Form for Adults (Parents) and Appendix XI, the Consent Form for Children that were used. In the patient information sheets and the consent forms, the full range of measures, as outlined in Chapter 3, Section 3.1.4. and summarised in Table 6, that were planned in the original study were included. As explained in Chapter 3, in Sections 3.1.4 and 3.1.5 above, not all questionnaires mentioned were administered. The revised schedule of instruments used was summarised in Table 7 on page 135.

Each parent was requested to independently complete the CBCL for each of their children in the household, the GHQ-28 for themselves, and the FAD in relation to their family as a whole. These questionnaires were administered at three points in time:

- a) Time 1: at enrolment in the study (on admission to the AC&FRU),
- a) Time 2: at discharge from the AC&FRU (usually six weeks after admission),  
and
- b) Time 3: six months after discharge from AC&FRU.

The researcher distributed the questionnaires again in the days preceding discharge. For Time 1 and Time 2, the completed forms were returned to the researcher on the same

day or on the following day. For Time 3 data, the researcher contacted the family by telephone one week prior to the six month post-discharge time and organised for the relevant questionnaires to be sent to the parents with the same instructions. The parents would return the completed questionnaires by post. Information from these questionnaires at each of the time intervals was not made available to the team, and therefore did not present as a source of contamination.

#### 4.3.2.2 Clinician questionnaires

For each family, the primary nurse and case manager who comprised the case management team independently would complete the CBCL Problem Scale for each child in the family. The CBCL Competency Scale was not completed by clinicians as this required a detailed knowledge of the child's performance in academic subjects, use of free time and participation in activities in the community. As the clinicians' observations were restricted to the inpatient setting, accurate completion of this section was not possible. The questionnaires were distributed by the researcher to the clinicians with instructions to complete the same in regards to their accumulated understanding of the child. The questionnaires were completed at two distinct time intervals:

- a) Time 1: at the end of the assessment period (two weeks after admission), and
- b) Time 2: at discharge from the AC&FRU (usually six weeks after admission).

These two time points coincided with the Time 1 and Time 2 points relating to the parent data. The Time 1 data collection occurred at the end of the two-week assessment period to enable the clinicians to gain as comprehensive understanding as possible of the concerns for each child. No formal therapeutic intervention occurred during this initial time period.

Time 3 data was not collected from the clinicians as post-discharge follow up plans varied for each family and did not always involve the AC&FRU team.

It needs to be emphasised that, as in Kazdin and Bass's (1988) study, the primary nurse and case manager completed the same CBCL form as the parents, and not the Child Behaviour Rating Form (CBRF; Edelbrock, 1985), which is an abridged version for

clinicians, modelled after the CBCL. It was possible to use the same questionnaire due to the family's inpatient status and the AC&FRU clinician's accumulative detailed knowledge of each family member over the assessment and treatment phases of the programme.

#### 4.3.3 Data analysis planned

Appropriate multivariate statistical techniques would be used to test the hypotheses set out in Section 3.2.3.2 of Chapter 3 above. The specific statistics to be subjected to analysis, generated by the measures to be used, are discussed below.

##### 4.3.3.1 Achenbach Child Behaviour Checklist

The completed and compiled CBCL protocols were scored using Achenbach's (1991a) revised computerised scoring programme. Separate ratings were attained, where possible, by mother, father, primary nurse and case manager for each child in the family. On inspection of the archival questionnaires, subject attrition across Time 1, Time 2 and Time 3 was noted, as was limited father participation. Therefore, most of the analyses would focus on the mother- and clinician-completed (combined primary nurse and case manager) scores at Time 1 and Time 2 (see Section 7.1 of Chapter 7, summarised in Tables 8 and 9 on pages 177 and 179 respectively).

To obtain a clinician-completed CBCL score for each child, the researcher would compare the primary-nurse-completed and case-manager-completed CBCL questionnaires for each child, so that a single composite clinician-completed CBCL profile could be compiled and then scored for each child. If discrepancies in the scores were found, an averaged score could be calculated as directed in the CBCL scoring manual.

Children were scored within Achenbach's (1991a) normative age groups: 4-5 years, 6-11 years, and 12-18 years; and according to gender. Sample sizes were too small to analyse the data within the six separate groupings based on age and gender. Instead, the T-score derived from the raw score would be used to provide a comparative analysis of all children across each age group, categorised by identified patient or sibling status.

Due to the size and composition of the subject population, it was planned to use T scores in this study to enable a comparative analysis of all children across age and gender groups, categorised by referred child or sibling status.

#### 4.3.3.2 The General Health Questionnaire-28

The parent-completed GHQ-28 self-report measure was scored according to 0, 1, 2, 3 Likert rating system for the four subscale domains (somatic symptoms, anxiety and insomnia, social dysfunction and severe depression) and total score, for Time 1 and Time 2. Separate ratings were attained where possible for the mother and the father in each family. Again given the subject attrition across Time 1, Time 2 and Time 3 and a limited father presence in the families admitted the multivariate analyses would focus only on the mother-completed data at Time 1 and Time 2 (see Section 7.1 of Chapter 7, summarised in Tables 8 and 9 on pages 177 and 179 respectively).

#### 4.3.3.3 The McMaster's Family Assessment Device

The parent-completed McMaster's Family Assessment Device (FAD) report regarding their family was scored according to the devised rating system incorporating the seven subscales (problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functioning) for Time 1 and Time 2. Separate ratings were attained where possible for the mother and the father in each family. Again given the subject attrition across Time 1, Time 2 and Time 3 and limited father data, the FAD multivariate analysis would focus on the mother-completed data at Time 1 and Time 2 (see Section 7.1 of Chapter 7, summarised in Tables 8 and 9 on pages 177 and 179 respectively).

## CHAPTER 5

### METHOD OF STAGE 2: CLINICIAN INTERVIEW STUDY

This chapter outlines the qualitative methodology planned pertaining to Stage 2 of the research in which clinicians were to be interviewed retrospectively concerning their various experiences in working in the AC&FRU. After commenting upon the nature of the qualitative methodology employed, the sample and the method of recruitment are described. This is followed by a description of the instruments to be used, a semi-structured in-depth interview and a clinician's questionnaire. Next, the procedure, incorporating ethics approval, the method of recruitment, data collection and data analysis, is outlined.

#### 5.1 An ethnographic qualitative methodology

With the overall aim of moving beyond the purely descriptive case study research design format that as reviewed above in Chapter 1, Section 1.3.5 and Chapter 2, Section 2.2.3 had been extensively (and almost exclusively) reported in past literature related to child psychiatry family inpatient treatment, an ethnographic qualitative research design was selected for Stage 2 of this current project.

Here, the purpose was to map the common in-depth experiences of the team of clinicians collaborating in their work in the AC&FRU. As Gall et al. (1996) observed, an ethnographic approach focusses on discovering cultural patterns in human behaviour, describing the perspective of members of the culture, and studying the natural settings in which the relevant culture is manifested. This was the intent, albeit, in a retrospective manner, in reference to understanding the underlying theory, practice and perceived outcomes of the AC&FRU programme. The ethnographic approach was also chosen as it permitted the current researcher to draw upon a range of data collection strategies (such as interviewing and document analysis) to derive such a 'cultural' understanding regarding the AC&FRU programme, based upon the lived experience of the clinician involved.

## 5.2 Participants

Each of the 11 clinicians who had been a member of the AC&FRU team for at least a 12 month period including between July 1995 and June 1997, and who were employed at least 0.5 EFT over that time, was to be invited to participate in Stage 2 of this research.

## 5.3 Instruments

### 5.3.1 Semi-structured interview

As noted in Section 2.2.3 of Chapter 2, qualitative data collection in the previous studies of family inpatient admission programmes, were rudimentary. Therefore, a semi-structured interview was designed specifically for the present study.

The interview protocol comprised 10 set questions requesting the participant to reflect in depth on their conceptualisations of the AC&FRU programme's underlying theory and practice, as well as perceived outcomes for both the families admitted to the programme and for themselves as clinicians. The interview questions were used as a guide and additional or re-worded questions were asked throughout the interview to elicit clarification and necessary elaboration on given points. The ten questions were:

1. How did the AC&FRU programme conceptualise the presenting family difficulties?
2. How did the AC&FRU programme conceptualise the place of the identified patient's difficulties in the context of the overall family functioning?
3. How did you see the AC&FRU programme addressing problems at a family level?
4. How did you see the AC&FRU programme address problems at an individual level?
5. How would you describe your own and other team members designated roles on the AC&FRU team?
6. What benefits to the family were provided by their admission to the AC&FRU? What contributed to these benefits?

7. In what ways was a family admission to the AC&FRU not beneficial? What contributed to this not being a beneficial intervention for the family? What were the barriers, difficulties or challenges?
8. How did you perceive outcomes for the identified patient compared with other family members?
9. Did you notice any changes in perception of family members at both an individual level and a family level over the course of treatment?
10. Can you say what outcomes there have been for you, what, if anything have you taken from your experience with the programme to your subsequent work practice?

A copy of the Clinician Semi-structured Interview is provided as Appendix XII.

### 5.3.2 Clinician's Self Report Questionnaire

The Clinician's Self-Report Questionnaire, designed by the researcher, was a brief list of seven questions pertaining to the clinician's professional experience before and after working with the AC&FRU as well as the participant's demographic details.

The following areas were addressed in the questionnaire:

1. time period of employment with the AC&FRU;
2. professional experience prior to employment with AC&FRU including the number of years and prior experience in the health field, mental health field, and child and adolescent mental health;
3. position held on AC&FRU team; and
4. professional training and experience since working on the AC&FRU team.

This questionnaire provided background information which might be important in relation to the interpretation of the interview material. A copy of the Clinician's Self-Report Questionnaire is provided as Appendix XIII.

## 5.4 Procedure

### 5.4.1 Ethics approval

Ethics approval for Stage 2 of this project was granted in 2000 by the Austin and Repatriation Medical Centre's Human Research Ethics Committee (see Appendix XIV) and by Victoria University Human Research Ethics Committee (see Appendix XV).

### 5.4.2 Method of recruitment

The potential participants for Stage 2 of this project, as identified in Section 5.2 above, were to be initially contacted by telephone. Telephone contact was planned, as most of the identified clinicians now worked in locations other than the Austin and Repatriation Medical Centre. The clinicians would be reminded of Stage 1 of the project, in which they had been involved, and Stage 2 of the project would be explained. It was to be explained that consent to be involved in Stage 2 of the project would involve:

- (a) completion of a self-report questionnaire regarding their professional training and experience which would take approximately 15 minutes; and
- (b) their individual involvement in a semi-structured interview with the researcher, reflecting on their conceptualisations of the underlying theory and practice of the AC&FRU programme, as well as the perceived outcomes for families admitted to the programme, which would take approximately 60 minutes.

In regard to possible risks, inconveniences and discomforts, beyond the time allocation to each task, the researcher would flag the possibility of some discomfort in reflecting on the programme due to the circumstances of its discontinuation. It was to be explained that if any adverse events occurred during or following the completion of the interview, the participant would have the opportunity to contact the researcher's supervisor Associate Professor Suzanne Dean for debriefing as required.



If the potential participant verbally agreed to be involved in Stage 2 of the project, an interview time and location of the participant's choosing was to be organised. The researcher would then mail the Participant Information Sheet (see Appendix XVI), Clinician Self Report Questionnaire and Consent Form, along with a covering letter asking the participant to read the information provided and, if agreeable to sign the Consent Form (see Appendix XVII) to complete the Clinician Self Report Questionnaire.

#### 5.4.3 Data collection

The researcher would interview each participant individually. On initial meeting, the researcher was to check that the participant had read and understood the proposed task. Any clarifications required would be provided before collecting the Consent Form signed by the participant and a neutral witness, then co-signed by the researcher. Also at this point, the completed Self Report Questionnaire would be collected. At the beginning of each interview, the preamble as outlined in the interview schedule was to be read to the clinician. Each interview was to be audio-taped with the participant's permission.

#### 5.4.4 Qualitative data analysis planned

All participants would be allocated a letter code (A, B, C, D, E, F, G, H, I or J) to maintain confidentiality, and the interviews transcribed by either a professional transcriber or the researcher. Transcripts would be checked by the researcher by reading the transcript and listening to the taped interview, so that any necessary amendments could be made. The transcripts were then to be analysed by the researcher, utilising the technique of thematic content analysis (Miles & Huberman, 1994), a form of textual analysis (Ertmer, 1997). Three levels of analysis, as outlined below, were entailed.

##### 5.4.4.1 First level of analysis: Identification of themes

In response to each set interview question, the researcher would identify themes or themes emerging in the responses made by the interviewee, who was assigned a letter

code. This would be conducted by a process of punctuating the transcript of the interview, noting references to specific issues, marking these in the margin with comments and allowing reference to particular issues to coalesce into themes.

The identified themes would be highlighted on the original typed transcript and numbered. Each theme and its number was to be taken and the theme rewritten in tabular form, either verbatim or paraphrased, and then tied with the interviewee's assigned code letter (e.g. A1 to A63 for the first interviewee). This would assist in later ready identification and location in the original transcript as necessary. The original typed interview transcript for each interviewee could then be placed aside.

#### 5.4.4.2 Second level of analysis: Sorting and grouping of themes

At the second level of analysis, for each interviewee, the identified themes of the first level analysis transcript would then be examined by the researcher. The researcher was to place each theme in a second level of table or matrix, under a heading designating the interview question to which the theme was most relevant. If themes emerged which did not directly relate to the set areas of enquiry, then these would be placed under the most relevant general subheading provided within the interview schedule – either theory, practice or outcomes.

For example, for Question 1, related to theory, if responses from interviewee A included responses directly tied to Question 1 but were also identified at other places in the interview, then the points under Question 1 may read A1, A2, A3 A22, A37. This sorting and grouping process was carried out for each interviewee's transcript.

#### 5.4.4.3 Third level of analysis: Further data reduction

The third level of analysis would involve identifying the main themes under each designated question and then breaking these down into subthemes, summarising and aggregating the themes where possible. Some themes, it was anticipated, would recur and impress as highly significant. Issues that impress as meaningful were to be identified by a process of clinical judgement. The researcher's familiarity with

working with families with multiple problems and an awareness of the pre-existing literature was expected to influence the identification of themes as significant.

The number of respondents making mention of the identified theme and subthemes would be noted, and these themes and subthemes hierarchically listed in table format, in accordance with the method recommended by Miles and Huberman (1994) for each question or area of enquiry, from the most frequently mentioned to the least frequently mentioned.

Appendix XVIII provides sample pages of this third level of analysis, based on responses made by participants in respect to Question 1 from the semi-structured interview.

The third level analysis tables, as eventually constructed, are presented in their entirety in Sections 8.3, 8.4, and 8.5 of Chapter 8. These tables are accompanied by verbatim examples of themes mentioned by specific clinician letter codes that were assigned at the first level of analysis.

## **CHAPTER 6**

### **RESULTS OF STAGE 1 EVALUATION: DESCRIPTION OF FAMILIES PARTICIPATING IN THE PROGRAMME**

In this chapter, the characteristics of the families and individual family members participating in the Austin Child and Family Residential Unit programme are described in full. While each of the 29 families admitted to the programme between July 1995 and June 1997 consented to participate in the research, not all of the families were represented in each of the outcome measures. This was due to constraints imposed by both family composition and age parameters of instruments used, as well as subject attrition across time. As a result varying numbers of cases were available for each instrument. A full review of the archival data available for analysis is detailed from Section 7.1 of Chapter 7, below.

In this chapter, first, the demographic characteristics of the 29 families are provided. Second, the demographic and diagnostic characteristics of the parents (or grandparent or guardian) are outlined. This is followed by an overview of the demographic characteristics of the children. More specific detail regarding the children is then provided, focussing specifically on diagnoses for the identified patients and their siblings. Finally, a summary regarding family members' diagnoses is provided.

#### **6.1 Family characteristics**

A total of 29 families consecutively admitted to the Austin & Repatriation Medical Centre's (A&RMC) Child and Adolescent Mental Health Service's (CAMHS) Child and Family Residential Unit (AC&FRU) between July 1995 and June 1997 were invited to participate in the study. All consented to participate.

Of the 29 families, 45% (n=13) were single-parent families, 45% (n=13) were intact two-parent families, 7% (n=2) were multi-generational families and one (3%) was a blended family. 21% (n=6) had one child, 48% (n=14) were two-child families, 21% (n=6) were three-child families, and 10% (n=3) were four-child families.

Converting the major wage earner's occupation to Hollingshead's (1975) seven point scale, the following socioeconomic distribution was found for the 29 families: 3.5% (n=1) were executives, 10% (n=3) managers, 14% (n=4) administrative workers, 3.5% (n=1) clerical or sales, 27.5% (n=8) skilled manual workers, 7% (n=2) semi-skilled, and 34.5% (n=10) unskilled workers. Within the unskilled category, were 20.5% (n=6) single-mother pensioners, 7% (n=2) were unemployed, and 7% (n=2) invalid pensioners.

Families were referred from a range of agencies and health professionals within Melbourne metropolitan and country Victorian regions. From within the A&RMC's CAMHS department, 24% (n=7) were referred. A further 31% (n=9) were referred from other metropolitan and rural CAMHS. Paediatricians, again within both metropolitan and rural areas, referred 24% (n=7) of the families admitted to the programme. Other health services referred 17% (n=5) of cases, and a private psychiatrist referred one family (3%).

Of these 29 families, 34% (N=10) had current or past involvement with Victorian State Government Child Protection Services.

The length of admission to the AC&FRU programme ranged from two weeks (assessment only) to six weeks (two weeks assessment and four weeks treatment), with the average length of stay being 5.41 weeks. Given the AC&FRU programme operated on a five-day-a-week basis, the 5.41 weeks, equated to 27 days, with a range of 10 to 30 days.

Of the 29 families, 25 (86%) families completed their allocated time on the programme. Twenty families stayed for a total of six weeks, three families stayed for five weeks, one family each stayed for four weeks and two weeks. For the family who completed two weeks with the programme, this comprised the assessment phase and ongoing treatment phase was not offered. The majority of the families completed six weeks with the programme, which as outlined in Section 3.1.1.3 of Chapter 3, was the usual length of stay. The lesser periods of four or five weeks with the programme, undertaken by four families reflected a review of the length of stay periods in the final year (1997) of operation of the programme.

Four families (14%), of the 29 families, left prior to completing their allocated time. One family left after five weeks, two families left after completing four weeks of the programme, and one family after completing three weeks of the programme.

At discharge, in reference to each family member, where a diagnosis or diagnoses was deemed appropriate by the psychiatrist involved, that diagnosis or diagnoses was noted. Diagnoses were based on the criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) multi-axial assessment system. Information for Axis I: Clinical Disorders, Axis II: Personality Disorders and Mental Retardation, Axis III: General Medical Conditions, Axis IV: Psychosocial and Environmental Problems (with a focus on relational problems) were provided. Information for the diagnoses was drawn from the family members' past history, presenting difficulties, clinical interviews and ward-based observations during the admission. Multiple diagnoses for family members were often made and are reflected in the parent and child characteristics outlined below.

Each of the 29 families was eligible to participate in different aspects of the study. This was due to constraints upon data collection imposed by both individual family composition (presence or absence of mother, father, sibling) and age parameters set by the Achenbach CBCL Problem Scale (applicable only for children four years or older) and Achenbach CBCL Competency Scale (applicable only for children six years or older). This meant that varying number of cases were available for each instrument, as determined by the available subject (IP, sibling, mother, father) and available respondent or rater (mother, father, clinician). Therefore different numbers of mothers and fathers were available to complete the scales relevant to child functioning, parent functioning and family functioning. Hence, a complex picture therefore presented, which is set out in detail in Section 7.1 of Chapter 7 and summarised in Table 8 on page 177.

## 6.2 Characteristics of parents or grandparent

From the 29 families who volunteered for the study, 44 parents were included.

### 6.2.1 Mothers

Mother data were available for all but one family where the mother was deceased. Twenty-seven were the biological mother and one was the maternal grandmother. The age range for the mothers (excluding the grandmother) was from 27 to 46 years, with the mean age of 34.93 years.

In reference to the mother (including the grandmother) data, all mothers were given an Axis I clinical disorder diagnosis. First, addressing clinical disorders, other than relational problems, three mothers were diagnosed with mood disorders (major depressive disorder, major depressive disorder with post partum onset), two mothers with chronic schizophrenia and one mother with a generalised anxiety disorder. These conditions had been diagnosed prior to admission to the AC&FRU programme. Second, addressing clinical disorders where relational problems were the principal focus of clinical attention, 18 mothers were diagnosed with a parent-child relational problem, two mothers with a partner relational problem and two mothers with a relational problem not otherwise specified.

On Axis II, six mothers were diagnosed with a personality disorder (borderline, dependent, and not otherwise specified). No Axis III diagnoses were determined.

In reference to Axis IV diagnoses, relational problems (as a diagnosis secondary to an Axis I and/or Axis II diagnosis) again presented. Nine mothers were diagnosed with a parent-child relational problem, two mothers with a partner relational problem and two mothers with a relational problem not otherwise specified.

### 6.2.2 Fathers

Of the 16 fathers involved in the study, in relation to the identified patient, 14 were the biological fathers, and there was one step-father, and one grandfather. The father's age range (excluding the grandfather) was from 28 to 46 years, with a mean of 37.80 years.

Diagnoses ascribed to the father (including the step-father and grandfather) centred solely on relational problems, to the exclusion of Axis I diagnoses. All of the 16 fathers were ascribed relational problems diagnoses with some being prescribed two relational problems diagnoses. All fathers were diagnosed with a parent-child relational problem, and five fathers were diagnosed with a partner relational problem. None of the fathers were given an Axis II, III, or IV diagnosis.

### 6.3 Child characteristics

Forty-eight children, all aged between four and 13 years, participated in this study. The lower limit of four was set because the Achenbach Child Behaviour Checklist (Achenbach, 1991a) is normed from age four upwards. Twenty-eight children from the 29 families (58%) were designated the identified patient. In one family the children were too young to participate in the study. 20 (42%) children were categorised as the sibling of the identified patient. Not all identified patients had a sibling in the required age range. Based on Achenbach's (1991) three age categories, the 48 children comprised 17% (n=8) aged 4-5 years, 71% (n=34) aged 6-11 years, and 12% (n=6) 12-18 years.

#### 6.3.1 Identified patients (IPs)

The 28 identified patients (IPs) had a mean age of 8.82 years, ranging from 4 to 13 years. Seventy-five percent (n=21) were male and 25% (n=7) were female.

The 21 male IPs categorised into Achenbach's (1991a) three age groups comprised: 14% (n=3) 4-5 years, 67% (n=14) 6-11 years, and 19% (n=4) 12-18 years. The seven female IPs comprised 14.5% (n=1) 4-5 years, 71% (n=5) 6-11 years, and 14.5% (n=1) 12-18 years.



A wide range of diagnoses, reflecting the heterogenous nature of child psychiatric communities, were made. Multiple diagnoses for the one child were often noted. Axis I clinical disorders diagnosed for IPs were disruptive disorders for 15 children (including attention deficit disorder, attention deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder), learning disorders for six children (reading disorder, mathematics disorder, learning disorder not otherwise specified), anxiety disorders for five children (including separation anxiety disorder, and reactive attachment disorder of infancy and early childhood), parent-child relational problems for five children, pervasive developmental disorders for three children (autistic disorder, pervasive developmental disorder not otherwise specified), elimination disorders for three children (encopresis, enuresis), and communication disorder for two children (receptive-expressive language disorder).

On Axis II, one child was diagnosed with mild mental retardation and one child with an obsessive –compulsive personality disorder. A range of Axis III medical conditions co-existed for the designated IPs, which included cleft lip and palate, biliary atresia, epilepsy and asthma.

In reference to Axis IV diagnoses, relational problems (as a diagnosis secondary to an Axis I and/or Axis II diagnosis) featured strongly. Fifteen children were diagnosed with a parent-child relational problem, two children were diagnosed with a sibling relational problem and one child was diagnosed with a relational problem not otherwise specified. In addition, one child was diagnosed with problems related to abuse or neglect (sexual abuse of a child) and one child was dealing with bereavement.

### 6.3.2 Siblings of the identified patient

For each family, the sibling closest in age, and where possible, of the same sex as the IP was selected for inclusion in the study. Twenty siblings, representing 69% of the families, participated in this study. The mean age for the siblings was 8.60 years, ranging from 4 to 13 years. Forty percent (n=8) of siblings were male and 60% (n=12) were females. In reference to sibling pairs, the cohort comprised 12 mixed-sex sibling pairs and eight same-sex sibling pairs, which included six male pairs and two female

pairs. Siblings with a current or past psychiatric diagnosis or intellectual disability were not excluded from the study.

Axis I clinical disorders diagnosed for the siblings were sibling relational problem for nine children, parent-child relational problem for eight children, disruptive disorders for seven children (including attention deficit disorder, oppositional defiant disorder and conduct disorder), learning disorders for four children (including reading disorder, mathematics disorder and learning disorder not otherwise specified) and anxiety disorders for two children (chronic childhood anxiety disorder and reactive attachment disorder of infancy and early childhood).

No diagnoses were made for the sibling population on Axis II. On Axis III one child was diagnosed with the medical condition, asthma. In reference to Axis IV diagnoses, relational problems (as a diagnosis secondary to an Axis I diagnosis) featured. Five siblings were diagnosed with a parent-child relational problem and two siblings diagnosed with a sibling relational problem.

### 6.3.3 Comparison of IP and sibling groups

The mean ages of the IP group (8.82 years) and sibling group (8.60 years) was highly comparable. However, the gender percentages in the two groups, was quite disparate. More males than females comprised the IP group whilst notably more females than males comprised the sibling group. However, this gender difference is not of major concern, given the standardisation of the Achenbach Child Behaviour Checklist T scores for both age and gender (Achenbach, 1991a).

## 6.4 Summary regarding diagnoses for family members

Across each of the family members categories (mothers, fathers, IPs, siblings) multiple diagnoses featured. Of note, all families were diagnosed with parent-child relational problems, along with other specific diagnoses for the identified patient (IP), and for some of the siblings and some mothers.

All the mothers in this study were ascribed an Axis I clinical diagnosis disorder. 81% were linked to relational problems and 22% of mothers had been diagnosed with a clinical disorder, other than relational prior to in-patient admission. In addition, 22% of mothers were diagnosed with a personality disorder as noted on Axis II. Diagnoses for the 16 fathers involved in the study centred solely on relational problems. All of the fathers were ascribed a parent-child relational problem and five fathers were diagnosed with a partner relational problem as well. None of the fathers attracted an Axis II, III, or IV diagnosis.

For the IPs in the study, diagnoses were notably heterogenous and co-morbidity of disorders commonly featured. Of note, disruptive difficulties from Axis I were ascribed to 54% of IPs, and relational problems (Axis I or IV) were ascribed to 82% of IPs. Similarly, for the sibling group, 35% were ascribed an Axis I disruptive disorder diagnosis, while 80% were ascribed a relational problems diagnosis (Axis I or IV).

## **CHAPTER 7**

### **RESULTS OF STAGE 1 EVALUATION:**

#### **ARCHIVAL STUDY OF OUTCOMES**

The outcome evaluation results relating to all aspects of the archival data are documented in this chapter. To begin, a description of the archival data available for analysis at Time 1, Time 2 and Time 3, on each of the measures for each respondent, is presented. The resultant analyses to be conducted, focusing only on Time 1 and Time 2 data, are explained. Attention then turns to the specific outcomes predicted by hypotheses of the study. Firstly, child functioning outcomes are presented, in respect of the identified patient and then in respect of the sibling of the identified patient, as perceived by the parents and the clinicians and as indicated by scores on the Achenbach Child Behaviour Checklist (CBCL). Secondly, the findings concerning the parents' self-reported functioning as indicated by scores on the General Health Questionnaire-28 (GHQ-28), are outlined. Finally, results relating to the family's functioning, as reported by the parents on the McMaster Family Assessment Device (FAD), are reported.

#### **7.1 Archival data available for analysis**

The number of cases producing scores available for analysis varied in respect of each instrument (Achenbach CBCL, GHQ-28 and the McMaster FAD), at the three points of time - Time 1 (on admission to the programme), Time 2 (at discharge from the programme), and Time 3 (six months post discharge from the programme) - by each group of respondents (mothers, fathers, and clinicians).

Both mothers and fathers, where part of the family composition, were asked to provide scores for the CBCL Problem and Competency Scales for IPs and siblings at Times 1, 2 and 3. Clinicians also provided scores for both the IP and sibling on the Achenbach CBCL Problem Scales at Times 1 and 2, as planned. However, as explained in Section 4.3.2.2 of Chapter 4, clinicians did not have access to the necessary information to complete the CBCL Competency Scale for either the IPs or siblings. Both mothers and

fathers self-reported on the GHQ-28, and for their families on the McMaster FAD at Times 1, 2, and 3.

However, as noted in Section 6.1 of Chapter 6, constraints upon data collection were imposed by both individual family composition (presence or absence of mother, father, sibling) and age parameters set by the Achenbach CBCL Problem Scale (applicable only for children four years or older) and Achenbach CBCL Competency Scale (applicable only for children six years or older). This meant that varying numbers of cases were available for each instrument (and with reference to the CBCL, the Problem and Competency Scales), as determined by the available subject (IP, sibling, mother, father) and available respondent or rater (mother, father, clinician). In other words, different numbers of mothers and fathers were available to complete the scales relevant to child functioning in the first instance, parent functioning in the second instance, and family functioning in the third instance.

Hence, a complex picture presents here, which is detailed below. First, the number of cases potentially producing data available for analysis from each respondent group, relating to child, parent and family outcomes, is explained. Then the actual number of cases producing data is described and presented in tabular form.

#### 7.1.1 Potential scores relating to the identified patient (IP)

Concerning mother-reported IP CBCL Problem Scale data, of the initial 29 families, 27 cases were available, due to family composition (one mother being deceased) and CBCL Problem Scale age parameters (one IP being younger than four years). Concerning mother-reported IP CBCL Competency Scale data, 23 cases were available, due to family composition (one mother being deceased) and CBCL Competency Scale age parameters (five IPs being younger than six years).

Concerning father-reported IP CBCL Problem Scale data, of the initial 29 families, 15 cases were available, due to family composition (13 fathers not being in family composition) and CBCL Problem Scale age parameters (one IP being younger than four years). With reference to father-reported CBCL Competency Scale data, 11 cases were

available, due to family composition (13 fathers not being in the family composition) and CBCL Competency Scale age parameter (five IPs being younger than six years).

Finally clinician-reported IP CBCL Problem Scale data for 28 of the 29 cases were available, due to CBCL Problem Scale age parameters (one IP being younger than four years). As explained in Section 4.3.2.2, clinicians did not possess the information necessary to complete the CBCL Competency Scale.

#### 7.1.2 Potential scores relating to the sibling of the IP

In reference to the mother-reported sibling CBCL Problem Scale data, of the initial 29 families, 19 cases were available, due to family composition (six families not having a sibling, and in one family the mother being deceased) and CBCL Problem Scale age parameters (in three families the sibling being younger than four years). Next, addressing mother-reported sibling CBCL Competency Scale data, 15 cases were available, due to family composition (six families not having a sibling, and in one family the mother being deceased) and CBCL Competency Scale age parameters (in seven families the sibling being younger than six years).

With reference to the father-reported sibling CBCL Problem Scale data, 12 cases were available. Again, this was due to family composition (six families not having a sibling, and in two of these six families a father not being in the family composition; with an additional eight families not having a father as part of the family composition) and CBCL Problem Scale age parameters (in three families the sibling being younger than four years, and in one of these families a father not being in the family composition). Next, turning to father-reported sibling CBCL Competency Scale data, nine cases were available, due to family composition (six families not having a sibling, and in in four of these six families there being no father in the family composition, with an additional seven families not having a father as part of the family composition), and CBCL Competency Scale age parameters (in seven families the sibling being younger than six years, and in two of these seven families a father not being part of the family composition).

Finally clinician-reported sibling CBCL Problem Scale data for 20 cases were available, due to family composition (six families not having a sibling) and CBCL Problem Scale age parameters (in three families the sibling being younger than four years). Again, clinicians did not complete the CBCL Competency Scale.

#### 7.1.3 Potential scores relating to parent functioning

For the parent GHQ-28 self-reports, mother-reported GHQ-28 data were available for 28 cases. One case could not be included as the mother was deceased. Father-reported GHQ-28 data was available for 16 cases. In 13 families, the father was not part of the family composition.

#### 7.1.4 Potential scores relating to family functioning

With reference to parent-reported McMaster FAD scores, mother-report data for 28 cases were available. Again, one case could not be included as the mother was deceased. Father-reported FAD data for the family was available for 16 cases. Once more, in 13 families, the father was not part of the family composition.

#### 7.1.5 Actual numbers of cases producing data in each category at each time

The potential number of cases producing data at each point of time (Time1, Time 2 and Time 3) did not, however, always produce these data. Although retention of respondents was reasonably high, across the time points, attrition did occur.

Table 8 on page 177 below displays both the potential number of cases producing data, and the actual number, for each rater or respondent group, at each of the three time points – Time 1 on admission, Time 2 at discharge, and Time 3 at six months post discharge follow-up. The number of cases is shown for the three instruments, the Achenbach Child Behaviour Checklist (CBCL) relating to child functioning, the General Health Questionnaire-28 (GHQ-28), relating to parent functioning, and the McMasters Family Assessment Device (FAD), relating to family functioning.

Table 8:

*Number of Cases Producing Data on the CBCL, GHQ-28 and FAD as Reported by the Mothers, Fathers and Clinicians at Time 1, Time 2 and Time 3*

*Actual No. of Cases Producing Data  
& Percentage of Cases Available*

Instrument	Subscale	Subject	Rater	Potential No. of Cases Available #	Time 1	Time 2	Time 3
1. CBCL	Problem	IP	Mother	27	27 100%	24 89%	11 41%
	Competency	IP	Mother	23	19 83%	16 70%	10 43%
	Problem	Sibling	Mother	19	19 100%	17 89%	5 26%
	Competency	Sibling	Mother	15	14 93%	11 73%	5 33%
	Problem	IP	Father	15	15 100%	10 67%	4 27%
	Competency	IP	Father	11	10 91%	7 64%	3 27%
	Problem	Sibling	Father	12	12 100%	7 58%	1 8%
	Competency	Sibling	Father	9	7 78%	4 44%	1 11%
	Problem	IP	Clinician	28	28 100%	27 96%	n/a
	Problem	Sibling	Clinician	20	20 100%	19 95%	n/a
2. GHQ-28	n/a	Mother	Mother	28	27 96%	22 79%	12 43%
	n/a	Father	Father	16	12 75%	9 56%	3 19%
3. FAD	n/a	Family	Mother	28	27 96%	20 71%	12 43%
	n/a	Family	Father	16	14 86%	6 38%	4 29%

Note: CBCL: Achenbach Child Behaviour Checklist; GHQ-28: General Health Questionnaire-28;

FAD: McMaster Family Assessment Device; Time 1: on admission; Time 2: at discharge; Time 3: six months post discharge; IP: Identified patient; Sibling: Sibling of the IP; n/a: not applicable

#: No of cases available due to family composition and age parameters of Achenbach CBCL



Table 8 reveals firstly that attrition occurred at Time 2 and Time 3 for all respondents on all instruments. Collection of the Time 3 data proved more difficult, due to staffing and significant programme changes with the AC&FRU, which compromised resources allocated to research activity. As Time 3 respondent numbers were so small, no analysis for data for this time period could be usefully conducted.

Mother-reported data displayed good to very good retention rates for all instruments from Time 1 to Time 2. For the CBCL Problem Scale, a retention rate of 89% for both the IP (N=24) and sibling (N=17) at Time 2 was achieved. The retention rate was somewhat less in reference to the mother-reported Time 2 CBCL Competency Scale for IPs (70%, N=16) and sibling (73%, N=11). In reference to the mother-reported GHQ data a 79% retention rate at Time 2 was observed, while for the FAD data at Time 2, a 71% retention rate was noted.

A different picture emerged in reference to the father-reported data. Across each of the instruments, for each of the subjects, in comparison to mother-reported data, poorer retention rates were found. Regarding the CBCL Problem Scale retention rate at Time 2 for the the IP at Time 2 was 67% (N=10) and for the sibling was 58% (N=7). For the CBCL Competency Scale, a further reduction in the retention rate was noted at Time 2, with 64% for the IP and 44% for the sibling. In reference to the father-reported GHQ data, a 56% retention rate at Time 2 was observed, and for the FAD at Time 2, a mere 38% retention rate was noted.

Finally, regarding the clinician-reported data, excellent retention rates were secured at Time 2 on the CBCL Problem Scale for the IP (96%, N=27) and sibling (95%, N=19).

In summary, due to the reduction in cases available for the planned analysis of mother and father data (across Times 1, 2 and 3) and of clinician data (across Times 1 and 2), a revised analysis was devised which could best respond to the available data. The revised multivariate analyses primarily focussed on mother-reported Time 1 and Time 2 data, and matched clinician-reported data as available. In reference to the father data, due to both low initial numbers and subsequent attrition across time, no multivariate analyses were possible, rather descriptive statistical analysis were employed.

Table 9 below, presents the number of mother-reported cases at both Time 1 and Time 2 that were available for analysis on the CBCL, GHQ-28 and the FAD.

Table 9:  
*Number of Mother-Reported Cases at both Time 1 and Time 2 Available for Analysis on the CBCL, GHQ-28 and FAD*

Instrument	Subscale	Subject	No. of Cases	Retention Rate
1. CBCL	Problem	IP	24	89%
	Competency	IP	16	70%
	Problem	Sibling	17	89%
	Competency	Sibling	11	73%
2. GHQ-28	n/a	Mother	22	79%
3. FAD	n/a	Family	20	71%

Note:  
CBCL: Achenbach Child Behaviour Checklist; GHQ-28: General Health Questionnaire-28;  
FAD: McMaster Family Assessment Device;  
Retention Rate: Based on the potential number of cases available due to family composition and CBCL age parameters  
n/a: not applicable

As can be seen in Table 9, on the CBCL Summary Problem Scales, 24 mother-reported IP cases and 17 mother-reported sibling cases were available for analysis from Time 1 and Time 2. Mother-reported Time 1 and Time 2 data were also available on the CBCL Competency Scales for 16 IP and 11 sibling cases. The lesser number of CBCL Competency Scale cases available compared to the CBCL Summary Problem Scale cases, is due the Competency Scale being applicable only for children six years or older, as well as a greater number of incomplete Competency Scale data sets. Mother-reported Time 1 and Time 2 data were also available for 22 GHQ-28 cases, and for 20 FAD cases.

As stated above in Section 7.1.5, the revised multivariate analyses primarily focussed on mother-reported Time 1 and Time 2 data, and matched clinician-reported data as available. In reference to the father data, only descriptive statistical analysis were employed.

## 7.2 Outcomes concerning child functioning: Achenbach Child Behaviour Checklist scores

### 7.2.1 Outcomes concerning the identified patients

As described in Section 3.2.3.2.1 of Chapter 3, several hypotheses were proposed in relation to perceptions of the identified patient (IP). First, Hypothesis 1a stated that psychopathology in the identified patient (IP) would be perceived by parents and clinicians as less at the time of discharge (Time 2) than at the time of admission (Time 1) to the AC&FRU programme, as indicated by scores at each of these times on the Achenbach Child Behaviour Checklist (CBCL) Summary Problem Scales (parents and clinicians) and Competency Scales (parents only). Second, Hypothesis 1b stated that psychopathology in the IP would be perceived as greater by parents than by clinicians at both admission (Time1) and discharge (Time 2) from the AC&FRU programme as indicated by scores on the Achenbach CBCL Summary Problem Scales (CBCL Competency Scale data was not collected from the clinicians). Third, Hypothesis 1c stated that psychopathology in the IP would be perceived by the parents as no different at the six month post discharge follow-up time (Time 3) than at the time of discharge (Time 2), as indicated by scores on the Achenbach CBCL Summary Problem and Competency Scales.

Due to the limited subject sample available, the third hypothesis, addressing the Time 3 data, could not be tested. In addition, as father data for the IPs was also limited, multivariate analyses could focus only on the mothers and clinicians results for the IPs. Thus, descriptive statistics are provided for mother, father and clinician data, and multivariate statistics for the mother and clinician data.

The first two hypotheses were tested by a multiple analyses of variance (MANOVA) for the mother- and clinician-completed Achenbach CBCL Summary Problem Scale items; and a separate two-factor analyses of variance (ANOVA) for the mother-completed Achenbach CBCL Competency Scale items.

The analyses actually conducted, together with their results, are presented below. First, CBCL Problem Scale scores as reported by the mothers and the clinicians for the IP are detailed. These scores are then compared with CBCL Problem Scale scores

for North American and Australian referred norms. Next, CBCL Competency scores as reported by the mothers for the IPs are presented. Then, father-reported CBCL Problem and Competency scores for the IP are reviewed. Finally, a summary of outcomes concerning the IP is outlined.

7.2.1.1        Problem scores as reported by the mothers and clinicians for the IP

Table 10 provides a summary of means and standard deviations separated out for the mother- and clinician-completed scores for each of the three Achenbach CBCL Summary Problem Scales for the IPs – Total, Internalising and Externalising at Time 1 (on admission) and Time 2 (at discharge).

Table 10  
*Mean and Standard Deviation (SD) on Mother- and Clinician-Completed CBCL Summary Problem Scores at Time 1 and Time 2 for the IPs (N=24)*

Summary Problem Scale	Time	Mother		Clinician	
		Mean	SD	Mean	SD
Total	1	72.25	11.58	66.71	8.18
	2	66.75	13.34	61.46	9.64
Internalising	1	68.71	11.46	65.96	6.32
	2	63.50	13.53	60.71	8.48
Externalising	1	69.71	13.97	64.04	10.00
	2	64.42	13.70	60.54	9.46

Note: Summary Problem Scale T scores: <60 normal range, 60-63 borderline range, >63 clinical range

As can be seen in Table 10, a reduction in symptomatology in terms of mean scores was indicated by the perceptions of both the mothers and the clinicians on each of the three Summary Problem Scales from Time 1 to Time 2. This finding is in the direction predicted by Hypothesis 1a.

Of note, however, the mothers’ ratings from Time 1 to Time 2 remained in the clinical range of reported symptomatology for each of the Summary Problem Scales. In contrast, clinicians’ ratings shifted from the clinical range at Time 1 to the borderline clinical range at Time 2, for each of the Summary Problem Scales for the IP. While this finding lends support to Hypothesis 1b that parents would identify more psychopathology compared with clinicians for the IP at both Time 1 and Time 2, as is

shown in the multivariate analysis to follow, this difference was not statistically significant.

Mothers were observed to report greater Externalising Problems than Internalising Problems, whilst for the clinicians the opposite trend was apparent with Internalising Problems reported as being higher. An average five point difference between Time 1 and Time 2 results for both mother and clinician ratings of the IP was reported.

Table 11, below, provides an overview of the scores reported by the mothers and clinicians for the IPs from Time 1 to Time 2 in functioning as shown in clinical and normal range performance as reported on the Achenbach CBCL Summary Problem Scales. For the purpose of this exercise, the borderline and clinical ranges have been combined under the clinical range. This allowed for a more substantial N in each subgroup and ensured clarity in reference to the distinction between the two categories. Therefore, scores rated 60 and above were classified as falling within the clinical range. Moreover, given the small sample size (n=24), raw numbers rather than percentages are considered to be more informative.

Table 11  
*Number of IPs (N=24) Placed in the Clinical and Normal Ranges by Mother- and Clinician Ratings for the Achenbach CBCL Summary Problem Scales at Time 1 and Time 2*

Summary Problem Scale	Time	Mother	Clinician
Total	1	N: n=5 (21%) C: n=19 (79%)	N: n=4 (17%) C: n=20 (83%)
	2	N: n=5 (21%) C: n=19 (79%)	N: n=8 (33%) C: n=16 (67%)
Internalising	1	N: n=4 (17%) C: n=20 (83%)	N: n=3 (12.5%) C: n=21 (87.5%)
	2	N: n=8 (33%) C: n=16 (67%)	N: n=10 (42%) C: n=14 (58%)
Externalising	1	N: n=6 (25%) C: n=18 (75%)	N: n=7 (29%) C: n=17 (71%)
	2	N: n=9 (37.5%) C: n=15 (62.5%)	N: n=9 (37.5%) C: n=15 (62.5%)

Note: Summary Problem Scale T scores:

N: normal range <60; C: clinical range 60 or above (incorporating borderline scores 60-63)

As can be seen in Table 11, on the Total Summary Problem Scale, mothers did not report any change from Time 1 to Time 2, with five IPs reported as remaining in the normal range of functioning and 19 IPs in the clinical range of functioning. In contrast, clinicians reported an increase from four to eight IPs in the normal range of functioning from Time 1 to Time 2.

With regard to the Internalising Summary Problem Scale for IPs, mothers reported an increase, in four to eight cases, and clinicians an increase for three to seven IPs out of the 24 IPs falling within the normal range of functioning from Time 1 to Time 2. On the Externalising Summary Problem Scale, mother's scores showed an increase in six to nine cases from Time 1 to Time 2 in the normal range of functioning. Clinician's scores reflected a similar trend, with an increase from seven to nine IPs placed in the normal range of functioning from Time 1 to Time 2. Of note, based on both the mothers' and the clinicians' reports, 15 of the 24 IPs remained in the clinical range of functioning for Externalising difficulties from Time 1 to Time 2.

Appendix XIX provides the more detailed tripartite division of change from Time 1 to Time 2 as reported by mothers and clinicians for the IPs.

A MANOVA procedure was then performed to determine whether the mothers and the clinicians rated the IPs differently on the three CBCL Summary Problem Scales. The MANOVA, with one repeated measure of time (Time 1, Time 2) was performed on the three dependent variables derived from the CBCL Summary Problem Scales items – Total Problem Score (Total), Internalising Score (Internalising), and Externalising Score (Externalising) for the IP data. The independent variable was the identity of the rater (mother, clinician), with one between subjects factor of rater (mother, clinician), and one within subject factor of time (Time 1, Time 2) observed. The SPSSx MANOVA programme was used for the analysis. Table 12 on page 184 below, provides a summary of the results of this analysis.

Table 12

*Summary Table for Repeated Measures MANOVA on Mother- and Clinician-Completed Achenbach CBCL Summary Problem Scale (Total, Internalising & Externalising) Scores for the IPs (N=24)*

Source	Wilks Lambda	F	d.f	Sig.
Between Subjects – Rater	.900	1.630	3, 44	.196
Within Subjects – Time	.524	13.345	3,44	.000
Within Subjects - Time*Rater	.997	.038	3, 44	.990

As shown in Table 12, a significant multivariate effect of time  $F(3,44)=13.345$ ,  $p<.0005$  was found, and observed to be in the direction of the IPs being perceived as improving from Time 1 (on admission) to Time 2 (on discharge) on the CBCL Summary Problem Scales for the IP. This result provides clear support for Hypothesis 1a.

However, a significant difference was not found between the scores of mothers and clinicians (raters), and hence multivariate analysis did not support Hypothesis 1b. Moreover, a significant difference was not found in the interaction between time and rater.

As there was not a significant rater effect observed in the above analysis, the combined mother and clinician means are provided by Table 13 to highlight the nature of the time effect.

Table 13:

*Combined Mean for Mother- and Clinician-Reported Scores for the IPs (N=24) at Time 1 and Time 2 on the Achenbach CBCL Three Summary Problem Scales*

Summary Problem Scales	Time 1- Mean	Time 2 – Mean
Total	69.48	64.10
Internalising	67.33	62.10
Externalising	67.50	62.48

Note: Summary Problem Scale T scores: <60 normal range, 60-63 borderline range, >63 clinical range

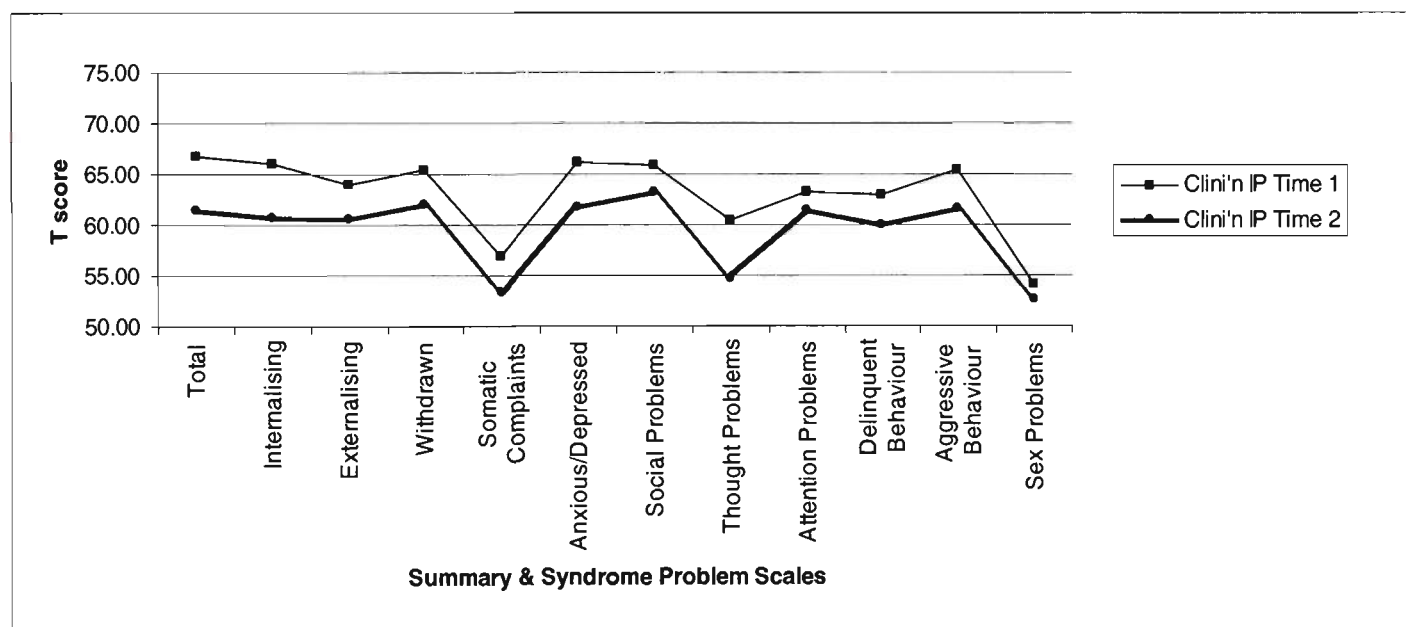
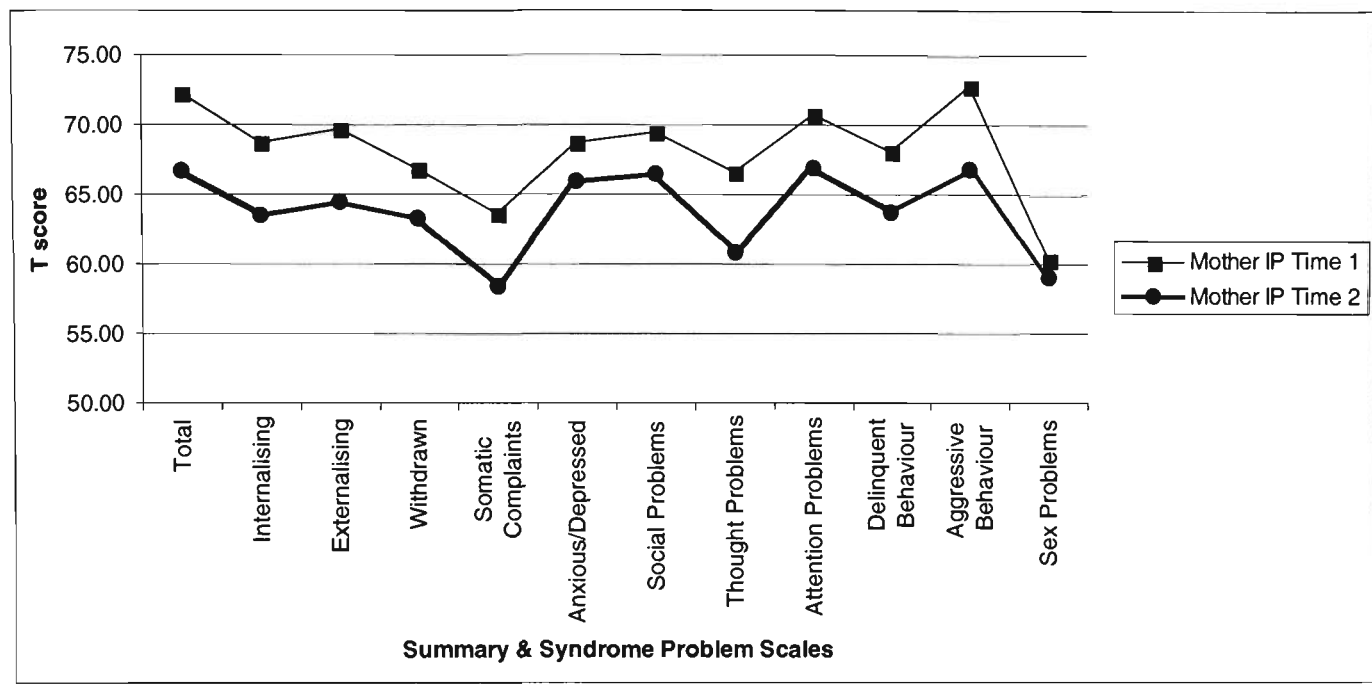
Table 13 shows that the combined mother- and clinician completed scores on the Summary Problem Scales placed the IP well into the clinical range of functioning on each of the scales at Time 1. An overall five point improvement in functioning was observed to be perceived for the IPs at the Time 2 period, on each of the Summary Problem Scales. Internalising and Externalising scales revealed a similar level of reported dysfunction and improvement.

Figure 1, on page 186 below, displays the profiles of the CBCL Summary and Syndrome Problem Scales reported by mothers and clinicians for the IPs at Time 1 and Time 2.

As can be seen in Figure 1 (and read in conjunction with Appendix XX), mothers' and clinicians' pattern of responding over Time 1 and Time 2 for the IPs was similar. The two separate panels allow comparison of the mother- and clinician- reported CBCL Summary and Syndrome Problem Scale mean scores for IPs at Time 1 and Time 2. The separate panels are provided for clarity given the proximity of scores across time periods by the two groups of raters.

Mothers reporting on IPs at Time 1 revealed mean scores on Aggressive Behaviour (72.79), Attention Problems (70.75) and Social Problems (69.42) to fall within the clinical range of functioning, Anxiety/Depression (68.75) and Delinquent Behaviour (68.13) mean scores fell within the borderline range of clinical functioning and Withdrawn (66.83), Thought Problems (66.63), Somatic Complaints (63.67) and Sex Problems (60.35) scores all fell within the normal range of functioning at Time 1. Of note, the mother-reported IP's means on all the Syndrome Problem Scales were within the normal range of functioning at Time 2.





Note:

1. Summary Problem Scales T scores: <60 normal range, 60-63 borderline range, >63 clinical range
2. Syndrome Problem Scale T scores: <67 normal range, 67-69 borderline range, >69 clinical range

Figure 1: Profiles of Achenbach CBCL Summary and Syndrome Problem Scales Reported by Mothers and Clinicians for IPs at Time 1 and Time 2 (N=24).

In contrast, while the clinicians reporting at Time 1 placed the IPs in the clinical range for each of the Summary Problem Scores (Total, Internalising and Externalising), this was not borne out in the mean scores for each of the Syndrome Problem Scales where the IPs were placed in the normal range of functioning. The most elevated scores were noted on the Anxious/Depressed (66.13), Social Problems (65.92), Aggressive Behaviour (65.50) and Withdrawn (65.50) Syndrome Problem Scales. Of note, mothers also reported Aggressive Behaviour and Social Problems as the most concerning. Clinician reports for the IPs at Time 2 noted improvements across each of the Syndrome Problem Scales. A similar pattern of improvement in relation to the degree (point difference) on each of the Syndrome Problem Scales was observed with the mother- and the clinician-reports regarding the IPs.

7.2.1.2            Comparison of CBCL North American and Australian referred norms with IP findings from this study

Finally, a comparison of North American (Achenbach 1991) and Australian (Nolan et al., 1996) Achenbach CBCL Summary Problem Scale scores for referred males aged 4-11 years with the mother- and clinician- reported findings for the IPs in this study at Time 1 and Time 2 can be made. Table 14 provides this overview.

Table 14:  
*Comparison of North American and Australian Achenbach CBCL Summary Problem Scale (Total, Internalising & Externalising) Scores for Referred Norms with Findings from the Current Study*

Study & Respondent	N	Total	Internalising	Externalising
Current study – clinicians	24	Time 1: 66.71	Time 1: 65.96	Time 1: 64.04
	24	Time 2: 61.46	Time 2: 60.71	Time 2: 60.54
Current study – mothers	24	Time 1: 72.25	Time 1: 68.71	Time 1: 69.71
	24	Time 2: 66.75	Time 2: 63.50	Time 2: 64.42
North Amercian referred norms (Achenbach, 1991)*	582	64.4	61.7	62.5
Australian referred norms (Nolan et al. 1996) *	628	66.9	64.4	64.5

Note: \* referred males aged 4-11 years

As shown in Table 14, mean scores for the IP population in this current inpatient study at Time 1 were uniformly higher in comparison to both the Australian and North American outpatient referred norms, while at Time 2 were viewed to be more comparable to the Australian referred (outpatient) norms. Australian inpatient norms, to the researcher’s knowledge, are not available.

7.2.1.3 CBCL Competency scores as reported by the mothers for the IPs

Concerning the Achenbach CBCL Competency scores concerning the IPs, Table 15 below provides a summary of the descriptive statistics in reference to the mother scores on the three subscales (Activities, Social and School), as well as the Total Competency score at Time 1 and Time 2.

Table 15  
*Mean and Standard Deviations on Mother-Completed Achenbach CBCL Competency Total and Subscale Scores at Time 1 and Time 2 for the IPs (N=16)*

Total Competence			Activities		Social		School	
Time	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Time 1	34.69	6.91	44.06	6.76	36.00	8.84	33.75	8.50
Time 2	35.19	8.05	45.81	6.68	33.75	9.37	36.00	10.06

Note: Competence scale T scores: >33 normal range, 30-33 borderline range, <30 clinical range

Table 15 reveals that the mothers placed the IPs within the normal range of functioning for the Total Competency score as well as for each of the subscale scores across both Time 1 and Time 2. Minor improvements were noted at Time 2 for Total Competence, Activities and School, whilst more difficulties for the IPs were observed on the Social subscale at Time 2 compared to Time 1. These findings for the Total Competence score and Activities and School subscale scores are in the direction predicted by Hypothesis 1a, but do not appear substantial.

Of interest, whilst the IPs scores did not fall within the borderline or clinical ranges, it needs to be noted that apart from the Activities subscale, the results from Social and School subscales fell well below the T score non-referred norms for this age

population (Non-referred norms: Activities: 48, Social: 48, School, 48, & Total Competence: 50).

An ANOVA procedure was then performed to determine whether the mothers rated the IPs significantly differently across the three Achenbach CBCL Competence Scales at Time 1 and Time 2. A separate two-factor ANOVA with replication of time (Time 1, Time 2) was performed on the three dependent variables derived from CBCL Competency Scales items – Activities, Social and School for the IP data. The independent variable was the identity of the rater (mother), with one between subjects factor of rater (mother), and one within subject factor of time (Time 1, Time 2) observed. Table 16 below provides a summary of the results of this analysis.

Table 16  
*Summary Table for Two Factor Analysis of Variance with Replication (Time) for Mother–Completed Achenbach Competency Subscale Scores for the IPs (N=16)*

Variables	d.f	SS	MS	F	P-value	P interpreted
Time	1	8.17	8.17	0.11	0.74	NS
Subscales	2	2160.08	1080.04	15.08	0.00	S
Time.Subscales	2	97.33	48.67	0.51	0.51	NS
Within	90	6443.37	71.59			
Total	95	8708.96				

As can be seen in Table 16, no significant difference was observed between Time 1 and Time 2 for the mother-completed CBCL Competency subscales. This finding therefore does not support Hypothesis 1a, which predicted the parents’ perceptions would register a significant reduction in symptomatology from Time 1 to Time 2. Moreover, no significant difference was detected in the interaction of time and the subscales for the mother-reported Achenbach CBCL Competency scores for the IPs.

7.2.1.4 Problem and competency scores as reported by the fathers for the IPs

Turning to data reported by the father for the IPs, Hypothesis 1a stated that psychopathology in the IPs as perceived by the parents would be less at time of discharge (Time 2) than at the time of admission (Time 1). The father-reported data

could not be analysed using multivariate statistical techniques due to the small sample size. Means and standard deviations on the CBCL problem and competency scale data available are provided in the tables below. Table 17 below provides a summary of the descriptive statistics for the father-completed scores for the three Achenbach CBCL Summary Problem Scales – Total, Internalising and Externalising at Time 1 and Time 2 for the IPs.

Table 17 shows that fathers’ perceptions consistently pointed to a reduction in symptomatology for the IPs from admission (Time 1) to discharge from the programme (Time 2). Fathers placed the IPs in the clinical range of functioning on each of the Summary Problem Scales at Time 1. At Time 2, fathers placed the IPs in the borderline range of functioning for Total Problem Score and the normal range of functioning for Internalising and Externalising Problem Scores. These findings are in the direction predicted by Hypothesis 1a.

Table 17  
*Mean and Standard Deviations on Father-Completed Achenbach CBCL Summary Problem Scale Scores at Time 1 and Time 2 for the IPs*

Summary Problem Scales	Time	N	Mean	SD
Total	1	15	70.07	11.70
	2	10	60.80	13.51
Internalising	1	15	64.73	11.91
	2	10	56.50	13.92
Externalising	1	15	67.00	13.67
	2	10	58.20	13.69

Note:  
Summary Problem Scale T scores: <60 normal range, 60-63 borderline range, >63 clinical range

Next, Table 18 on page 191 below, provides a summary of the descriptive statistics in reference to fathers’ scores on the Achenbach CBCL Competency subscales, as well as Total Competency score for the IPs for Time 1 and Time 2.

Table 18

*Mean and Standard Deviations on Father-Completed Achenbach CBCL Competency Total and Subscale Scores at Time 1 and Time 2 for the IPs*

Competency Scales	Time	N	Mean	SD
Total	1	10	30.40	9.45
	2	7	36.14	10.37
Activities	1	12	40.58	7.13
	2	7	44.86	5.58
Social	1	11	33.18	9.46
	2	7	35.00	11.14
School	1	11	32.91	10.54
	2	7	38.86	12.72

Note:

Competence Scale T scores: >33 normal range, 30-33 borderline range, <30 clinical range

Table 18 reveals that fathers’ perceptions concsistently registered an improvement in functioning on each of the Achenbach CBCL Competency subscales and Total scale scores. This finding lends support to Hypothesis 1a. Of interest, at Time 1 fathers’ percpetions placed the IP in the borderline range of functioning for the Total Competency score and School subscale score, and the normal range of functioning on the Activities and Social subscales. At Time 2, fathers’ perceptions placed the IPs in the normal range of functioning on each of the Competency subscale and Total scale scores. Again, similar to the mother-reporting for the IPs, these scores still fall well below the T score for non-referred norms for this age population (Non-referred norms: Activities: 48, Social: 48, School, 48, & Total Competence: 50).

7.2.1.5        Summary of outcomes   concerning the identified patient outcomes

Hypothesis 1a stated that psychopathology in the IP would be perceived by parents (mothers and fathers) and clinicians as less at the time of discharge (Time 2) than at the time of admission (Time 1) to the AC&FRU programme, as indicated by scores on the Achenbach CBCL Summary Problem Scales (parents and clinicians) and Competency Scales (parents only). Hypothesis 1a was in the main supported.

For each of the CBCL Summary Problem Scales (Total, Internalising and Externalising), mothers’ and clinicians’ results reached statistical significance. Whilst

fathers' results followed a similar trend, multivariate analysis was not possible due to the small father sample size. With regard to the CBCL Competency Total and Subscale (Activities, Social and School) scores, mothers and fathers consistently registered an improvement in functioning from Time 1 to Time 2 on each of the scales, apart from mothers' perceptions on the Social Subscale. Nevertheless, statistical significance was not achieved on the mothers' results for the IP, and again multivariate analysis was not possible on the fathers' results due to the small father sample size.

Hypothesis 1b stated that psychopathology in the IP would be perceived as greater by parents than by clinicians at both the time of admission (Time 1) and the time of discharge (Time 2) from the AC&FRU programme, as indicated by scores at each of these times on the Achenbach CBCL Summary Problem Scales. This hypothesis was tested with matched mother and clinician IP data. Whilst a clear trend was observed, with mothers identifying more psychopathology for the IPs at both Time 1 and Time 2 compared to the clinician's observations, this difference did not reach statistical significance. Here, father data could not be tested at all due to the small sample size.

Hypothesis 1c which stated that psychopathology in the IP would be perceived by the parents as no different at six months post discharge follow-up time (Time 3) than at the time of discharge (Time 2) from the AC&FRU programme, as indicated by scores at each time period on the Achenbach CBCL Summary Problem and Competency Scales. This hypothesis could not be tested, for either mothers' or fathers' perceptions due to the limited Time 3 data available.

#### 7.2.2 Outcomes concerning the siblings of the identified patient

As described in Section 3.2.3.2.2 of Chapter 3, several hypotheses were proposed in relation to the sibling of the identified patient (the sibling). Hypothesis 2a stated that psychopathology in the sibling would be perceived by the parents as greater at the time of discharge (Time 2) than at the time of admission (Time 1) to the programme, as indicated by scores at each of these times on the Achenbach CBCL Summary Problem and Competency Scales. Hypothesis 2b stated that psychopathology in the sibling would be perceived by clinicians as less at the time of discharge (Time 2) than at the time of

admission (Time 1) to the AC&FRU programme, as indicated by scores on the Achenbach CBCL Summary Problem Scales. Hypothesis 2c stated that psychopathology in the sibling would be perceived by the parents as less at the six month post discharge follow-up time (Time 3) than at discharge (Time 2), as indicated by scores on the Achenbach CBCL Summary Problem and Competency Scales.

As with the IPs data, due to the limited subject sample available, the third hypothesis, addressing the Time 3 data, could not be tested. In addition, as father data for the siblings was also limited, multivariate analyses were restricted to the mothers' and clinicians' results for the siblings. Thus, descriptive statistics are provided for mother, father and clinician data, and multivariate statistics for the mother and clinician data.

The first two hypotheses were tested by a multiple analyses of variance (MANOVA) for the mother- and clinician-completed Achenbach CBCL Summary Problem items; and a separate two-factor analyses of variance (ANOVA) for the mother-completed Achenbach CBCL Competency Scale items.

The analyses actually conducted, together with their results, are presented below. First, CBCL Problem Scale scores as reported by the mothers and the clinicians for the siblings are detailed. Next, CBCL Competency Scale scores as reported by the mothers for the siblings are reviewed. Then, father-reported CBCL Problem and Competency Scale scores for the siblings are presented. Finally, a summary of the outcomes for the siblings is outlined.

#### 7.2.2.1 Problem scores as reported by the mothers and clinicians for the siblings

First, Table 19 on page 194 below, provides a summary of descriptive statistics separated out for the mother- and clinician-completed scores on the three CBCL Summary Problem Scales – Total, Internalising, and Externalising at Time 1 and Time 2 for the siblings.



Table 19

*Mean and Standard Deviations on Mother- and Clinician-Completed Achenbach CBCL Summary Problem Scales at Time 1 and Time 2 for the Siblings (N=17)*

Summary Problem Scale	Time	Mother		Clinician	
		Mean	S.D	Mean	S.D.
Total	1	64.47	13.11	60.29	7.63
	2	58.35	13.23	57.71	6.87
Internalising	1	63.71	10.29	60.65	7.83
	2	58.00	12.72	59.47	7.81
Externalising	1	63.00	15.07	58.18	11.94
	2	57.06	14.19	54.82	9.89

Note: Summary Problem Scale T scores: <60 normal range, 60-63 borderline range, >63 clinical range

As can be seen in Table 19, a decrease in symptomatology was reported by both mother and clinician on each of the Summary Problem Scales from Time 1 to Time 2 for the siblings. This is the same trend found with the mother and clinician ratings for the IPs.

Whilst mothers rated the siblings at Time 1 in the clinical range (Total and Internalising) or at the upper end of the borderline clinical range (Externalising), each of the Summary Problem Scales were reported to be in the normal range at Time 2. Clinician’s ratings at Time 1 were in the borderline range for Total and Internalising Problem Scales and moved to the normal range at Time 2, whereas the Externalising score remained in the normal range across Time 1 and Time 2.

The mean change across Time 1 and Time 2 as reported by the clinicians for the siblings was 2.37 points (compared to 5.08 for the IPs); whilst the mean change across Time 1 and Time 2 as reported by the mothers for the siblings as 5.92 (which is comparable to their IP mean change in score of 5.33).

Table 20 on page 195 below, provides an overview of the changes reported by the mothers and clinicians for the siblings from Time 1 to Time 2 in functioning, as shown in clinical and normal range performance measured by the Achenbach CBCL Summary Problem Scales. For the purpose of this exercise, the borderline and clinical ranges have been combined under the clinical range. Therefore, scores rated 60 and

above were classified as falling within the clinical range. Given the small sample size (n=17), raw numbers rather than percentages are considered to be more informative to the reader. A detailed breakdown of the tripartate division is provided in Appendix XXII.

Table 20:

*Number of Siblings (N=17) Placed in the Clinical and Normal Ranges by Mother- and Clinician-Ratings on the Achenbach CBCL Summary Problem Scales at Time 1 and Time 2*

Summary Problem Scale	Time	Mother	Clinician
Total	1	N: n=5 (29%) C: n=12 (71%)	N: n=8 (47%) C: n=9 (53%)
	2	N: n=9 (53%) C: n=8 (47%)	N: n=9 (53%) C: n=8 (47%)
Internalising	1	N: n=7 (41%) C: n=10 (59%)	N: n=5 (29%) C: n=12 (71%)
	2	N: n=11 (65%) C: n=6 (35%)	N: n=6 (35%) C: n=11 (65%)
Externalising	1	N: n=7 (41%) C: n=10 (59%)	N: n=10 (59%) C: n=7 (41%)
	2	N: n=10 (59%) C: n=7 (41%)	N: n=11 (65%) C: n=6 (35%)

Note: Summary Problem Scale T scores: N: normal range <60; C: clinical range 60 or above (incorporating borderline scores 60-63)

As can be seen in Table 20, for the Total Summary Problem Scale for siblings, an increase of five to nine mothers reported siblings falling within the normal range of functioning, from Time 1 to Time 2. Over this same time period clinicians reported an increase from eight to nine siblings functioning in the normal range. Based on both mother and clinicians reports, this left eight siblings functioning in the clinical range at Time 2.

With regard to the Internalising Summary Problem Scale four mothers reported siblings shifting into the normal range of functioning, with an increase from seven to 11 siblings from Time 1 to Time 2. Clinicians again reported only one child shifting

from the clinical to the normal range from Time 1 to Time 2 with a change from five to six siblings.

On the Externalising Summary Problem Scale, an increase of seven to ten mothers reported siblings functioning in the normal range from Time 1 to Time 2, with clinicians maintaining the one child increase, with ten to eleven siblings functioning within the normal range from Time 1 to Time 2. This left seven and six siblings functioning in the clinical range at Time 2 as reported respectively by mothers and clinicians.

Of note, when comparing the mother and clinicians reports of IPs and siblings from Time 1 to Time 2 on the Summary Problem Scales, clinicians reported greater movement (in number of children) from clinical to normal functioning for the IPs than the siblings, whereas the mothers reporting followed a fairly similar trend with both IP and sibling groups. The number of children remaining in the clinical range of functioning at Time 2 in both groups is also noteworthy. For the sibling group, between 35% (mothers- Internalising, clinicians – Externalising) and 65% (clinicians – Internalising) of children remained in the clinical range of functioning at Time 2. For the IP group between 62.5% (clinician – Externalising) and 79% (mothers – Total) remained in the clinical range of functioning.

A MANOVA procedure was then performed to determine whether the mothers and the clinicians rated the siblings differently from each other on the three CBCL Summary Problem Scales. The MANOVA with one repeated measure of time (Time 1, Time 2) was performed on the three dependent variables derived from the CBCL Summary Problem Scales items – Total Problem Score (Total), Internalising Score (Internalising), and Externalising Score (Externalising) for the sibling data. The independent variable was the identity of the rater (mother, clinician), with one between subjects factor of rater (mother, clinician), and one within subject factor of time (Time 1, Time 2) observed. The SPSSx MANOVA programme was used for the analysis. Table 21 on page 197 below provides a summary of the results of this analysis.

Table 21

*Summary of Repeated Measures MANOVA on Mother- and Clinician-Completed Achenbach CBCL Summary Problem Scale Scores for the Siblings (N=17)*

Source	Wilks Lambda	F	d.f.	Sig.
Between Subjects – Rater	.978	.227	3,30	.877
Within Subjects – Time	.652	5.327	3,30	.005
Within Subjects - Time*Rater	.896	1.164	3,30	.340

As shown in Table 21, a significant multivariate effect of time,  $F(3,30)=5.327$ ,  $p.005$ , was found and observed to be in the direction of siblings improving from Time 1 (on admission) to Time 2 (on discharge). Whilst this result did not support Hypothesis 2a, which predicted that the parents would identify more problems for the siblings from Time 1 to Time 2, it did however support Hypothesis 2b which predicted that the clinicians would identify an improvement in sibling functioning from Time 1 to Time 2.

As with the mother- and clinician-completed IP results, a significant difference was not found between the raters (mothers and clinicians), with both groups reporting an improvement in functioning for the siblings from Time 1 to Time 2. Moreover, a significant difference was not found in the interaction between time and rater as reported by the mothers and clinicians for the siblings.

As there was not a significant rater effect observed in the above analysis, a table of combined mother and clinician means is provided in order to highlight the nature of the time effect. These results are presented in Table 22 below.

Table 22

*Combined Mean for Mother- and Clinician-Reported Scores for the Siblings (N=17) at Time 1 and Time 2 for the Achenbach CBCL Summary Problem Scales*

Summary Problem Scores	Time 1- Mean	Time 2 – Mean
Total	62.38	58.03
Internalising	62.18	58.74
Externalising	60.59	55.94

Note: Summary Problem Scale T scores: <60 normal range, 60-63 borderline range, >63 clinical range

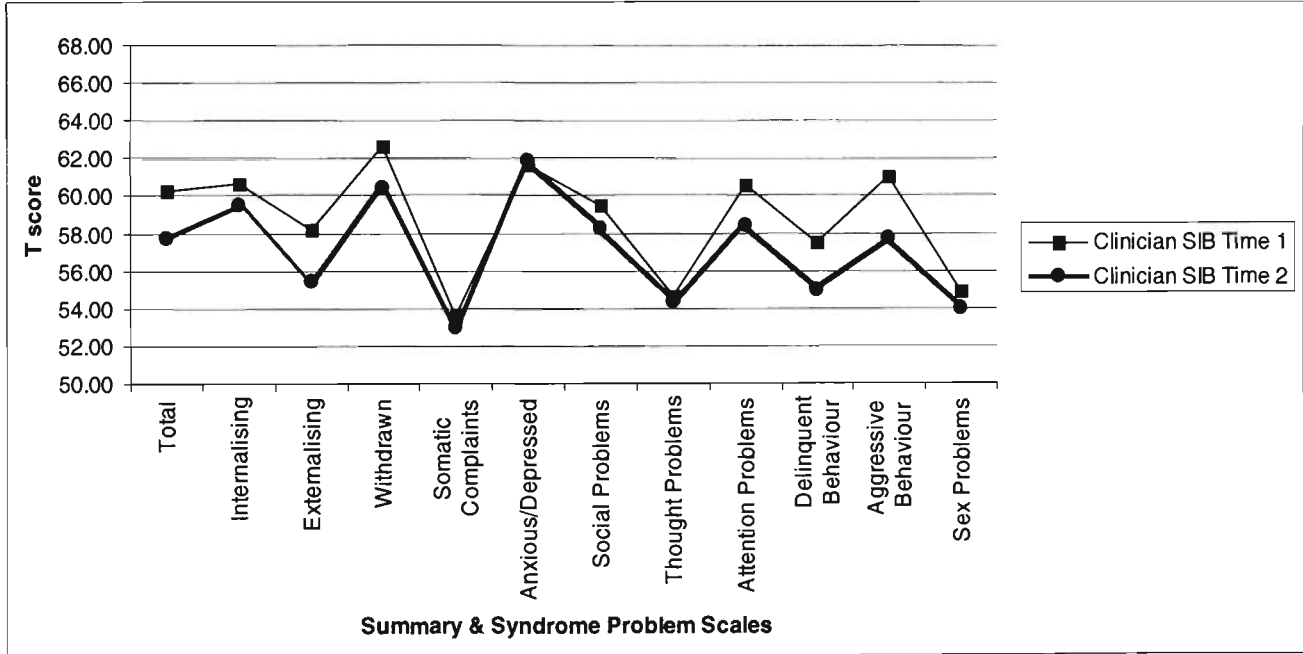
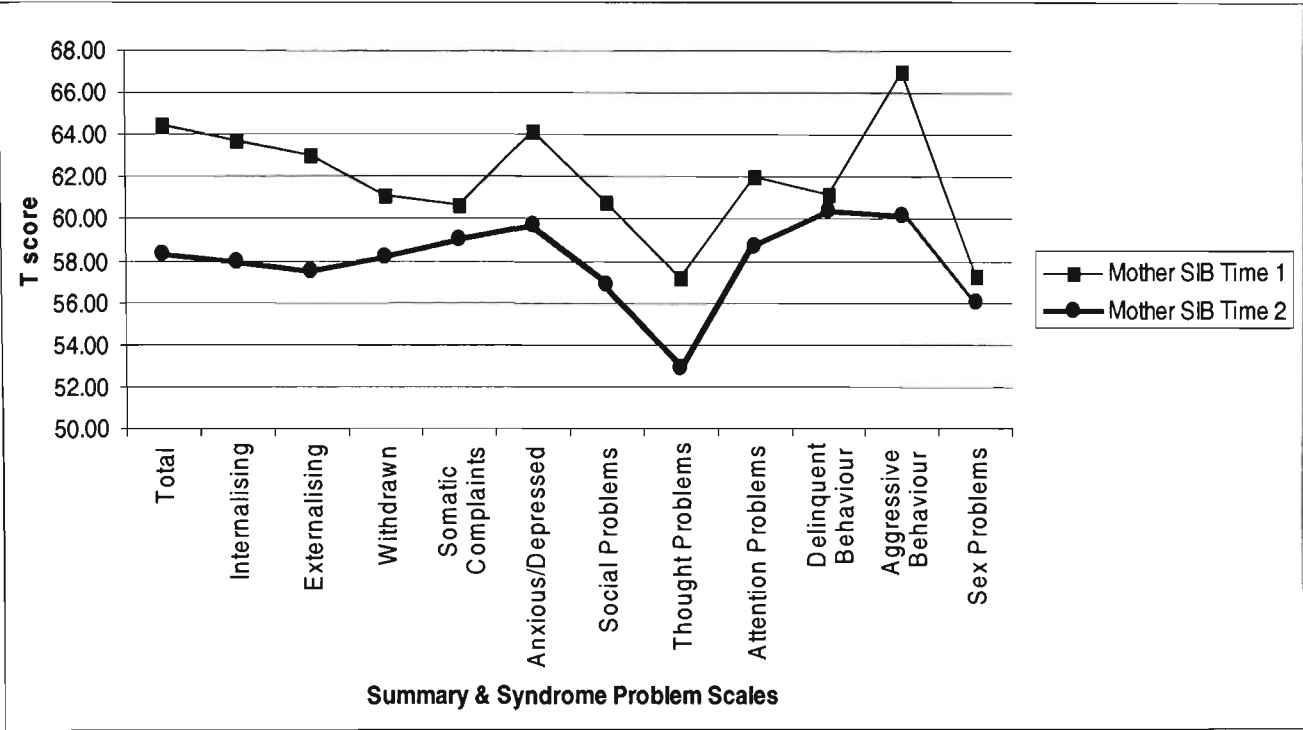
As shown in Table 22, addressing the combined mother- and clinician-completed scores for the siblings on the Summary Problem Scales, siblings were consistently placed in the borderline clinical range of functioning on each of the scales at Time 1. Internalising difficulties attained a marginally higher score in comparison with the reported Externalising problems for the siblings. At Time 2, with a 4.35 (Total), a 3.44 (Internalising), and 4.65 (Externalising) point improvement, all scores placed the siblings within the normal range of functioning at Time 2.

Figure 2, on page 199 below highlights the reported differences between mother- and clinician-ratings of the siblings on the CBCL Summary and Syndrome Problem Scales, at Time 1 and Time 2, in more detail.

As can be seen in Figure 2 (and read in conjunction with Appendix XXII), a reduction in symptomatology was reported by both the mothers and the clinicians for the siblings on each of the CBCL Summary and Syndrome Problem Scales from Time 1 to Time 2, apart from clinicians reporting on the Anxious/Depressed Syndrome Problem Scale, where a slight increase (61.65 – 61.88) in symptomatology was noted. This, however, was still within the normal range of functioning.

Whilst the mother's reports placed the siblings in the clinical (Summary Scales: Total and Internalising) and borderline clinical (Summary Scales: Externalising, Syndrome Scales: Aggressive Behavior) range of functioning at Time 1, by Time 2 mothers reported that the siblings were in the normal range of functioning.

In comparison, clinician's reports placed the siblings in the borderline clinical range of functioning for the Total and Internalising Summary Problem Scales at Time 1, and in the normal range of functioning for the Externalising Summary Problem Scale and the nine Syndrome Problem Scales at both Time 1 and Time 2.



- Note:
1. Summary Problem Scales T scores: <60 normal range, 60-63 borderline range, >63 clinical range
  2. Syndrome Problem Scale T scores: <67 normal range, 67-69 borderline range, >69 clinical range

Figure 2: Profiles of Achenbach CBCL Summary and Syndrome Problem Scale Mean Scores as Reported by Mothers and Clinicians for the Siblings at Time 1 and Time 2 (N=17).

Mothers compared to the clinicians consistently reported more difficulties for the siblings in each of the Summary Problem Scales across Time 1 and Time 2, apart from Internalising difficulties where clinicians observed more difficulties for the siblings at Time 2, compared to the mothers (mothers: 58.00, clinicians: 59.47). With reference to the Syndrome Problem Scales, again the mothers reported higher scores compared to the clinicians at Time 1, apart from on the Withdrawn subscale. At Time 2 on the Syndrome Problem Scale, clinicians were reporting higher sibling scores than the mothers, on four of the scales (Withdrawn, Anxious/Depressed, Social Problems, and Thought Problems).

7.2.2.2 Competency scores as reported by the mothers for the siblings

In relation to the Achenbach CBCL Competency scores, Table 23 provides a summary of the descriptive statistics in reference to mother-reporting of the scores on the three subscales (Activities, Social and School), as well as the Total Competency scores for the siblings across Time 1 and Time 2.

Table 23  
*Mean and Standard Deviations on Mother- Completed Achenbach CBCL Competency Total and Subscale Scores at Time 1 and Time 2 for the Siblings (N=11)*

	Total Competence		Activities		Social		School	
Time	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Time 1	40.45	7.70	46.09	8.14	40.18	7.86	39.18	4.49
Time 2	41.73	6.94	46.45	5.77	42.55	8.10	38.64	4.20

Note: Competence scale T scores: >33 normal range, 30-33 borderline range, <30 clinical range

As shown in Table 23, mothers placed the siblings within the normal range of functioning for the Total Competency score, as well as for each of the subscale scores at both Time 1 and Time 2. Very minor improvements were noted by mothers at Time 2 for Total Competence, Activities and Social, whilst slightly more difficulties for the siblings were observed on the School subscale at Time 2 compared to Time 1. These findings, apart from that pertaining to the School subscale, do not support

Hypothesis 2a which predicted that the parents would identify more difficulties for the sibling at Time 2 compared to Time 1.

Of note, these results, showing an overall improvement in mother-reporting of sibling functioning from Time 1 to Time 2 follows a similar pattern to the IP reported data by the mothers. Noteworthy, however, is that the siblings scores were higher across all measures at both time intervals in comparison to the IPs results, with the most similar results being found on the social subscale. Nevertheless, the siblings scores were still well below the T score non-referred norms for this age population (Non-referred norms: Activities: 48, Social: 48, School, 48, & Total Competence: 50).

A separate two-factor ANOVA procedure was then performed to determine whether the mothers rated the siblings differently across the three CBCL Competence subscales at Time 1 and Time 2. The ANOVA with replication of time (Time 1, Time 2) was performed on the three dependent variables derived from CBCL Competency Scales items – Activities, Social and School for the sibling data. The independent variable was the identity of the rater (mother), with one between subjects factor of rater (mother), and one within subject factor of time (Time 1, Time 2) observed. Table 24 below provides a summary of this analysis.

Table 24  
*Summary Table for Two Factor Analysis of Variance with Replication (Time) for Mother-Completed Achenbach Competency Subscale Scores for the Siblings (N=11)*

Variables	d.f	SS	MS	F	P-value	P interpreted
Time	1	8.73	8.73	0.20	0.66	NS
Subscales	2	618.55	309.27	7.01	0.00	S
Time.Subscales	2	24.36	12.18	0.28	0.76	NS
Within	60	2648.18	44.14			
Total	65	3299.82				

As can be seen in Table 24, mirroring the pattern for the IPs as reported by the mother, no significant difference was observed over Time 1 and Time 2. This finding does not support hypothesis 2a which predicted that the parents would report more difficulties for the sibling at Time 1 compared to Time 2. Moreover, no significant difference was detected in the interaction of time and the subscales for the mother-reported Achenbach Competency scores for the siblings.



Hypothesis 2a stated that psychopathology in the siblings as reported by the parents would be perceived as greater at Time 2 than Time 1. As remarked above, this hypothesis, addressing the father-reported data, could not be statistically tested using multivariate analysis due to the relatively small sample size of fathers. Means and standard deviations on the CBCL problem and competency scale data that was available are provided in the tables below.

Table 25 below provides a summary of the descriptive statistics for the father-completed scores for the three Achenbach CBCL Summary Problem Scales – Total, Internalising and Externalising at Time 1 and Time 2 for the siblings.

Table 25  
*Mean and Standard Deviations on Father-Completed Achenbach CBCL Summary Problem Scale Scores at Time 1 and Time 2 for the Siblings*

Summary Problem Scales	Time	N	Mean	SD
Total	1	12	59.25	11.15
	2	7	49.86	15.32
Internalising	1	12	58.17	9.43
	2	7	52.29	12.26
Externalising	1	12	57.00	11.62
	2	7	46.86	11.82

Note: Summary Problem Scale T scores: <60 normal range, 60-63 borderline range, >63 clinical range

As can be seen from Table 25, fathers consistently reported a reduction in symptomatology for the siblings from on admission to the programme (Time 1) to at discharge from the programme (Time 2). This finding – like the mother-report finding for siblings, is the reverse of the trend hypothesised. Hypothesis 2a was therefore not supported by the father data for the siblings. As did mothers, fathers perceived an improvement in the functioning of the sibling across the two time periods.

However, fathers actually placed the siblings in the normal range of functioning at each time interval and on each subscales. This is in contrast to the mother-reporting

of the siblings. Mothers only placed siblings clearly in the normal range of functioning at Time 2.

Table 26, below, provides a summary of the descriptive statistics in reference to father-reporting of the scores on the Achenbach CBCL Competency Subscales as well as Total Competency score for the siblings across Time 1 and Time 2.

Table 26  
*Mean and Standard Deviations on Father-Completed Achenbach CBCL Competency Total and Subscale Scores at Time 1 and Time 2 for the Siblings*

Competency Scales	Time	N	Mean	SD
Total	1	7	38.43	7.28
	2	4	41.25	4.11
Activities	1	8	43.13	9.66
	2	5	43.40	6.54
Social	1	8	37.38	8.53
	2	4	41.00	0.00
School	1	7	39.86	10.17
	2	4	42.00	8.12

Note: Competence Scale T scores: >33 normal range, 30-33 borderline range, <30 clinical range

Table 26 shows that fathers consistently reported an improvement in functioning on each of the Achenbach CBCL Competency Subscales and Total scale scores. This finding again is the reverse of the trend hypothesised. Once again Hypothesis 2a was not supported. Both mothers and fathers perceived an improvement in the functioning of the sibling across the two time periods. Siblings were placed well within the normal range of functioning by the fathers at both Time 1 and Time 2.

7.2.2.4      Summary of the findings concerning outcomes for the siblings of the identified patient

Hypothesis 2a, which stated that psychopathology in the sibling would be perceived by the parents as greater at the time of discharge (Time 2) than at the time of admission (Time 1) to the AC&FRU programme, as indicated by scores on the CBCL Summary Problem and Competency Scales, was not supported by the findings. Rather, the reverse was found, as both mothers and fathers reported an improvement

in functioning from Time 1 to Time 2 for the siblings on each of the Summary Problem and Competency Scales, except for mothers on the Competency School Scale where more pathology was shown.

Hypothesis 2b, stated that psychopathology in the sibling would be perceived by clinicians as less at the time of discharge (Time 2) than at the time of admission (Time 1) to the AC&FRU programme, as indicated by scores on the Achenbach CBCL Summary Problem Scales, was supported.

Hypothesis 2c, which stated that psychopathology in the sibling would be perceived by the parents as significantly less at six months post discharge follow-up (Time 3) than at discharge (Time 2) from the AC&FRU programme, as indicated by scores on the Achenbach CBCL, could not be tested due to the limited Time 3 data available.

### 7.3 Outcomes concerning parent functioning: General Health Questionnaire-28 scores

An initial correlational analysis was performed on the General Health Questionnaire-28 (GHQ-28) Total score and the McMaster Family Assessment Device's (FAD) seven subscales, to determine whether there was a significant relationship between the GHQ-28 Total score and any of the FAD subscales. If a significant relationship was found then these two measures (GHQ-28 & FAD) needed to be treated as measures dependent on each other. However, no significant relationship was found, and the treatment intervention could be considered in relation to each of these measures independently. In other words, separate analyses could be performed for the GHQ-28 and the FAD as originally intended.

As set out in Section 3.2.3.2.3 of Chapter 3, two main hypotheses were proposed in relation to parent functioning. First, Hypothesis 3a stated that parents' self reports of mental health difficulties would be less at the time of discharge (Time 2), than at the time of admission (Time 1) to the AC&FRU programme, as indicated by scores at each of these times on the GHQ-28. Second, Hypothesis 3b stated that parents' self-report of mental health difficulties would be no different at the six month post discharge follow-up

time (Time 3) than at the time of discharge (Time 2), as indicated by scores at each of these times on the GHQ–28.

The first hypothesis was addressed separately for the mothers and the fathers as outlined below. The second hypothesis could not be addressed at all due to the limited data available at Time 3.

7.3.1 Mother self-report on the General Health Questionnaire-28

Hypothesis 3a was tested using a two-factor ANOVA, with replication of time (Time 1, Time 2) performed on the four dependent variables derived from the GHQ-28 four subscales items – Somatic Symptoms, Anxiety & Insomnia, Social Dysfunction, and Severe Depression.

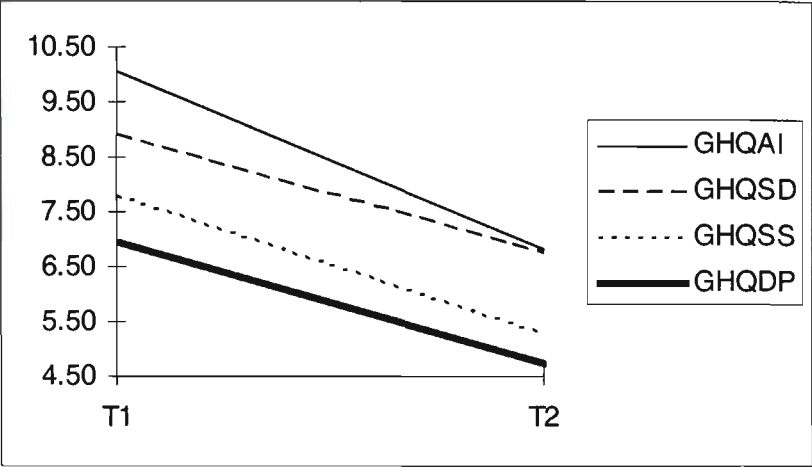
Table 27 displays the ANOVA results in relation to the GHQ-28 four subscales as self-reported by mothers at Time 1 and Time 2. As shown in Table 27, a significant overall difference from Time 1 to Time 2 was found, supporting Hypothesis 3a that mothers would report fewer difficulties in their functioning at discharge from the programme than at admission.

Table 27  
*Summary Table for Two Factor Analysis of Variance with Replication (Time) for Mother Self-Report on the General Health Questionnaire-28 Subscales (N=22)*

Variables	d.f.	SS	MS	F	P-value	P interpreted
Time	1	285.09	285.09	10.21	0.00	S
Subscales	3	187.30	62.43	2.24	0.09	NS
Time.Subscales	3	7.41	2.47	0.09	0.97	NS
Within	168	4690.36	27.92			
Total	175	5170.16				

No significant difference, however, was observed between the four GHQ-28 subscale scores. Figure 3 below on page 206 displays the mean score for each GHQ-28 subscale at Time 1 and Time 2, representing the change over time as self-reported by the mothers.

As can be seen in Figure 3, on each of the GHQ-28 subscales, a reduction in symptomatology was observed from Time 1 to Time 2 as reported by the mothers. At Time 1, symptoms of Anxiety and Insomnia achieved the highest score (M=10.05, SD=5.55), followed by Social Dysfunction (M=8.91, SD=4.14), then Somatic Symptoms (M=7.77, SD=5.64) and finally Severe Depression (M=6.95, SD=6.68). The subscale scores at Time 2 displayed the same pattern in scoring from highest to lowest. Changes in the subscale mean score from Time 1 to Time 2 ranged from 2.18 to 3.23 points.



Note: AI: Anxiety & Insomnia, SD: Social Dysfunction,  
SS: Somatic Symptoms, DP: Severe Depression  
T1: Time 1, T2: Time 2

Figure 3: Mean General Health Questionnaire-28 Subscale Scores Self-Reported by Mothers at Time 1 and Time 2 (N=22).

### 7.3.2 Father self-report on the General Health Questionnaire-28

Hypothesis 3a regarding fathers perceiving an improvement in own functioning across Time 1 and Time 2, as indicated by scores on the GHQ–28, could not be statistically tested by ANOVA as planned, due to the small father sample sizes at both Time 1 (N=12) and Time 2 (N=9). Means and standard deviations on the data available are provided in Table 28 on page 207 below.

Table 28

*Mean and Standard Deviations on Father Self-Report on the General Health Questionnaire-28 Total and Subscales Scores at Time 1 and Time 2*

		SS		AI		SD		DP		Total	
	N	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Time 1	12	4.33	3.68	5.92	5.14	7.58	2.64	3.25	5.40	19.46	16.08
Time 2	9	2.78	2.59	3.78	3.07	6.44	3.48	0.89	1.69	9.62	9.07

Note:

SS: somatic symptoms, AI: anxiety & insomnia, SD: social dysfunction, DP: severe depression

As shown in Table 28, fathers reported fewer difficulties in their general functioning at discharge from the programme (Time 2) than at admission (Time 1) on each of the four GHQ-28 subscales and GHQ-28 Total scale score. At Time 1, symptoms of Social Dysfunction achieved the highest score (4.33) followed by Anxiety and Insomnia (5.92), then Somatic Symptoms (4.33) and finally Severe Depression (3.25). The subscale scores at Time 2 displayed the same pattern in scoring from highest to lowest. The pattern of symptom reduction as self- reported by the fathers from Time 1 to Time 2 was fairly uniform across each of the subscales ranging from 1.44 (Social Dysfunction) to 2.36 (Severe Depression) point change.

### 7.3.3 Comparison of outcome of mother and father self-reports on the General Health Questionnaire-28

Table 29 on page 208 below, provides a comparison of the mother- and father-completed GHQ-28 subscale means and standard deviations. It shows that, as previously discussed, both mothers’ and fathers’ self-reports indicated an improved self perception from admission to the programme (Time 1) to discharge from the programme (Time 2), on each of the GHQ-28 subscale and GHQ-28 Total scale measures. When comparing mother and father self-reports, fathers consistently reported fewer difficulties than the mothers on each of the subscales, at both Time 1 and Time 2. The subscale most similarly reported on by mothers and fathers at Time 1 and Time 2 was Social Dysfunction. On each of the other subscales (Somatic Symptoms, Anxiety & Insomnia, & Severe Depression), the difference in mother and father self-reports ranged from 3.44 to 4.13 points at Time 1 to 2.49 to 3.79 points at

Time 2. Mothers’ self-reports across Time 1 and Time 2 consistently displayed greater variability than did fathers’ self reports.

Table 29

*Mean and Standard Deviations on Mother and Father Self-Report on the General Health Questionnaire-28 Total and Subscales Scores at Time 1 and Time 2*

		SS		AI		SD		DP		Total	
		Mo	Fa	Mo	Fa	Mo	Fa	Mo	Fa	Mo	Fa
Time 1	Mean	7.77	4.33	10.05	5.92	8.91	7.58	6.95	3.25	33.68	19.46
	S.D.	5.64	3.68	5.55	5.14	4.14	2.64	6.68	5.40	20.13	16.08
Time 2	Mean	5.27	2.78	6.82	3.78	6.73	6.44	4.68	0.89	23.50	9.62
	S.D.	4.20	2.59	4.70	3.07	4.73	3.43	6.07	1.69	18.09	9.07

Note: SS: somatic symptoms, AI: anxiety & insomnia, SD: social dysfunction, DP: severe depression

N: mother – Time 1 (N=22), Time 2 (N=22); father – Time 1 (N=12), Time 2 (N=9)

Mo: mother, Fa: father

### 7.3.4 Summary of outcomes regarding the hypotheses concerning the parents’ functioning

In summary, both mothers and fathers self-reported an improvement in functioning from on admission to the programme (Time 1) to at discharge from the programme (Time 2), as shown in their responses to the GHQ-28. The mothers’ results were found to be statistically significant, providing firm support to Hypothesis 3a. The fathers results, however, due to the small sample size available at both time periods, were not able to be analysed using multivariate statistics, but descriptive statistical findings displayed the same trend, lending support to Hypothesis 3a.

Hypothesis 3b, regarding potential change from at discharge from the programme (Time 2) to six months post discharge (Time 3), could not be tested due to the small subject sample for both mothers and fathers available at Time 3.

## 7.4 Outcomes concerning family functioning: McMaster's Family Assessment Device scores

As set out in Section 3.2.3.2.4 of Chapter 3, two main hypotheses were proposed in relation to family functioning. First, Hypothesis 4a stated that parents would identify fewer difficulties for the family at the time of discharge (Time 2) than at the time of admission (Time 1) to the AC&FRU programme, as indicated at each of these times by scores on the McMaster Family Assessment Device (FAD). Second, Hypothesis 4b stated that parents would identify the difficulties for the family as no different at the six month post discharge follow-up time (Time 3) than at the time of discharge (Time 2), as indicated at each of these times by scores on the McMaster FAD.

The first hypothesis is addressed below separately for the mothers and the fathers. The second hypothesis, involving Time 3 could not be addressed due to the limited subject sample available.

### 7.4.1 Mothers' report for the family on the McMaster's Family Assessment Device

Hypothesis 4a, regarding mothers' perceptions of an improvement in the family's functioning across time was tested using a two-factor ANOVA with replication of time (Time 1, Time 2) performed on the seven dependent variables derived from the McMaster Family Assessment Device (FAD) subscales items, namely Family Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behaviour Control, and General Functioning. The ANOVA procedure determined whether or not the mother-ratings were statistically different on each subscale across Time 1 and Time 2. Table 30, page 210 below, displays the ANOVA results in relation to the FAD seven subscales as reported by mothers at Time 1 and Time 2. It shows that a significant overall time effect was observed from Time 1 to Time 2 for the FAD subscales, supporting Hypothesis 4a that mothers' perceptions would register an improvement in family functioning across the time period.



Table 30

*Summary Table for Two Factor Analysis of Variance with Replication (Time) for Mother-Report for the Family on the McMaster’s Family Assessment Device (N=20)*

Variables	d.f.	SS	MS	F	P-value	P interpreted
Time	1	1.32	1.32	4.74	0.03	S
Subscales	6	8.15	1.36	4.86	0.000	S
Time.Subscales	6	0.47	0.08	0.28	0.95	NS
Within	266	74.24	0.28			
Total	279	84.17				

A significant difference was also found between the subscales, but there was no significant effect between time and the subscale variables. A simple pairwise contrast analysis was then conducted to determine where the significant effect between the seven subscales was lying. The main differences were found to lie between the Behaviour Control subscale with each of the following subscales: Global Functioning, Communication and Affective Involvement. Table 31 below provides a summary of descriptive statistics, as reported by the mother for the seven FAD subscales at Time 1 and Time 2.

Table 31

*Mean and Standard Deviations on Mother-Completed McMaster Family Assessment Device Subscale Scores at Time 1 and Time 2 (N=20)*

		PS	CM	RL	AR	AI	BC	GF
Time 1	Mean	2.39	2.42	2.53	2.16	2.22	2.02	2.33
	SD	0.75	0.48	0.47	0.55	0.61	0.52	0.59
Time 2	Mean	2.20	2.33	2.32	2.03	2.21	1.75	2.27
	SD	0.47	0.41	0.44	0.50	0.58	0.44	0.51

Note: PS: Problem Solving, CM: Communication, RL: Roles, AR: Affective Responsiveness, AI: Affective Involvement, BC: Behaviour Control, GF: General Functioning

As can be seen from Table 31, a lower score was reported by the mothers at Time 2 compared to Time 1 for each of the seven FAD subscales, indicative of improvement in aspects of perceived family functioning over the course of the treatment intervention. The greatest difference was observed on the Behaviour Control subscale (0.27 points), followed by Roles (0.21 points), then Problem Solving (0.19 points) and

Affective Responsiveness (0.13 points). Lesser differences emerged for Affective Involvement (0.01 points), Global Functioning (0.06 points) and Communication (0.09 points) from Time 1 to Time 2.

Of note, drawing on the cut-off norms for non-clinical families (Miller, et al., 1985), and comparing them to the means provided in the current study at Time 1, mothers placed their families in the clinical range of functioning on each of the seven subscales, save for Affective Responsiveness. At Time 2, the mean scores for three of the subscales (Affective Responsiveness, Problem Solving and Behaviour Control) fell within the healthy range of family functioning.

7.4.2 Fathers report for the family on the McMaster’s Family Assessment Device

Hypothesis 4b, regarding fathers’ perceptions of family functioning across Time 1 and Time 2 could not be statistically tested due to the small sample size. Means and standard deviations on the data available are displayed in Table 32, below.

Table 32  
*Mean and Standard Deviations on Father-Completed McMaster Family Assessment Device Subscale Scores at Time 1 and Time 2*

	PS		CM		RL		AR		AI		BC		GF	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Time 1	2.31	0.49	2.24	0.55	2.34	0.57	2.28	0.73	2.09	0.61	1.91	0.42	2.24	0.72
Time 2	1.91	0.58	2.22	0.55	2.00	0.49	2.31	0.83	2.02	0.47	1.65	0.45	1.72	0.63

Note: PS: Problem Solving, CM: Communication, RL: Roles, AR: Affective Responsiveness, AI: Affective Involvement, BC: Behaviour Control, GF: General Functioning  
Time 1 (N=14), Time 2 (N=6)

Table 32 demonstrates that fathers consistently reported an improvement in family functioning from admission to the programme (Time 1) to discharge from the programme (Time 2), on each of the FAD subscales except for Affective Responsiveness where marginally more difficulties were reported by the fathers. Whilst these results lend support to Hypothesis 4b, they cannot be further substantiated due to the small sample size at Time 1 (n=14) and notable further sample attrition at Time 2 (n=6).

7.4.3

Comparison of mothers’ and fathers’ percpetions on the McMaster’s Family Assessment Device

Table 33 below provides a comparison of mean and standard deviations of scores for the mothers and fathers on the FAD. The small sample of father responses (Time 1: n=14; Time 2: n=6) limited further statistical analysis.

Table 33

Mean and Standard Deviations on Mother-Completed and Father-Completed McMaster Family Assessment Device Subscale Scores at Time 1 and Time 2

		PS		CM		RL		AR		AI		BC		GF	
		Mo	Fa	Mo	Fa	Mo	Fa	Mo	Fa	Mo	Fa	Mo	Fa	Mo	Fa
Time 1	Mean	2.39	2.31	2.42	2.24	2.53	2.34	2.16	2.28	2.22	2.09	2.02	1.91	2.33	2.24
	SD	0.75	0.49	0.48	0.55	0.47	0.57	0.55	0.73	0.61	0.61	0.52	0.42	0.59	0.72
Time 2	Mean	2.20	1.91	2.33	2.22	2.32	2.00	2.03	2.31	2.21	2.02	1.75	1.65	2.27	1.72
	SD	0.47	0.58	0.41	0.55	0.44	0.49	0.50	0.83	0.58	0.47	0.44	0.45	0.51	0.63

Note: PS: Problem Solving, CM: Communication, RL: Roles, AR: Affective Responsiveness, AI: Affective Involvement, BC: Behaviour Control, GF: General Functioning  
N: mothers: Time 1 (N=20), Time 2 (N=20); fathers: Time 1 (N=14), Time 2 (N=6)  
Mo: mother, Fa: father

Table 33 reveals that fathers consistently perceived less family pathology at both Time 1 and Time 2 than mothers, on each of the subscales except for Affective Responsiveness. On the Affective Responsiveness subscale, fathers reported higher scores than the mothers. Standard deviations for the mothers’ scores on each of the subscales at Time 1 and Time 2 were lower than that reported by the fathers except for Problem Solving at Time 1, Behavior Control at Time 1 and Affective Involvement at Time 2. A similar trend for mother and father data across Time 1 and Time 2, with a reduction in perceived symptomatology on each of the subscales over time was observed, apart from father’s reporting on Affective Responsiveness, where a slight increase at Time 2 was observed.

#### 7.4.4 Summary of outcomes regarding the hypotheses concerning the family's functioning

In summary, both mothers' and fathers' perceptions registered an improvement in family functioning from admission to the programme (Time 1) to discharge from the programme (Time 2) as shown in their responses on the FAD subscales, apart from fathers who perceived a slight decline in functioning in the area of Affective Responsiveness. The mothers' results were statistically substantiated, providing firm support to Hypothesis 4a. While the fathers' results were not able to be analysed using multivariate statistics, descriptive statistical findings displayed the same trend lending support to Hypothesis 4a.

Hypothesis 4b, regarding potential change from discharge from the programme (Time 2) to six months post discharge (Time 3), could not be tested due to the small subject sample of both mothers and fathers available.

### 7.5 Overall findings in terms of hypotheses of the study

Setting aside the hypotheses that involved data collection at Time 3, the findings of the archival study for child, parent and family functioning can be summarised as follows.

#### 7.5.1 Outcomes concerning child functioning

In reference to both the IPs and the siblings, an improvement in functioning from Time 1 to Time 2, on each of the CBCL Summary Problem Scales (Total, Internalising and Externalising) was indicated by the scores generated by the mothers, fathers and clinicians. For mothers and clinicians, where sample sizes were large enough to allow multivariate analysis, this effect was found to be statistically significant. Fathers' perceptions also registered an improvement in functioning for both the IPs and siblings from Time 1 to Time 2, on each of the CBCL Competency Total and Subscales (Activities, Social, and School) scores. Mothers similarly followed this trend, although their perceptions did not suggest improvement for the IP's on the Social Subscale, or for the siblings on the School Subscale.

### 7.5.2 Outcomes concerning parent functioning

Both mothers' and fathers' self-reports indicated an improvement in their own functioning from Time 1 to Time 2, on each of the GHQ-28 Total and Subscale scores (Somatic Symptoms, Anxiety and Insomnia, Social Dysfunction, and Severe Depression). For mothers, where multivariate analysis was possible, this was shown to be a statistically significant effect.

### 7.5.3 Outcomes concerning family functioning

Both mothers' and fathers' perceptions indicated an improvement in family functioning from Time 1 to Time 2, as shown on each of the FAD Subscale scores (Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behaviour Control, and General Functioning), although fathers' perceptions suggested a slight decline in functioning in the area of Affective Responsiveness.

### 7.5.4 Conclusion

Thus, despite certain limitations, the outcome data collected in respect to the effectiveness of the AC&FRU programme from 1995 to 1997, revealed that the programme was successful in achieving certain of its main therapeutic aims during the period of admission. Unfortunately, resourcing of the research at the time of data collection and the eventual closure of the programme had prevented consistent collection of follow-up data. The archive of data was incomplete in this respect. The limitations of the study are discussed in detail in Section 9.1 of Chapter 9 below, before a comprehensive interpretation of the findings is presented.

Limitations aside, the overall positive thrust of the findings of this archival study did certainly warrant the implementation of Stage 2, as planned, to explore particular aspects of the programme, hitherto unexamined. Chapter 8 documents the findings of Stage 2.

## **CHAPTER 8**

### **RESULTS OF STAGE 2 EVALUATION:**

#### **INTERVIEW STUDY OF CLINICIANS' VIEWS OF PROCESS AND OUTCOMES OF THE PROGRAMME**

This chapter documents the results of the retrospective interview study of the clinicians' views of the process and outcome of Austin Child & Family Residential Unit (AC&FRU) programme. Outlined initially are the demographic and work history details of the clinicians who were involved in the programme and who participated in Stage 2 of this project. This is followed by systematic presentation of the findings of the interviews with the clinicians. First to be addressed are the clinicians' conceptualisations of the programme's theoretical orientation in reference to the presenting family difficulties, as well as the identified patient's difficulties within the overall family context. Second, the clinicians' experiences of the practice of the programme are explored. This incorporates views of the manner in which the overall programme responded to family problems and individual problems, as well as how team roles and general team functioning were played out. Third, attention turns to the clinicians' perceptions of outcomes for the families engaged in the programme, in terms of benefits gained, challenges experienced and changes in perception by family members. Finally, findings from the clinicians' reflections on outcomes for themselves as a product of working in the programme are presented.

#### **8.1 Conduct of the clinicians' interviews**

The participants in Stage 2 of this study were former Austin Child & Family Residential Unit (AC&FRU) clinical team members (clinicians) between the designated period of July 1995 to June 1997. Of the ten Stage 2 clinicians, nine had been involved in Stage 1 of this project. The one clinician who had not been directly involved in Stage 1 of the study, due to not fulfilling a case management role, had been an AC&FRU team member for the entire 11-year period of the programme. It was deemed important to include this team member's reflections regarding the programme. Of the remaining two team members who had been involved in Stage 1

of the project but were not involved in Stage 2 – one declined to be involved, and the other was not approached as this team member had not satisfied the given criteria of having been a team member for at least a 12-month period. Thus, ten of the eleven clinicians (91%) approached, agreed to be involved in Stage 2 of the study.

The ten clinician interviews were conducted between November 2000 and March 2001 at locations of each clinician's choosing. Four interviews were conducted in the home of the clinician, three interviews were conducted in the home of the interviewer, two interviews were conducted at the clinician's workplace and one interview was conducted via the telephone as the clinician was now residing outside of Australia. All interviews (apart from the telephone interview) were conducted face to face with the interviewer, were uninterrupted, and took between 60 and 90 minutes to complete.

It can be noted that all clinicians who participated in Stage 2, approached the interview with enthusiasm. The clinicians expressed to the researcher an eagerness in responding to the opportunity to reflect in a critical way upon their experience of being involved in, and contributing to the programme. All appeared frank and fullsome in their responses to the interview.

## 8.2 Clinicians' demographic and work history details

A summary of the clinicians' demographic and work history details, drawn from the self-report questionnaire, is displayed in Table 34 on page 217 below.

As displayed in Table 34, the participants were four male and six female clinicians. This group comprised six psychiatric nurses, two psychiatrists, one psychologist, and one social worker. The mean age when starting their employment on the Unit was 35.8 years with an age range from 29 to 44 years. The mean age when finishing on the Unit was 39.8 years with an age range from 34 to 48 years. The average length of employment on the Unit was four years, ranging from a 12 month training rotation to one team member being employed on the Unit over the entire operating life of the programme, that is to say 11 years. Staff retention was clearly high on the Unit, seeing many staff progress from junior to comparatively senior positions within the team. The effective fulltime (EFT) hours of clinicians ranged from 0.5 (half time) to 1.0 EFT (full time), with a mean of 0.85 EFT.

Table 34

*Descriptive Statistics for Demographic and Work History Details for Former Austin Child & Family Residential Unit Clinicians*

Demographic & Work History Details	N	Mean	Range
Sex	10	n/a	6 females 4 males
Age when started on the Unit	10	35.8 years	29 – 44 years
Age when finished on the Unit	10	39.8 years	34 – 48 years
Length of time working on the Unit	10	4.0 years	12 months – 11 years
Effective full time (EFT) hours employed	10	0.85 EFT	0.5 – 1.0 EFT
Position on the team by professional discipline	10	n/a	6 psychiatric nurses 1 consultant child psychiatrist 1 trainee child psychiatrist 1 clinical child psychologist 1 social worker
Years of prior experience working in the health field including mental health	10	11.25 years	3 years – 21 years
Years of experience in child psychiatry prior to joining to team	10	2.5 years	0 years – 7 years
Family therapy training experience	10	n/a	4 undertaken training while employed with AC&FRU 3 completed training prior to AC&FRU employment 2 incorporated aspects of family therapy in basic professional training 1 no formal family therapy training
Area of work since finishing with the AC&FRU	10	n/a	6 child & adolescent psychiatry 2 community family work 2 community adult psychiatry

Note: n/a: not applicable

All clinicians had had some experience working in the health care field prior to their employment on the AC&FRU. This ranged from three to 21 years' experience. Not all clinicians, however, had worked in the speciality of child and adolescent psychiatry prior to their employment on the Unit. Whilst the mean was 2.5 years of prior child and adolescent experience, two clinicians had not had any prior experience, with the most being seven years of experience in the field of child and



adolescent psychiatry prior to their employment with the AC&FRU team. Most of the clinicians had engaged in formal family therapy training either prior to their employment with the AC&FRU programme or during this period of employment.

With regard to the clinicians’ work subsequent to their involvement with the AC&FRU team, six former team members had continued to work in the area of child and adolescent psychiatry, two had taken up community positions involving family work, and two had moved into the area of community adult psychiatry.

8.3 Clinicians’ views of the programme’s theoretical orientation

While certain clinicians were very familiar with the full range of theoretical orientations within child psychiatry, others appeared less familiar. Nevertheless, all interviewees were keen to discuss their conceptualization of presenting family difficulties, and IP’s difficulties in the overall family context. Even when these conceptualisations were grounded more in principles and practices, they certainly implied abstract notions linked to theoretical frameworks as outlined in Section 1.1 of Chapter 1.

All tables display the themes and subthemes relating to theoretical conceptualisations that emerged in the analysis. The responses are presented in terms of the third level of content analysis described in Section 5.4.4.3 of Chapter 5. They are accompanied by exemplary quotes tagged to clinician letter codes that were assigned at the first level of analysis as outlined in Section 5.4.4.1 of Chapter 5.

8.3.1 Conceptualisation of presenting family difficulties

Table 35, on page 219 below, presents an overview of the responses by the clinicians to Question 1, which asked about how they perceived the principles according to which the AC&FRU conceptualised the difficulties presented by families admitted to the Unit.

Table 35

*Clinicians' Conceptualisations of Presenting Family Difficulties*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Family systems principles	9	Seen as the main or one of main viewpoints (6) Difficulties seen in the context of the family and the wider system (6) Drawn from various family therapy models (3)
Psychodynamic principles	7	Favoured by several people on the team who worked primarily with individuals within the family (5) Various psychodynamic models identified (2) Seen as the main or one of main viewpoints (2) Details of the framework (2) Psychodynamic theory not consciously integrated into milieu work (1)
Integration of several theoretical frameworks	7	Range of theoretical perspectives applied (6) Impressions regarding the manner in which various theories interacted (5) Uncertainty regarding how several theoretical models worked together (1) Team debates partially derived from differing theoretical perspectives (1)
Cognitive-behavioural principles	5	Cognitive-behavioural principles predominately used in the milieu setting (4) Use of behavioural strategies allowed other issues to be explored and addressed (1)
Biopsychosocial principles	5	Described as a wholistic approach incorporating a range of factors and influences which impact on the individual and families (5) Nurses predominately mentioned and worked within this theoretical orientation (5)
Psychiatric diagnosis or biological status	5	Consideration given to possible psychiatric diagnosis or biological status of individual (5)
Developmental psychology theory	3	No subthemes
Other relevant comments	2	Team not seen to have a 'conscious' way of conceptualising family difficulties (1) Theory and practice seen to be different (1)

Table 35 reveals that the most frequently mentioned theme here centred on the utilisation of family systems principles. Nine of the ten clinicians raised this theme. Six clinicians identified this as the main or one of the main viewpoints in the AC&FRU. Six clinicians also characterised the family systems theoretical orientation in terms of the team viewing the presenting difficulties in the context of the family and the wider system. As Clinician J noted, the team ‘tried to understand the child’s difficulties in terms of the family context and wider social context that the family was embedded’. The wider social context could include school and extended family (Clinician B), as well as involvement with care and protective services and the justice system (Clinician D). A further three clinicians noted that the family systems conceptualisation drew upon various family therapy models.

The next most quoted themes, each mentioned by seven clinicians, focussed on the utilisation of psychodynamic principles, and the integration of several theoretical frameworks in the team’s conceptualisation of the presenting family difficulties.

First, the employment of psychodynamic principles was the most prominent subtheme to emerge, presented by five clinicians. This theoretical framework was particularly favoured by those on the team who worked primarily with individuals within the family. A further three subthemes, each mentioned by two clinicians, included psychodynamic principles being seen as the main or one of the main viewpoints, identifying the application of various psychodynamic models and general details regarding the theoretical framework. Finally, one clinician observed that psychodynamic theory was not consciously integrated into the milieu work with the families. ‘The nurse would recount on what she saw, but never talked about her own experience of it’ (Clinician I).

In regard to the integration of several theoretical frameworks, subthemes identified included mention by six clinicians that a range of theoretical frameworks were applied within the programme. Clinicians reflected that ‘different practitioners would bring their own theoretical perspective to the family’ (Clinician A) and ‘the team approach assisted in drawing together and integrating (these) viewpoints’ (Clinician C). Five clinicians made reference to the manner in which the various theoretical models interacted. A broad range of comments emerged, such as ‘systemic and

psychodynamic theories interacted fairly well' (Clinician B) and 'behavioural strategies used were encompassed by a systems understanding' (Clinician J). While Clinician A considered that the programme employed a 'good mixture of theories' and that 'so much of what was done could be seen from multiple (theoretical) perspectives', Clinician H reflected that the 'the mode of practice was seen to be dependent on which process of the Unit was being observed'. Finally, several singularly reported subthemes also emerged. One clinician expressed uncertainty regarding how several of theoretical models worked together. Clinician I, in hindsight, considered that systems theory and psychiatry's Diagnostic and Statistical Manual (DSM) approach brought conflict, being contradictory in how they conceptualised presenting difficulties. The other singularly noted subtheme here was the observation that team debates regarding diagnosis or the investment of team resources partially derived from differing theoretical perspectives. However, Clinician A reflected that, 'the perspectives were more determined by the roles clinicians were playing, than their theoretical perspectives, even though it was often couched in theoretical terms by others'.

Further themes, each raised by five clinicians, included the utilisation of cognitive-behavioural principles, biopsychosocial principles and attention to psychiatric diagnosis or biological status of individuals.

With regard to the employment of cognitive-behavioural principles, the main emerging subtheme, noted by four clinicians, was that these principles were predominately used within the milieu setting in relation to children's behavioural management contracts, and in practical parenting work. It was also reported by one clinician was that 'the use of behavioural strategies allowed other issues to be explored and addressed' (Clinician J).

The five clinicians who identified biopsychosocial principles in their view of conceptualisation of the presenting family difficulties, described the same as a wholistic approach incorporating a range of factors and influences that impact on the individual and families. Of note, the psychiatric nurses predominately mentioned and worked within this theoretical orientation (five clinicians).

Five clinicians mentioned psychiatric diagnosis or biological status of individuals as part of the team's conceptualisation of the presenting family difficulties. It was indicated that 'most people were willing to consider biological presentations' (Clinician A) and 'at times the child had their own specific mental health issues' (Clinician D), such as severe attention deficit hyperactivity disorder (Clinician J), pervasive developmental disorder (Clinician G) or obsessional behaviour and thinking (Clinician D). However, 'straight psychiatric conditions were minimised as people had been through the filters (other agencies, outpatients services)' prior to admission to the programme (Clinician A).

A further theme raised by three clinicians centred on aspects of developmental psychology theory. The child's maturity and overall response to life circumstances (Clinician B) was mentioned, as well as learning or educational theory (Clinician J).

Finally, two other relevant comments were made concerning the manner in which the programme conceptualised the family's presenting difficulties. First, Clinician B reflected that the team did not have a 'conscious way' of conceptualising the difficulties. Second, Clinician H viewed the theory and practice as different, and found the same to be dependent on which aspect of clinical practice was under discussion.

### 8.3.2 Conceptualisation of IP's difficulties in the overall family context

Table 36, below on page 223, presents a summary of the themes and subthemes emerging in responses by participating clinicians to Question 2 regarding their conceptualisation of the place of the identified patient's (IPs) difficulties within the context of overall family functioning.

Table 36

*Clinicians’ Conceptualisations of the Place of the IP’s Difficulties in the Context of Overall Family Functioning*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
IPs difficulties seen as a response to wider system issues	10	Response to the family environment (9) Response to the parental environment (3) Response to interactions with sibling/s contributing to the difficulties (2) Viewed as a symptom of a larger problem (2)
Specific difficulties noted for the IP in own right	6	Diagnosable conditions (4) IP’s difficulties called for more focus in Unit (3)
Inter- relationship between the child and the family	3	No subthemes
The team’s understanding of the difficulties developed as the family became better known	3	No subthemes
IP’s difficulties considered in the context of developmental norms	2	No subthemes

The main theme here, as displayed in Table 36, involved conceptualisation of the identified patient's (IP’s) difficulties in the context of the overall family functioning, centred on the difficulties being seen in the context of the wider system. This was stated by all 10 clinicians. Several subthemese emerged. First, nine of the ten clinicians described the difficulties as a response to the familial environment. As Clinician C noted, ‘to us the IP was not the IP, we worked with the whole family’. Second, three clinicians viewed the IP’s difficulties as a response to the parental environment. Third, two clinicians perceived interactions with the siblings as important in contributing to the IP’s difficulties. Finally, a further two respondents viewed the IP’s difficulties as a symptom of a larger family problem.

The second most frequently noted theme, regarding the clinicians’ conceptualisation of the place of the IPs difficulties in the context of overall family functioning, was that of the IPs having specific difficulties in their own right. Six clinicians voiced this

view, four stating that the IP always had a diagnosable condition, while three considered that the IP at times required more focus than other family members.

The next main theme, reported by three clinicians, viewed the IP's difficulties as 'an inter-relationship between the child and the family'. As Clinician F described, 'the team was interested in not just presenting behaviours, but also interactions'. Thus the fit between the child and the family was addressed (Clinician J).

The fourth theme identified, also by three clinicians, noted that the team's understanding of the difficulties developed as the family became better known. The final theme, identified by two clinicians, drew attention to the IP's difficulties in the context of developmental norms.

#### 8.4 Clinicians' views of the practice of the programme

Clinicians' views regarding the practice of the AC&FRU programme, drawn from Questions 3, 4 and 5 are presented below. Areas covered include how the programme addressed problems at a family level and an individual level, as well as clinicians' views regarding team roles and general team functioning. All tables display the themes and subthemes relating to the clinicians' conceptualisations regarding the practice of the programme that emerged in the analysis. The responses are presented in terms of the third level of content analysis described in Section 5.4.4.3 of Chapter 5. They are accompanied by exemplary quotes tagged to clinician letter codes that were assigned at the first level of analysis as outlined in Section 5.4.4.1 of Chapter 5.

##### 8.4.1 Views of the programme addressing family problems

Table 37 on page 225 below, provides an overview of the themes and subthemes emerging in responses by the clinicians to Question 3, regarding how the AC&FRU programme addressed problems at a family level.

Table 37

*Clinicians’ Conceptualisations Regarding How the Programme Addressed Problems at a Family Level*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning sutheme (in brackets)
Work within the therapeutic milieu	10	Ward-based family treatment programme (7); Particular components of the programme (6) Through the processes of the Unit (7); Admission involved the whole family (4)
Working with the different family subsystems	8	Parent therapy/work (6) Individual therapy (3) Couple work (3) Adults having their own time (3) Case management meetings (2)
Family therapy sessions	7	No subthemes

The most frequently mentioned theme shown in Table 37 focussed on the work that was undertaken within the therapeutic milieu. All ten clinicians identified this theme. As Clinician J observed, 'the whole milieu was directed towards addressing family issues'. Two particular subthemes emerged, each mentioned by seven clinicians. The first centred on the ward-based family treatment programme. While a range of features regarding the ward-based programme were identified, six clinicians made mention of particular components of the programme. These included routines, positive reinforcement, limit setting, whole family activities and children having special time with the parents. Realistic goals were set and programmes were tailored to the needs of the family. The second subtheme involved the general processes of the Unit, described by Clinician A as the 'subtle piecemeal components of the ward processes'. Again, while numerous aspects of the processes were reported, one component observed by four clinicians was the fact that the admission involved the whole family.

The next main theme, raised by eight clinicians, entailed the work undertaken by the team with the different family subsystems. Examples of work with the different family subsystems, as noted in the subthemes here, included parent therapy (six clinicians), individual therapy (three clinicians), couple work (three clinicians), adults



having their own time (three clinicians), and through the mechanisms of the case management meetings (two clinicians).

The final main theme in relation to how the AC&FRU addressed problems at a family level was identified by seven clinicians related to formal family therapy sessions. Family therapy was considered by Clinician A as the ‘overt conceptualisation’ of the manner in which the programme addressed problems at a family level. Transgenerational work was at times an aspect of the therapy (Clinician B), as well as ‘identifying family relationships that cut across subsystems’ (Clinician G). As Clinician H commented, ‘the focus was on the link with the family as a whole’.

#### 8.4.2 Views of the programme addressing individual problems

Table 38, on page 227, sets out a summary of the themes and subthemes emerging in responses by clinicians to Question 4, regarding how the presenting problems were addressed at an individual level.

As shown in Table 38, the main theme, identified by eight clinicians, in response to how problems were addressed at an individual level within the programme, focussed on the team approach to children within the family. Emerging subthemes included responses that were specific to the sibling in the family, with six team members making the observation that many siblings were experiencing difficulties in their own right. Five clinicians noted that the children (IP and siblings) in the family had formal therapeutic input. As Clinician J observed, ‘the team took great care in looking at each of the children within the family’. This included a formal psychiatric assessment, incorporating the child’s developmental history (Clinician G), and attention to educational (Clinicians I and J), medical and biological (Clinician I) needs as required. Three clinicians made mention of informal therapeutic input provided to the children through the ward milieu. A further three clinicians made mention of specific individual concerns identified for the children, such as issues of attachment (Clinician H), over-involvement in parental difficulties (Clinician I), and exclusion from their base school (Clinician B). The final two subthemes, each mentioned by two clinicians, reflected the diverse familial presentations. On the one hand, two clinicians considered the IP was not always the person in the family with the most

difficulties, and on the other hand, two clinicians noted that the therapeutic work often focussed around the IP.

Table 38

*Clinicians’ Conceptualisations Regarding How the Programme Addressed Problems at an Individual Level*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning subtheme (in brackets)
Team response to children in the family	8	Responses specific to the sibling/s of the IP – many siblings identified as having problems as well (6) Formal therapeutic input provided for all children (5) Informal therapeutic input provided for all children (3) Identification of individual concerns for the children (3) Responses specific to the IP – the IP was not always the person in the family with the most difficulties (2) Therapeutic input often focussed around the IP (2)
Team response to parents as individuals or as a parental couple	7	Identification of individual concerns for the parents related to past history and current issues (5) Parents related to as individuals (4) Parents related to as parents or parental couple (4) Awareness that the parents viewed the team as a ‘surrogate parental figure’ (1)
Team response to each family member as an individual	7	Formal individual sessions for each family member (5) Each individual in the family was recognised in their own right (5) Informal time available for each family member (1)

The next theme, raised by seven clinicians, considered the team response to parents as individuals or as a parental couple. Several subthemes emerged. Five clinicians recalled the identification of individual concerns for the parents related to their past history (history of difficult and, or abusive relationships), or current issues (significant psychiatric problems, marital difficulties, and limited parenting skills). It was also observed that parents were considered both as individuals (four clinicians) and as parents or as a parental couple (four clinicians). At an individual level, the team sought to understand the parent’s developmental, family of origin and relationship histories. At a parental level, the ‘parents were thought of as a subsystem’ (Clinician

J), and inpatient work was seen to focus very much on their parenting practices. The last subtheme to emerge, noted by one clinician, was an awareness that the parents viewed the team as a 'surrogate parental figure'. Clinician H observed that this was 'aroused...transferentially in the adults in either a satisfying or frustrating way', depending on whether team members adequately met the parent's unconscious needs.

The final main theme, also observed by seven clinicians, was the team response to each family member as an individual throughout the admission. Three subthemes emerged here. First, five clinicians noted that formal individual sessions were provided for each family member. As Clinician A commented, 'the programme intended to deliver an individual formulation and treatment for each person'. Second, a further five clinicians recalled that each individual in the family was recognised in his or her own right. An effort was made to 'hear' each individual child and parent (Clinician H). Finally, one clinician noted that informal therapeutic time in the milieu was available for each family member.

#### 8.4.3 Views of team roles and general team functioning

Tables 39, 40, and 41, relate to themes and subthemes emerging in responses by the clinicians to Question 5, regarding team members' designated roles and their views on the general team functioning within the AC&FRU programme.

First, Table 39, on page 229 below, provides an overview of the themes and subthemes emerging in response to the clinicians' general comments regarding team roles and the role and function of the case management team.

The role and function of the case management team was reflected upon by six clinicians, expressed in three main subthemes. First, the importance of having a collaborative working relationship within the case management team (between the primary nurse and the case manager) was raised by six clinicians. Clinician H noted that 'the case management team optimally operated as a tightly knit team discussing what was happening for the family' and 'it was very important to be able to work closely and respect each others' role'. Moreover, Clinician B noted, the case management team 'provided that link between the Unit and the team'. Second, a

range of clinical and management responsibilities were identified by five clinicians as being part of the case management’s team’s role and function. Clinician D considered that the ‘case management team held responsibility for overseeing the family’s stay on the Unit’. These responsibilities included organising the admission and an assessment plan, devising a clinical formulation regarding the family’s presenting difficulties, and drawing up with the family a management plan involving goals (Clinicians B, C, F, and H). The third subtheme, mentioned by four clinicians, acknowledged issues presenting for the case management team and the forums available to address the same. Clinician B indicated that ‘some case managers and primary nurses worked better together than others’, while Clinician I suggested that ‘the case management team worked well when individuals got to know and understand each other, and their respective skills and abilities’. Conflict between case management team members could impact on these team members and the family with whom they were working (Clinician C). Other team members and formal supervision could be drawn upon to address presenting difficulties or challenges (Clinician D).

Table 39

*Clinicians’ Conceptualisations Regarding the Role and Function of the Case Management Team, and Team Member’s Roles*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Case management team’s role and function	6	Importance of a collaborative working relationship within the case management team (between the primary nurse and case manger) observed (6) Clinical and management responsibilities (5) Presenting issues for the case management team and forums to address the same (4)
Team members’ roles clearly defined	5	Distinction made between nurses and other clinician’s roles (5) Distinction between roles handled reasonably well and the importance of same observed (3) Both nurses and clinicians viewed as role models for many families (1)

The main theme in relation to team members roles was that the roles were perceived as clearly defined. Five clinicians made mention of this, and several subthemes emerged. First, all five respondents made a distinction between the nurses' and the other clinicians' roles. In regard to team leadership, Clinician B observed that 'the team leader and the nurse unit manager had complementary roles but different responsibilities'. The case management team roles were also noted to be 'very clear and defined' (Clinician C). Clinician F noted that the 'nurses worked with the (whole) family' whilst 'other clinical staff worked mainly with individual (family subsystems)'. Clinician A similarly reflected that the nurses were 'trying to deal with more a whole part compared with other staff'. It was the perception by several clinicians that the nursing staff 'ran' the Unit : 'the whole of life was managed by the nursing staff on the ward' (Clinician A), and, as Clinician B suggested, 'the nurses knew what was going on' and 'at the end of the day had the balance of power in terms of how things went'. Second, the distinction between roles was viewed by three clinicians to be handled reasonably well, and the importance of this was underlined. As Clinician B noted, 'nursing and clinical work was described as an 'upstairs, downstairs' split but, rather than being divisive, it was seen as two components of the work...one relied on the other, they were ... interdependent'. Moreover, Clinician G acknowledged the importance of 'other team members being not as involved as the primary nurse (with a family), and perhaps retaining more objectivity'. The final subtheme emerging, for one clinician, was that both the nurses and the other clinicians were viewed as role models by many families.

Table 40, on page 231 below provides an overview of the themes and subthemes emerging in responses by clinicians when specifically asked about the role and function of the primary nurse and case manager. A number of subthemes in relation to the primary nurse role emerged.

First, seven of the 10 clinicians noted that the primary nurse held a central role with the family. As Clinician I stated, 'I felt the nurses were at the centre of the activity and what was happening'. Clinician J considered that 'the primary nurse was responsible for actually making things work, for the family to actually to be able to be here (in the programme)'. It was also duly observed that the primary nurse worked most closely and spent the most time with the families (six clinicians), and were considered to have

the ‘best view’ of what was going on in the family (three clinicians). Clinician H reflected that ‘the primary nurse saw the family within the context of the milieu, other staff and the other family which provided a much broader perspective than the case manager’. In addition, three clinicians viewed the primary nurse as providing a supportive and containing function for the families. For example, Clinician I considered that the nurse was ‘keeping the whole family in mind’ and was ‘supporting as well as creating structure’ for the families.

Table 40  
*Clinicians’ Conceptualisations Regarding the Role and Function of the Primary Nurse and Case Manager*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Primary nurse	10	Held a central role with the family (7) Described as a demanding and challenging position combining multiple roles (5) Involved in engagement with and observation of the family (5) Established the family ward-based treatment program and worked alongside the family (5) Recognition of intra- and interpersonal dynamics associated with the role (5) Involved in preparatory tasks pre- and on admission of the family (4) Wrote an assessment and treatment phase report for the family (4) Advocated for the family and liaised with other team members (3)
Case manager	8	Management responsibilities – case co-ordination, devising and overseeing assessment, treatment and discharge plans for the family (7) Clinical responsibilities – conducting case management meetings, family or parent work sessions, outpatient family work (5) Perceived as a ‘lonely’ position (1)

The next subtheme, identified by five clinicians, involved describing the role of the primary nurse as demanding and challenging combining multiple roles. Clinician C likened the role to ‘a bit of everything – best friend, mentor, role model, teacher, organiser, extended arm of the parent, bridge, mediator and therapist’. Clinician E noted the role required considerable thinking and planning, as the primary nurse was working with a number of subsystems within the family, and often with parents, who were extremely fragile and struggling with their own psychiatric concerns. Clinician J characterised the role as ‘tricky’, as a ‘participant-observer role, but not having a clearer therapeutic role with the family, yet living alongside them for the length of each shift’.

The third subtheme here, mentioned by five clinicians, recognised the primary nurse’s involvement in engaging with and observing the family. As Clinician D reflected, ‘the primary nurse developed an understanding of where they were at and how they functioned, by observing as they went about their day to day activities’. Through a ‘participant-observer’ (Clinician I) model, the ‘nursing team worked at making the families feel comfortable, non-threatened, not judged although observed’ (Clinician F).

A further five clinicians made note of viewing the primary nurse establishing the family ward-based treatment programme and working alongside the family in its implementation. As Clinician F described, the primary nurse ‘tried to problem solve and understand the difficulties with the family in a different way’. This involved ‘working closely with the parents to set and achieve their goals’, and ‘meeting several times a week to see how the programme was going’ (Clinician G). Other specific activities of the primary nurse were seen to be devising strategies and interventions to be incorporated in establishing appropriate (parent-child) boundaries, addressing parenting styles, developing effective limit setting (Clinician D), assisting parents to contain the children when they were out of control, containing the parents (Clinician G), and providing positive feedback and validating the family’s efforts (Clinician I).

In a fifth subtheme, five clinicians mentioned a range of intra- and interpersonal dynamics which they considered to be associated with the primary nurse role. Clinician A observed the potential for ‘blurring of boundaries’, as the nurses ‘handled

a lot of ...the feeling...identified more with the families'. Similarly, Clinician G noted that there was potential for the primary nurse to 'get caught up in what was happening for the family and lose objectivity', and Clinician B that there was a tendency for the primary nurse to identify with either the child or the adult in the family. Clinician D recalled the importance of the nurses not to be drawn into taking over the parenting of the child, and Clinician G recollected the value of 'trying to stay neutral to the whole family'.

The next subtheme in the clinicians' perceptions, mentioned by four clinicians, focussed on the primary nurse being involved in a range of preparatory tasks before and upon admission of the family to the Unit. These ranged from the pre-admission involvement in the family 'screen' interview (Clinician C), arranging and attending a family home visit with the case manager, and discussing with the family practicalities related to the admission (Clinician D). On admission, the primary nurse was involved in the initial orientation of the family to the Unit which included explanations about Unit rules and functions, expectations of the family, and communicating any needs the family had to the rest of the team (Clinicians D and G). Other practical tasks such as designating bedrooms (Clinician C), organising the family's weekly timetable of meetings (Clinician D) and overall providing a safe environment (Clinician I) were also mentioned.

A seventh subtheme, again raised by four clinicians, was focussed on the primary nurse writing an assessment and treatment phase report regarding the family. This involved making an assessment concerning 'how the family functioned in the milieu' (Clinician J), 'looking at relationships between family members, the marital relationship, sibling relationship, observations about the behaviours of the identified patient' (Clinician F). The report which was presented at the multidisciplinary team meeting, alongside other clinicians' reports (Clinician D), was viewed as a process of integrating information provided by the nurse's own and other nursing staff's observations of the family drawn from the regular contact with the family (Clinician D).

The final subtheme here, noted by three clinicians, was revealed as the role of the primary nurse in advocating for the family and liaising with other team members. The



importance of clear ongoing dialogue with nursing colleagues and other team members was highlighted ‘to ensure support with the primary nurse role and thereby support for the family’ (Clinician C). As Clinician A noted, the primary nurse had the ‘role of representing the family’s concerns to the (respective) individual therapists’. Therefore, the primary nurse’s observations regarding family interactions, roles within the family, coping styles of the parents, parenting styles, parent’s mental health issues, mood and behaviour of the children, how the children spent their time and choice of activities, and how the children interacted with other children, were considered to be important ongoing communications (Clinician D).

As also shown by Table 40 on page 231 above, the case manager’s role was commented on in detail by eight clinicians. Two subthemes emerged here. The first addressed the management responsibilities pertaining to the role. Seven clinicians discussed this, mentioning the tasks of case co-ordination, devising and overseeing the family assessment and treatment, as well as discharge plans. As Clinician H noted, the ‘case manager had the responsibility of trying to formulate all information and present a coherent plan of management’ for the family. Discharge planning was described as involving working with the initial referrer and meeting with people from other services such as rural Child & Adolescent Mental Health Services and the schools (Clinician B). The second subtheme, discussed by five clinicians, focussed on the clinical responsibilities of the case manager. These included conducting case management meetings, undertaking family or parent work sessions as well as outpatient family work (Clinician B and E). Clinician J summarised the case manager’s role as incorporating both clinical and management responsibilities, and described it as ‘an important therapeutic role’ in which ‘half of the co-ordinating amounted to containing the family and all of those involved from the team’. Finally, one clinician characterised the case manager’s role as ‘a lonely position’ in that ‘often the families were difficult’ and the case manager ‘had to hold the hope for the family that things would change’ (Clinician B).

Table 41, on page 236 below, relates to views of the roles held by team members other than, or in addition to, those of the case manager or primary nurse. Clinicians who had had roles other than, or in addition to, that of the case manager or primary

nurse were each asked about these roles they had taken. Several clinicians volunteered information concerning their view of other team members' roles as well.

Table 41 first reveals that the role of clinical team members in general, other than nursing staff, was raised by seven clinicians. Several subthemes in relation to this role emerged. Six of the seven clinicians observed that all of the clinical team members (other than the nursing and very part time staff) undertook the same generic work on a rotational basis, as either the case manager for the family, and/or acted as subsystem clinician in seeing either the parents, family or individual family members. Second, one clinician made note that the allocation of clinical staff to families was based on staff availability. Third, another single clinician highlighted that the clinical team members were not formally trained as family therapists but, rather, were experienced in working with families. Last, a single clinician described the clinical team members (other than nursing staff) as 'visiting practitioners' in that they were not 'full-time on the ward', and 'had the luxury of focussing on one narrow field, compared with the nurse's 'whole part' in treatment (Clinician A).

Views of the roles of the team leader and the nurse unit manager were each discussed by three clinicians. As Clinician B noted, 'the team leader and the nurse unit manager were the two people in charge of the team'. The team leader position, which was held by the consultant child psychiatrist, centred on leadership, management and broad clinical responsibilities. In all, the team leader 'was responsible overall for the service' (Clinician B). This included co-ordinating all the disciplines (Clinician J), managing the whole referral, admission and discharge process, overseeing management plans (Clinician B), 'thinking about structures that would support the team maintenance functions', and understanding and managing 'the tensions that would develop' (Clinician J). The nurse unit manager was described by three clinicians as having a central role in multidisciplinary team relationships, and held clinical and management responsibilities within the milieu and for the nursing team (Clinician B). It was observed by Clinician B that 'it was essential that the team leader and the nurse unit manager got on, because they relied enormously on each other', and they were viewed as 'having a good working relationship'.

Table 41

*Clinicians' Conceptualisations Regarding Others' Roles Within the Team*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Clinical team members (other than nursing staff)	7	<p>All clinical team members (other than nursing staff) undertook the same generic work – case manager and/or subsystem clinician for the family on a rotational basis (6)</p> <p>Allocation of clinical team members to families was based on staff availability (1)</p> <p>Clinical team members were not trained family therapists but were experienced in working with families (1)</p> <p>Clinical team members described as 'visiting practitioners' (1)</p>
Team Leader (Consultant Child Psychiatrist)	3	Held leadership, management and broad clinical responsibilities (3)
Nurse Unit Manager	3	<p>Held a central role in multidisciplinary team relationships (3)</p> <p>Held clinical and management responsibilities within the milieu and for the nursing team (1)</p>
Clinical Child Psychologist	2	<p>Held specific responsibilities (2)</p> <p>Held generic responsibilities (1)</p> <p>Had preference for child psychotherapy family subsystem work (1)</p>
Social Worker	2	<p>Applied a psychosocial theoretical orientation to team responsibilities (2)</p> <p>Held generic responsibilities (1)</p>
Trainee Child Psychiatrist	1	Half-time training position (1)
Occupational Therapist	1	No subthemes
Night Nurses	1	<p>Provided back up to other team members(1)</p> <p>Spent time primarily with the parents providing support and encouragement (1)</p> <p>Provided guidance for parents with night-time settling routines with children (1)</p> <p>Perceived as less threatening than day staff (1)</p>
Teachers	1	Perceived as important to the children (1)

The clinical child psychologist and social worker roles were the next most frequently mentioned, each by two respondents. Several subthemes emerged here. First, two respondents observed that the clinical child psychologist held specific responsibilities in relation to the position. These included psychological and cognitive testing, input regarding cognitive behavioural aspects of the programme, and addressing developmental issues in relation to the norms (Clinicians H and I). Generic responsibilities (case management and family subsystem work) were noted by one clinician, and another single clinician considered that the clinical child psychologist had a preference for child psychotherapy subsystem work. In reference to the social worker role, two clinicians perceived that a psychosocial theoretical orientation was applied to team responsibilities. According to Clinician B, the social worker engaged in more family and parent subsystem work than in individual child psychotherapy, and brought 'more of a systemic perspective to the team considering the child's external world'. The social worker 'worked to have home visits integrated into the programme', and 'advocated working more so with families that were considered unworkable'. One clinician also noted that the social worker also held generic team responsibilities (case management and family subsystem work).

Finally, the trainee child psychiatrist, occupational therapist, night nurses and teachers roles were commented upon by one clinician each. Here it was commented that both the occupational therapist and (half-time) trainee child psychiatrist position and occupational therapist also held generic team responsibilities. Within the night nurse role, several subthemes were identified. The night nurses provided back-up to other team members and spent time primarily with the parents providing support and encouragement with their work in the programme, as well as guidance with night-time settling routines with the children. It was perceived that the night nurses were experienced by families as 'less threatening' (Clinician E) than the other staff. Finally, the teachers were seen to be 'important to the children' (Clinician B), in the context of often poor prior experiences of school contrasting with the individual attention that could be provided in this setting.

The final response also drawn from Question 5 is set out in Table 42, on page 238 below. It related to themes and subthemes arising in perceptions of the team

relationships functioning and of the presentation and management of issues and tensions within the team.

Table 42

*Clinicians' Conceptualisations Regarding Team Relationships and Issues for, and Tensions within the Work Practice*

Theme	Number of Clinicians Mentioning	Subthemes emerging & number of clinicians mentioning subtheme (in brackets)
Understanding regarding issues for & tensions within the team	8	<p>Issues &amp; tensions related to clinical practice and management (6)</p> <p>Issues &amp; tensions related to the nature of the clinical work (5)</p> <p>Issues &amp; tensions related to the team members designated roles (5)</p> <p>Issues &amp; tensions linked to 'parallel process' in operation (4)</p> <p>Issues &amp; tensions related to the team's hierarchical structure (3)</p> <p>Team issues &amp; tensions viewed as inherent in this type of workplace setting (3)</p>
Outcomes regarding team issues & tensions	7	<p>Outcomes perceived as positive or constructive (5)</p> <p>Resolution of issues not always achieved (3)</p>
Forums & structures available to discuss issues for team members	4	<p>Special/reflective team meetings (3)</p> <p>Within established clinical meeting and management structures (2)</p> <p>Through external resources (2)</p> <p>Low turn-over of families allowed the team time to recover from difficulties (1)</p>
Problems identified regarding the forums used to address team issues.	3	<p>Lack of genuine motivation and commitment from the team leadership (1)</p> <p>Lack of regular external facilitation (1)</p> <p>Lack of support from clinical team members (other than nursing staff) (1)</p>

The most frequently emerging theme here, as indicated by Table 42, concerned the team members' understanding of the issues and tensions within the team. Eight clinicians made mention of this and a number of subthemes emerged. First, six clinicians mentioned issues and tensions related to clinical practice and management. Two clinicians each mentioned issues associated with the therapeutic physical holding intervention (Clinicians B and I) and discharge planning and follow-up practices (Clinicians B and I). Single respondents raised matters related to the management of child sexual abuse issues (Clinician A), general family management (Clinician D), team member's attitudes towards the families (Clinician I), not involving the family enough in the whole process (Clinician I), needing to find ways of working with families considered 'unworkable' (Clinician B), concerns regarding the leadership of the team (Clinician H), demands of the school catering for a wide age range (Clinician J) and finally, changes to the programme (practice and team members) which made consolidation of learning difficult (Clinician F).

The second subtheme regarding issues for and tensions within the team, related to the nature of the clinical work. Overall five clinicians raised this area, and a number of features of the work were seen to be important. Two clinicians each observed that issues related to parental abuse and neglect of children, and witnessing or being a recipient of aggression and violence within the family created issues and tensions for the team. As Clinician J indicated, 'the more volatile cases raised everybody's anxiety and made collaboration more difficult'. Moreover, staff found it difficult to see wives being treated disrespectfully by their husbands due to cultural differences (Clinician D), or to experience a child acting out a parent's anger, for example by kicking staff without the parents intervening (Clinician B). Single clinicians also identified involvement with Protective Services, families having different standards to staff, and generally managing both the family's and staff member's own levels of stress, as features of the clinical work that created issues for and tensions within the team.

The third subtheme, noted by five clinicians, concerned the understanding of the issues for and tensions within the team relating to team members' designated roles. Three clinicians mentioned issues related to interdisciplinary rivalry. As Clinician J observed, 'different disciplines often ended up in different camps, from having very

different understandings and very different backgrounds', giving the example that teachers did not necessarily have psychodynamic understanding. Further, Clinician A considered that 'under pressure, signs of interdisciplinary rivalry surfaced between the nursing and other clinical staff in relation to behavioural interventions', and Clinician B reflected that 'there was probably envy on the clinicians' behalf, of the everyday hands-on experience with the children that the nurses and teachers had'. A further three clinicians also observed that the nurses were dissatisfied with not being involved in more formal therapeutic work, such as in the role of case manager or family therapist.

The fourth subtheme, observed by four clinicians, was the identification of a parallel process in operation between the family's and the team's functioning, which contributed to the understanding of the issues for and tensions within the team. As Clinician A observed, 'tensions in the family radiated into the staff'. Difficulties in the team were often seen to coincide with difficulties such as aggression and violence with the families (Clinician B), or 'if the case manager and primary nurse were in conflict, something was often happening for the family as well' (Clinician I). Moreover, some of the roles and presenting issues in the team were seen to have parallels with traditional family life and structure (Clinicians A and B). Issues within the team, for example between the nursing and other clinical staff, were viewed as a parallel process between an employed father and a home duties mother (Clinician A).

The fifth subtheme, noted by three clinicians, focussed on the team's hierarchical structure. It was reported that the nurses were perceived as an 'underlink' (Clinician C), or felt 'secondary', to, or 'lesser' than the case managers (Clinician I). As Clinician A recalled, the nurses would 'feel like the diggers and the officers would come and visit'.

The final subtheme to emerge, commented upon by three clinicians, conceptualised the understanding of the issues for and tensions within the team as inherent in intensive, inpatient child psychiatry work involving whole families with complex, longstanding difficulties.

The second main theme relating to issues for and tensions within the team concerned the outcomes regarding team issues and tensions. Seven clinicians mentioned this

theme and two subthemes emerged. Five clinicians perceived the outcomes regarding team issues and tensions as positive or constructive, while three noted that the resolution of issues was not always achieved.

The third main theme here, raised by four clinicians, related to the forums and structures made available to discuss issues for team members. Several subthemes emerged. Three clinicians mentioned the fortnightly special or reflective team meetings (Clinicians B, F and J), two clinicians reported on forums within the established clinical meeting and management structures (Clinician I and J), and another two made note of the use of resources external to the team (Clinician B and I). One clinician reflected that the low turnover of families allowed the team time to recover from difficult incidents (Clinician B).

The final main theme to be identified in reference to team relationships and issues for and tensions within the team, revolved around problems regarding the forums used to address team issues. Three clinicians made note of this. One clinician each suggested that difficulties were linked to a lack of genuine motivation and commitment from the team leadership (Clinician H), a lack of regular external facilitation (Clinician B), and, finally, a lack of support from clinical team members other than nursing staff (Clinician C). Addressing this last point, Clinician C suggested that ‘the difficulties were taken away from the experience that the nurse had and...addressed on a more clinical or intellectual or philosophical level, rather than ... how the nurses were really coping with it’.

## 8.5 Clinicians’ views of the programme’s outcomes

Clinicians’ perceptions regarding the outcomes of the AC&FRU programme are addressed below. First, general comments regarding perceived outcomes for the families, as well as outcomes for particular family members, and factors that contributed to the benefits are documented. Next, potential factors that may have limited the benefits, as well as challenges the families may have experienced as inpatients are addressed. Finally, outcomes for the clinicians themselves being involved in the programme are reported.



All tables display the themes and subthemes relating to the perceived outcomes of the AC&FRU programme that emerged in the analysis. The responses are presented in terms of the third level of content analysis described in Section 5.4.4.3 of Chapter 5. They are accompanied by exemplary quotes tagged to clinician letter codes that were assigned at the first level of analysis as outlined in Section 5.4.4.1 of Chapter 5.

8.5.1            General comments regarding perceived outcomes for families

Table 43 provides an overview of themes and subthemes emerging in responses by the clinicians to Question 6 concerning their perceptions of outcomes for the families who engaged in the AC&FRU programme.

Table 43  
*Clinicians’ Conceptualisations Regarding the Overall Generally Perceived Outcomes for the Families*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Overall positive family outcomes identified	8	No subthemes
Variable outcomes for the families, and for different family members reported	6	Variable outcomes for the families (4) Variable outcomes for different family members (4)
Questioned the definition of, and time-frame used to assess outcomes	5	Outcomes not necessarily best viewed at time of discharge from programme (3) Definition of outcomes is broader than reduced pathology (2)
Uncertainty regarding long-term effects of the programme	5	No subthemes
Recognition of the need for formal outcome research	3	No subthemes
Acknowledgement that the process of change was very difficult for the families	2	Nosubthemes

Six main themes were identified regarding the overall perceived outcomes for the families admitted to the programme.

Eight of the ten clinicians, reported perceptions of positive outcomes for the families involved. A range of comments were made. 'Instinct suggests that the work was beneficial and the programme worked well' (Clinician B). Two clinicians observed 'dramatic changes' for some families (Clinician A and E), while Clinician F described 'the beneficial effects of the programme filtered into everyone at the end – first the parents became more effective, the IP was then less disruptive, and then the other family members felt home was a nicer place to be'.

The second main theme, observed by six clinicians, suggested that variable outcomes for the families, and for different family members were achieved as a result of the programme. First, variable outcomes for the families were mentioned by four clinicians. Clinician G reflected that outcomes for the families were mixed, some families changed considerably, whilst others, albeit somewhat tempered, retained their focus on the children being the problem. Moreover, Clinician J suggested that despite changes, there were 'still ongoing difficulties' for the families. Second, different outcomes were noted for different family members. For instance, changes at an intrapsychic level were seen to vary enormously between parents (Clinician A), whilst children of a younger age were viewed to experience a more obvious change (Clinician I), and as Clinician J observed, 'outcomes were usually very positive for the IP, slightly less for the siblings, and perhaps a lesser extent the parents.'

The third main theme, noted by five clinicians, questioned the definition of, and the time-frame used, to assess outcomes for the families. Three clinicians considered that outcomes were not best assessed at discharge from the programme, since therapeutic work continued beyond this time (Clinicians A, F and J). Two clinicians made mention of the outcome being broader than reduced psychopathology, and incorporated change in perceptions and averting crises, such as a child being excluded from school or removed from home, into their definition of positive outcome (Clinician B and C).

The fourth main theme, identified by five clinicians (all of whom had acknowledged overall positive (short-term) outcomes for the families), concerned uncertainty regarding the long-term effects of the intervention, and whether gains made could be maintained post-discharge. Clinician A considered that the intervention may not have been sufficient for long term change, while Clinician D indicated that a support network was necessary to maintain the improvements after discharge.

The next main theme, recognised by three clinicians, was of the need for formal outcome research to be built into the programme. Clinician D expressed concern regarding the lack of formal follow-up of families regarding outcomes and the barriers to maintaining changes, whilst Clinician B considered that if the team had a more formalised mechanism for feedback and evaluation, impetus would have been provided to integrate changes into the programme.

The final theme mentioned by two clinicians acknowledged that the process of change was very difficult for the families. As Clinician C reflected, ‘most people struggled with integrating the change rather than the...presenting problem...Everything the families knew was changing – not just individuals but the whole family’.

#### 8.5.2 Views of specific benefits to the family from involvement with the programme

Table 44 on page 245, presents an overview of the themes and subthemes emerging in responses provided by clinicians to Question 6 regarding the perceived specific benefits provided to the family by their admission to the AC&FRU programme.

As can be seen in Table 44, the main theme, identified by eight clinicians, regarding clinician’s perceptions of the benefits provided to the family by their admission to the programme was the family’s acquisition of new knowledge and skills. Several subthemes emerged. The first, mentioned by six clinicians, centred on developing skills regarding how to manage the presenting problems, such as parent management skills (Clinicians A, C, E, F and H). The second subtheme, reported by five clinicians, related to the acquisition of new knowledge about themselves and other family members. Clinician G recalled that individual family members started to identify and appreciate strengths within each other. Parents were also noted to

develop a better intuition regarding themselves in relation to their parenting (Clinician A). Finally, four clinicians noted that families acquired knowledge about the nature or what might be contributing to the problem. This incorporated an appreciation of how to think through a systemic approach to the difficulties (Clinicians A and D).

Table 44

*Clinicians’ Conceptualisations Regarding the Perceived Benefits Provided to the Family by their Admission to the Programme*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Acquisition of new knowledge & skills for the family	8	Skills on how to manage the problems (6) Knowledge about themselves and each other (5) Knowledge about the nature/what might be contributing to the problem (4)
Emotional relief & support	7	Provided assistance & emotional relief (4) Installed hope (3) Family felt empowered (1)
Changes at a deeper psychological/psychotherapeutic level	4	Realisation of own experiences of being parented linked to current relationship with children (1) Parents felt ‘held’ by the team which allowed them to give more in their parenting (1) Realisation of interconnectedness with each other (1) Changes observed in family’s ‘self story’ (1)
Time/opportunity to be together as a family	4	No subthemes
Time for reflection on themselves & their family	3	No subthemes
Opportunity to experience a different family life than at home	3	No subthemes

The second main theme regarding the benefits provided to the family from the programme, observed by six clinicians, focussed on the emotional relief and support provided. One subtheme, identified by four clinicians, was the team providing assistance and emotional relief. As Clinician J remarked, ‘parents were enormously relieved that things had...changed for the child when there had been such a long history of difficulties’. Three clinicians reflected that hope had been restored in the families from the admission, whilst one responded recalled that the families felt empowered by the admission.

The next main theme regarding the benefits to the family, identified by four clinicians, concerned changes occurring for the family at a deeper psychological level. One clinician each stated that parents realised their own experiences of being parented were linked to their current relationship with their children (Clinician H), and that the new realisation of their interconnectedness with each other was important (Clinician C). In addition, single clinicians also commented on the parents feeling emotionally ‘held’ by the team which allowed them to give more in their parenting (Clinician A), and on changes occurring in the family’s ‘self story’ (Clinician J).

A further four clinicians observed that the admission to the Unit provided the family with the time or opportunity to be together as a family (Clinicians B, C, G and J). Other main themes regarding the benefits provided to the family by their admission to the programme, each reported by three clinicians, were time for reflection on themselves and their family (Clinicians C, G and J) and the opportunity to experience a different family life than at home (Clinicians B, C and D).

8.5.3 Views regarding what contributed to benefits for the family

Table 45, on page 247 below, summarises the themes and subthemes emerging in responses by clinicians to Question 6 also, regarding the factors that contributed to the benefits provided to the family by their admission to the AC&FRU programme.

Table 45

*Clinicians' Conceptualisations Regarding the Factors that Contributed to the Benefits Provided to the Family by their Admission to the Programme*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Theme (in brackets)
The therapeutic milieu/environment provided	9	Supportive and containing environment facilitated (9) Psychiatric nurses working alongside the families/parents (7) The model (& ongoing) support of parents being in charge (3) Interaction with the other family on the Unit (3)
Overall programme features	8	Planning for the family – pre, during and post admission (6) Providing a clearly structured programme (4) Intensity & combination of interventions offered (4) Process of collaborative work with the family (4) Specific strategies incorporated in the ward-based programme (3) Input from the Austin Special School (1)
Cohesive team functioning	7	Importance of a team approach (5) Awareness of team issues & of issues for the team (3) Mechanisms that made the team work better (3) Importance of the smaller treating team (2)
Family's physical separation from normal home environment	6	Less outside & routine domestic distractions (5) Provided the opportunity to focus on the family's difficulties (3) Disrupted the family's sense of isolation (1)

As can be seen in Table 45, the most frequently mentioned theme here, noted by nine of the ten clinicians, centred on what was offered within the therapeutic milieu or environment. Several subthemes were identified. First, all nine of the clinicians mentioned the supportive and containing environment facilitated within the therapeutic milieu. As Clinician J observed, 'by providing a containing environment...families were able to address some of their difficulties'. Support and

containment were also acknowledged by the families in their expression of gratitude to the team (Clinicians A, C, E and F). Second, seven respondents identified the value of the psychiatric nurses working alongside the parents and the families in the milieu. The programme was staffed 24 hours a day with psychiatric nurses (Clinicians D and J), using a primary nursing model (Clinicians C and G), in which the nurses participated in the milieu with the families and shared their experiences (Clinician I). Modelling, encouragement and support were provided in a non-critical and non-punitive manner (Clinician D), which helped the families 'see through the change and become more confident' (Clinician C). A further three clinicians observed the importance of the model and ongoing support of the parents being in charge of their family. Clinician B noted that 'nursing staff ...continually reinforced that the parents were the ones in charge and making the decisions'. It was considered that the parents 'could be more in charge because they were supported ... which led to a different experience' (Clinician B). The final subtheme linked to the importance of the therapeutic milieu involved the interaction with the other family on the Unit, named by three clinicians. Families not only learnt from team members, but also, as Clinician H observed, from other families on the Unit and how they managed difficulties. Moreover, at times the relationship with the other family on the Unit would develop into a friendship (Clinician B).

The next main theme to be identified by the clinicians with regard to the factors that contributed to the benefits provided to the family focussed on the overall programme features. Eight of the ten clinicians discussed this factor and several subthemes emerged. The first subtheme, noted by six clinicians, identified the importance of planning in the programme covering pre-, during and post admission for the family. Pre-admission involved identifying previous interventions and their outcomes (Clinician G), meeting with the family and identifying admission goals (Clinician J) and maintaining the policy of all family members attending the programme (Clinician D). Planning during the admission was centred on having a clear boundary between the assessment and treatment phases of the programme (Clinicians D and J). Post admission planning focussed on collaboration with other agencies (Clinician J), and 'ensuring there was something...sufficiently holding that (the family) could return to...resources within the family or available to the family beyond admission – emotional, practical, social supports' (Clinician H). Finally, quality assurance

practices were also observed to also be part of the planning process (Clinician D). The second subtheme, mentioned by four clinicians, concerned the importance of providing a clearly structured programme for the family. There were set roles, rules and routines around how things worked within the programme (Clinicians C, D and J) and the families were seen to respond well to this structure (Clinicians E and J). As Clinician E recollected, the programme 'hit them with routine they had never had'. The third subtheme, also observed by four clinicians, reviewed the intensity and combination of interventions offered to be of importance in the programme. Clinician A spoke of the 'critical mass of investment' in the family, in terms of staff and resources which needed to 'hit the system (intervene) at two or three levels minimum' to effect change for the family. Other subthemes recognised as valuable features of the overall programme included the process of collaborative work with the family (Clinicians C, D, H and I), specific strategies incorporated in the ward-based programme (Clinicians B, C and G) and finally input from the Austin Hospital School (Clinician J).

The third most frequently documented main theme regarding the factors that contributed to the benefits for the family related to the importance of cohesive team functioning. Seven clinicians made note of this theme and several subthemes were identified. First, observed by five clinicians was the importance of the multidisciplinary team approach. As Clinician I reflected, 'the multidisciplinary team approach helped us maintain a certain perspective and objectivity'. Second, awareness of team issues and of issues for the team was identified by three clinicians. For example, Clinician H considered that 'resolving issues is considered most important in an inpatient team because each person is...heavily reliant on the work of the other person'. Mechanisms that made the team work better were also recognised as important by three clinicians. These included communication (Clinician C) and clarity of roles, purpose and team management structures (Clinician J). Finally, the importance of the smaller treating (case management) team was also identified (two clinicians). As Clinician A noted that 'forming a parental team/executive pair that functioned appropriately and adequately was considered pivotal to a good outcome'.

The last main theme, cited by six clinicians, regarding specific factors that contributed to the benefits for the families related to the families' physical separation from their



normal home environment. Several subthemes were noted. Five clinicians considered the reduction in outside and routine domestic distractions as useful (Clinicians D, E, G, H and I), three thought this separation from home provided the opportunity to focus more fully on the family's difficulties (Clinicians A, D and E), and one clinician reported the view that the admission to the Unit assisted to disrupt the family's sense of isolation (Clinician H).

#### 8.5.4 Views regarding outcomes for the parents, IPs and siblings.

Table 46, on page 251 below, presents a summary of the themes and subthemes emerging in responses by the clinicians to Questions 8 and 9, regarding the perceived outcomes and changes in perceptions for the identified patient and other family members through their involvement with the AC&FRU programme. The table addresses outcomes for parents, identified patients and siblings separately.

The most frequently mentioned theme relating to parent outcomes was their improved understanding of the presenting difficulties. All ten clinicians raised this theme. Several subthemes emerged. Eight clinicians observed that parents became able to identify new factors in relation to the presenting difficulties. Three clinicians (A, E and F) identified an increase in understanding of, and empathy for, the child (IP) by the parents. A further three clinicians (B, H and J) made reference to the parents developing a different story regarding themselves as both parents and individuals. Two clinicians (F and J) observed the family to have less focus on the IP child being 'the problem', while Clinician A reflected that insight into the difficulties could contribute to increased frustration and intrapsychic crises for the some parents.

The second most frequently mentioned theme identified for parent outcomes was the development of parenting skills and strategies. This was observed by six clinicians. Three subthemes emerged. The first, mentioned by five clinicians, was increased assertiveness and sense of 'being in charge' (Clinicians A, B, F, G and H). The second subtheme, observed by Clinicians A, D and G, was increased nurturance and understanding of the child's needs. The final subtheme recalled by Clinician G was the development of routines for the family.

Table 46

*Clinicians' Perceptions of Perceived Outcomes for the Parents, Identified Patients and Siblings Involved in the Programme*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
A. Parents		
Improved understanding of the presenting difficulties	10	Able to identify other contributing factors in relation to the difficulties (8) Increased understanding of & empathy for the child (IP) (3) Allowed for a different story as parents and individuals (3) Less focussed on the child (IP) being 'the problem' (2) Insight into the difficulties could contribute to increased frustration & intrapsychic crises for the parents (1)
Developed parenting skills & strategies	6	Assertiveness/being 'in charge' in the family (5) Increased nurturance & understanding of child's needs (3 ) Routines for the family (1)
Improved couple relationship	1	More warmth, improved understanding, tolerance, and communication (1)
B. Identified Patient		
Improvement in child's ability to relate to self & others	6	Improvement in mood & self esteem (5) Improvement in relationship with parents (2)
Relief from the blame for & the burden of holding the problems in the family	5	No subthemes
Improvement in difficult behaviour	4	No subthemes
Improvement in school work	3	No subthemes
Overall positive outcomes identified	3	No subthemes
Not all outcomes positive	2	No subthemes

Continued on the next page

Table 46 (continued from previous page)

*Clinicians’ Perceptions of Perceived Outcomes for the Parents, Identified Patients and Siblings Involved in the Programme*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
C. Sibling/s of the Identified Patient		
Changes experienced by the siblings as challenging	4	Angry and resentful regarding the changes (3) Uncertain regarding impact of the changed family dynamics ( 2)
Overall positive experiences & outcomes identified	3	Linked to input from the parents and the team (2) Seen to be more able to express feelings & needs (1) Improvement in school work (1) More overt helping of, &joining with others (1)

The third theme in relation to the outcomes and changes in perception of the parents was an improvement in the couple relationship. Clinician E observed that there was growing warmth, understanding, tolerance and communication between the couples during the course of the admission to the programme.

The second category of outcomes concentrated on the identified patients (IPs). The most frequently mentioned theme with reference to outcomes and changes in perception for the IP over the course of the admission to the AC&FRU programme, noted by six clinicians, was a greater ability of the IP to relate to self and others. Five clinicians (B, D, E, F and J) observed an improvement in the IP’s mood and self esteem, whilst two clinicians (F and H) noted an improvement in the IP’s relationship with the parents.

The second theme for the IPs, mentioned by five clinicians, was that the IP experienced relief from the blame for, and the burden of holding, the problems in the family. As Clinician F described, ‘the anxiety and stress...with being associated as a difficult child was lifted...they became the proverbial caterpillar to butterfly’.

Other themes regarding the outcomes and changes in perception for the IP included an improvement in difficult behavior (Clinicians C, D, E and J), an improvement in

school work (Clinicians B, G and J), and an identification of positive outcomes overall (Clinicians D, I and J). Finally, two clinicians noted that not all outcomes were perceived as positive for the IP. Clinician I recalled one family in which there seemed to be no change in the IP and a difficulty met by the team in gauging what was happening in the family.

The third and final category here focussed on the siblings of the identified patient. The main theme, mentioned by four clinicians, was that changes were experienced as challenging by the siblings during their admission. Two subthemes emerged. First, three clinicians noted that the siblings appeared angry and resentful regarding the changes. As Clinician J observed, the IP at times ‘took the heat’ for the siblings, and when dynamics changed, interactions became more uncomfortable for the siblings. Second, two clinicians noted that siblings seemed uncertain regarding the impact of the changes occurring within the family. As Clinician F commented, interventions ‘changed the dynamics in the family...the jigsaw had altered... it was uncharted territory’ and the siblings were unsure regarding how matters were going to develop. The other main theme, noted by three clinicians, identified overall positive experiences and outcomes for the siblings. Two clinicians linked this to input from the parents and the team, whilst one clinician each noted that the siblings were seen to be more able to express their feelings and needs, showed an improvement in their school-work and displayed more overt joining and helping others.

#### 8.5.5 Views regarding factors limiting the benefits of the programme

Table 47, on page 254 below, provides an overview of the themes and subthemes emerging in responses by the clinicians to Question 7, regarding factors perceived by clinicians as possibly limiting the benefits the programme. It must be noted that in mentioning these factors, the clinicians were not referring to work with every family.

The predominant theme here was that in the instance of a lack of shared goals between the family and the team, benefits were limited. This was mentioned by seven clinicians and two subthemes emerged. First, noted by six clinicians, was the possibility of a disparate agenda developing between the parents and the team. The differing agenda presented in a range of ways including parents wanting the nurses to be responsible for their children (Clinicians E and J), the family seeking a prescribed

solution to their difficulties (Clinician F) or another agenda, not discussed prior to admission, such as the father facing criminal proceedings being foremost in the family’s mind (Clinician G). The second subtheme, mentioned by four clinicians, focussed on a family member not acknowledging, or not being ready to work on the presenting difficulties. This was most often shown in the father not being available to engage in the programme in an ongoing manner (Clinicians A, C, E and F).

Table 47

*Clinicians’ Views Regarding Possible Factors Limiting the Benefits of the Programme*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Lack of shared goals between the family & the team	7	Disparate agenda developing between the parents & the team (6) Family member not acknowledging, or ready to work on the difficulties (4)
Family lacked the necessary psychological resources	6	Limited psychological mindedness (6) Parents needs coming before the child’s needs (3)
Lack of shared language between the family & the team	5	Parents not accepting the team’s formulation or diagnosis (3) Parents unable to shift from the mindset of the child as the problem (3)
Families coerced into accepting the admission by other agencies	5	Lack of choice provided re admission (4) Family not helped to own the process of admission (2)
When the family configuration was changing	1	No subthemes

The second most frequently mentioned theme regarding possible factors that limited the benefits of admission to the programme was that of a family lacking the necessary psychological resources for engaging in the programme. Six clinicians raised this theme. A subtheme, identified by all six of these clinicians, centred on limited psychological mindedness with which this subgroup of patients presented. Some families presented as too emotionally fragile to engage productively in the programme (Clinician A), experiencing feelings of pride, shame or embarrassment (Clinician C),

or feeling too threatened (Clinician A). Violence in the family (Clinician B) precluded engagement, as did any apparent need for a family to 'maintain the chaos or difficulties, to serve as a distraction from other more pressing issues' (Clinician D). As Clinician H put it, the family needed to be able to say 'Yes, I'm here in order to get my family working better, at the same time I'm under the microscope (but) I know this is happening for my benefit rather than for any other persecutory purpose'. Another subtheme relating to limiting factors, noted by three clinicians, focussed on when the parent's needs coming before the child's needs. As Clinician J indicated, 'the parents needed to think to some extent of doing this in the service of the child and the family as a whole...If this was primarily about addressing their own individual needs then it wasn't terribly useful'. Parental self preoccupation might be observed in the context of marital discourse, their own significant mental health concerns (Clinician D), in the absence of having their own needs sufficiently met (Clinician J), and finding it difficult to witness their children securing attention they had not received as children themselves (Clinician B).

The next most frequently mentioned response in relation to factors that limited the benefits of the admission, noted by six participants, was the lack of shared language between the family and the team. Two particular subthemes each mentioned by three clinicians emerged. The first subtheme was the possibility of the parents not accepting the team's diagnostic formulation (Clinicians C, E and H). The second subtheme focussed on the parents possibly being unable to shift their mindset of seeing the child as the problem in the family (Clinicians D, G and H).

A further theme, raised by five clinicians, in relation to factors that limited the benefits of the admission, was that of families possibly feeling coerced into accepting the admission by other agencies. The potential lack of choice regarding the admission was a subtheme identified by Clinicians A, B, H and J, and as noted by two of these, this would not help a family to own the process of the admission. A typical example of a clinician's view centred around Victorian State Government Child Protection Services involvement, where admission was viewed as a last resort to 'to keep welfare from taking the kids away' (Clinician A). As Clinician B observed, 'when families came (to the Unit) under pressure...it didn't work well', as 'families didn't have some

ownership of the admission themselves and thereby commitment to be on the Unit' (Clinician J).

The final theme to emerge concerning factors limiting the benefits of the admission, mentioned by one clinician, was the situation of a changing family configuration. As Clinician J observed, when a child had not been with the family pre-admission, or when parents were sorting out whether to remain together or not, the value of the admission was compromised.

#### 8.5.6 Views regarding the challenges families experienced as inpatients

Table 48, on pages 258 and 259 below, provides an overview of the themes and subthemes emerging in responses by the clinicians to Question 7, regarding the challenges, barriers and difficulties the families experienced whilst inpatients with the AC&FRU programme.

Table 48 reveals that one of the most frequently cited themes in relation to the challenges that families experienced as inpatients, noted by seven clinicians, was the family being constantly observed by the team. The clinicians variously described it as 'being in a fishbowl' (Clinicians D, E and J), the daily experience of having 'many eyes on them' and being 'watched, judged, assessed' (Clinician H). For example, Clinician H thought that the patients 'felt probably like refugees in some sort of camp'. Two clinicians mentioned that the subsequent lack of privacy for the family as a further issue.

The next most frequently mentioned theme, reported also by seven clinicians, and with a number of minor subthemes, was the assessment and treatment process being experienced as intrusive and emotionally difficult. A subtheme raised by three clinicians was the formal sessions exploring the parents' developmental histories. As noted by Clinician B, it was the 'parents' preference to focus on the children than to talk about themselves', and Clinician E recalled parents saying that the team asked 'too many personal questions'. Further subthemes to emerge, each mentioned by two clinicians, included the sequelae associated with the disclosure of trauma (Clinicians C and H), having many people involved with their family (Clinicians G and J), acting

out behaviour (Clinicians F and J), and the IP being confronted with people managing the difficulties in different ways (Clinicians A and H). With reference to the latter two subthemes, as Clinician H observed 'if the child was being tyrannical at home, being displaced from that position was a very difficult task...having to live through that to see the benefit ... and to see why, and how ...they were put in that position was very difficult for them'.

The next most often emerging theme in relation to difficulties or challenges associated with the admission was focussed on the therapeutic or physical holding intervention. Six clinicians (A, B, C, F, G and I) raised this issue. The main subtheme to emerge, voiced by all six clinicians was that it presented major challenges for the parents to do with their child, whilst two clinicians (C and I) noted that the parents required considerable support to do the intervention. Clinician C captured these themes with the comment 'I think parents needed to separate out their own pain from their kid's pain, to be able to take charge'.

The realisation of how demanding the admission and programme would be was as the next main theme identified by five clinicians (B, C, D, G and H) as a challenge experienced by the families as inpatients. Two subthemes emerged. Three clinicians noted the emotional depth required by the families to address the difficulties. As Clinician B reflected, 'a lot was demanded of the parents when they felt so needy themselves'. Two clinicians commented on the constant intensity of what was required both during the programme and after discharge.

The artificiality of the ward environment was a further main theme identified by four clinicians (A, F, G and I). Three observed that the presenting problems were not always captured in the milieu setting, and, as two clinicians noted, the ward environment at times was seen to raise artificial problems and provide temporary solutions.



Table 48

*Clinicians’ Views Regarding the Challenges Families Experienced as Inpatients*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Nmber of Cinicians Mntioning Subtheme (in brackets)
Constantly being observed by the team	7	Constant, intensive observation by the team (7) Lack of privacy for the family (2)
The assessment & treatment process was experienced as intrusive & emotionally difficult	7	Formal sessions that explored the parent’s developmental histories (3) Sequela of disclosure of trauma (2) IPs confronted with people managing the difficulties in different ways (2) Acting out behaviour (2) Having many people involved with their family (2)
Therapeutic physical holding intervention	6	Presented major challenges for the parents to do it with their child (6) Parents required considerable support to do the intervention (2)
Realising how demanding the admission/programme would be	5	Emotional depth necessary to address the difficulties (3) The constant intensity of what was required during the programme & post discharge (2)
Artificiality of the ward environment	4	Concerning behaviours not always apparent in this setting (3) Raised artificial problems & provided temporary solutions (2)
Needing to comply with the hospital & Unit’s rules, regulations and protocols	4	Siblings required to attend the Austin Special School (2) Parents retaining responsibility for their children (1)
Practical or physical issues from the family’s perspective	4	Issues related to work & other commitments (3) Location of the Unit; geographical distance from other commitments (2) Limited physical space on the Unit (2) Medical concerns (1)

Continued on next page

Table 48 (continued from previous page)

*Clinicians' Views Regarding the Challenges Families Experienced as Inpatients*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Referral to and involvement with protective services	3	Linked to feelings of fear, betrayal & mistrust (3)
Presence of another family on the Unit	3	Acting out behaviour within other family not managed (1) Making comparison of family programmes (1) Using the other family as a distraction from own family's concerns (1)
Programme being located in a hospital setting	3	Hospital setting viewed as institutional & hierarchical (1) Hospital setting linked the programme to a medical model approach (1) Physical safety issues identified (1)
Cultural factors	3	Related to language (1) Related to class (1) Related to food (1)
Lack of progressive re-integration back into their home/community	2	Intensive inpatient focus followed by limited contact with the team (2) Suggested alternative arrangements re re-integration (2)
Poor previous experience with mental health professionals	2	No subthemes
Admission not long enough to consolidate at a deeper psychotherapeutic level	2	No subthemes
Parents feeling criticised or blamed	1	No subthemes
Personality clashes between family & team members	1	No subthemes
The team not getting to grips with the family's issues	1	No subthemes
If the milieu was disruptive & non containing	1	No subthemes
Compromised team resource availability due to threat of Unit closure	1	No subthemes

Another theme identified by four clinicians (D, E, H and J) was the need for families to comply with the hospital and Unit's rules, regulations and protocols. The Unit's protocol that the siblings of the identified patient attend the Austin Hospital Special School was noted by two clinicians as a particular issue, and one clinician recalled the requirement of parents retaining responsibility for their children as a particular challenge for some families.

The next theme, also observed by four clinicians (A, D, G and I), were practical or physical issues viewed by clinicians as challenges to families associated with the admission. These included issues related to work and other commitments (three clinicians), the geographical distance of the Unit from other family commitments (two clinicians), the limited physical space provided on the Unit (two clinicians), and family medical concerns that prevented the family from participating fully in the programme (one clinician).

Referral to and involvement with Victorian Government Child Protection Services over the course of the admission was another theme suggested by three clinicians (D, E and G) to challenge the family as inpatients. All three clinicians suggested that Protection Services involvement proved difficult, due to feelings of fear, betrayal and mistrust.

A further theme cited by three clinicians (A, F and G) was the presence of another family on the Unit leading to challenges for the family as an inpatient. Subthemes here, each identified by one clinician, involved acting out behaviour within the other family not being well managed, comparisons being made with the other family's programme, and the other family's issues being a distraction from their own family's concerns.

Another three clinicians (A, C and I) viewed the programme being located in a hospital setting as a challenge that beset the families. One clinician each noted that the hospital setting was seen as institutional and hierarchical, linking the programme to a medical model approach. Physical safety issues within the hospital setting were also identified by another clinician.

Cultural factors related to language, class, and food, were noted by three clinicians (B, D and F) as further potential difficulties tied to the admission.

Two clinicians (D and I) each recalled the lack of progressive re-integration back into the family's own home and community, poor previous experience with mental health professionals, and the fact that the admission was not long enough to consolidate at a deeper psychotherapeutic level as concerns associated with admission.

Finally, other themes, each raised by one clinician, involved challenges associated with parents feeling criticised or blamed (Clinician B), personality clashes between the family and team members (Clinician A), the team not getting to grips with the family's issues (Clinician A), the milieu possibly being experienced as disruptive and non-containing (Clinician J), and, lastly, team resources being compromised due to the threat of closure of the Unit (Clinician A).

#### 8.5.7 Views regarding outcomes for themselves as clinicians being involved in the programme

Table 49, on page 262 below, summarises the themes and subthemes emerging in responses by the clinicians to Question 10, in reference to how they perceived outcomes, for themselves, of their involvement with the AC&FRU programme.

As shown in Table 49, the most frequently mentioned theme concerning how the clinicians perceived outcomes for themselves in relation to their involvement with the AC&FRU programme, centred on the programme having had a significant influence on their ongoing clinical practice. This was mentioned by eight of the ten clinicians. Several subthemes emerged. Six clinicians each mentioned that their experience working on the programme provided them with a set of sound skills which they were still using in their clinical practice. More specifically, some reported using aspects of the AC&FRU framework in their ongoing clinical practice. Three clinicians mentioned that their experience on the Unit enabled them to gain increased insight into family and wider system dynamics.

Table 49

*Clinicians’ Views Regarding How They Perceived Outcomes for Themselves in Relation to their Involvement with the Programme*

Theme	Number of Clinicians Mentioning	Subthemes Emerging & Number of Clinicians Mentioning Subtheme (in brackets)
Significant influence on ongoing clinical practice	8	Provided a sound skill set used in current clinical practice (6) Using aspects of the AC&FRU framework in ongoing clinical practice (4) Gained increased insight into family & wider system dynamics (3)
Gratitude for having had the AC&FRU work experience	4	No subthemes
Ongoing self education re work with families	4	No subthemes
Continuing direct work with families	3	No subthemes

The second main theme to emerge, identified by four clinicians, was gratitude for having had the AC&FRU work experience. A further four clinicians noted as an outcome of their AC&FRU experience that they have been involved in ongoing self education regarding work with families.

Finally, three clinicians explicitly mentioned, as a product of their AC&FRU experience, that they were involved in ongoing work with families. However, information provided in the clinician’s self report questionnaire indicated that eight clinicians continued to be involved in work directly with families, with the remaining two clinicians integrating family systems thinking into community adult psychiatry work practice.

## 8.6 Summary of findings concerning clinicians' views of theory, process and outcomes of the programme

### 8.6.1 Theory: Clinicians' views of the programme's theoretical orientation

Taken overall, the clinicians' views revealed that, as a group, they drew upon multiple theoretical perspectives in their conceptualisation considered of the presenting family difficulties. Foremost, family system principles were identified as important, closely followed by an integration of several theoretical frameworks including a strong psychodynamic theoretical orientation. Several other theoretical frameworks were also mentioned.

All clinicians considered that the programme conceptualised the IP's difficulties within the context of the family system and the wider system, further indicating use of the family systems theoretical orientation. Most clinicians also stated, however, that the IP's difficulties were simultaneously acknowledged by the programme to present in their own right.

### 8.6.2 Practice: Clinicians' views of the practice of the programme

All clinicians viewed the work within the therapeutic milieu as the primary path by which the team addressed problems at a family level. This was closely followed by consideration of the therapeutic work with the different family subsystems (parent, individual, couple sessions, case management meetings), as well as formal family therapy sessions.

The clinicians perceived that the team addressed problems at an individual level by responding to each member of the family as an individual. Both formal and informal therapeutic input were viewed as being provided to each child in the family (IP and siblings), as well as to the parents. The parents were seen to be considered both as individual persons, and as in parental roles.

Several themes were identified by clinicians in relation to team members' designated roles and in their views on general team functioning. First, clinicians noted that roles for team members were clearly defined, with a particular a distinction made between

nurses and other clinicians' roles. The role and function of the case management team was also highlighted, identifying a range of clinical and management responsibilities, with the importance of a collaborative working relationship between the case manager and primary nurse emphasised. The roles and functions of the case manager and primary nurse were further articulated. The case manager's position was seen as circumscribed as setting clinical and management responsibilities, whilst the primary nurse role, mentioned by all clinicians, was seen as encompassing a wide range of tasks and responsibilities, and noted to be central for the family. The roles of other AC&FRU team members were also mentioned. It was perceived that clinical team members (other than nursing staff) undertook the same generic case manager or family subsystem work on a rotational basis, with recognition of some preferences in family subsystem work. Some clinicians considered it important that specific responsibilities, linked to professional discipline and experience, were also held by team members.

A number of themes emerged in responses by clinicians regarding team relationships, and regarding issues for and tensions within the team. Clinicians' views of the source of these issues and tensions were wide ranging. Some issues and tensions related to clinical practice and management, some to the challenging nature of the clinical work, some to the team's hierarchical structure, and some to team members' designated roles. Certain clinicians also perceived a parallel process between the family and team members' concerns to be operating, while others viewed team issues and tensions to be inherent in intensive, inpatient work involving whole families with complex, longstanding difficulties. Outcomes regarding team issues and tensions were perceived by five of the clinicians as positive or constructive, whilst three reflected that resolution of issues was not always achieved. A number of forums and structures were noted to be available to team members to discuss issues, and several team members identified problems regarding these structures and forums.

### 8.6.3 Outcomes: Clinicians' experience of the programme's outcomes

While most of the clinicians identified overall positive (short-term) outcomes for the families admitted to the programme, there was some question regarding whether these outcomes would have been sustained in the longer term. Moreover, the majority of

clinicians questioned the usual restriction of assessment of outcomes to simple scale measures, seeking to broaden the definition from a reduction in psychopathology. The time-frame used to assess the outcome was also questioned.

The main gains the clinicians perceived to be made by the family through their involvement with the programme related to the acquisition of new knowledge and skills. These centred on improved management of the presenting problems, increased knowledge about themselves and other family members, and increased knowledge about the nature of the presenting problem. Emotional relief, support and the installation of hope for the family were also seen to be provided. Changes for the families at a deeper psychological level were also identified as outcomes by some of the clinicians.

The factors seen to be contributing to these benefits to the family through their admission focussed on certain features of the programme itself (the planning, the structure, the strategies, the intensity of the work and the collaboration involved), and features of the therapeutic milieu (supportive, containing, nurses working alongside the family). Cohesive team functioning, as well as the family being physically separated from their normal home environment, were also considered to contribute to the benefits for the family.

Three main factors were viewed by the clinicians to potentially limit the benefits of the programme. These were seen to arise when goals or language were not shared between the family and the team, when the family lacked the necessary psychological resources, or when families felt coerced into accepting the admission by other agencies.

The main challenges perceived by clinicians to face families as inpatients were experiencing the process as intrusive and emotionally difficult, and being constantly observed by the team. The physical holding intervention was also perceived by the clinicians as a difficulty for the families, as well as the families coming to realise the extent of the demands of the programme. A long list of other perceived difficulties or challenges in relation to the admission were also identified by the clinicians for the families, ranging from the artificiality of the ward environment, to involvement with Protection Services.



Clinicians reported as important a number of outcomes and changes in perception for all family members. Parents were primarily viewed as gaining an improved understanding of the presenting difficulties. They were seen as able to identify further contributing factors in relation to the presenting difficulties, to have an increased understanding and empathy for the IP, and overall were less focussed on the IP being 'the problem'. The clinicians also saw the admission facilitating parents to develop a different story as parents and as individuals, and to develop a broader range of parenting skills and strategies. The main changes observed for the IP were an improvement in the child's ability to relate to self and others, as shown in improvement in the IP's mood and self esteem, and relief from the blame for and burden of holding the problems in the family. Finally, clinicians characterised the siblings of the identified patient as sometimes resentful and uncertain regarding the impact of the changed family dynamics, but as having also had positive experiences in the context of the changes occurring within the family.

For themselves, the clinicians perceived a significant influence on their ongoing clinical practice as the main outcome of their involvement in the programme. This entailed consolidating a sound set of skills and using aspects of the programme framework in their current practice, gaining increased insight into family and wider system dynamics. The clinicians also expressed gratitude for having had the AC&FRU programme experience. Eight of the ten clinicians had continued to be involved in working directly with families and several had engaged in ongoing professional education related to family work.

## **CHAPTER 9**

### **DISCUSSION OF THE FINDINGS**

Understanding of the meaning and implications of the findings of Stages 1 and 2 of the present study must take account of the limitations and strengths of the research. Therefore, this chapter initially provides an overview of these limitations and strengths of the methods employed at each stage. In this context, the chapter goes on to discuss the main outcome findings for the children, for the parents, for the family as a whole, and finally for the clinicians involved in the programme, drawn from Stage 1 and Stage 2 findings.

Discussion of the qualitative findings regarding the theoretical framework in which the programme was embedded then follows. Lastly, the practices of the programme, as perceived by the participating clinicians are discussed. Encompassed are findings concerning what contributed to the benefits of the programme, the factors that limited these benefits, and challenges and difficulties experienced by both the families as inpatients and by the team members working in the programme.

#### **9.1 Strengths and limitations of the present research**

A number of areas of potential limitation as well as strength of the present study are identified. These are addressed in reference to the parameters of internal validity (how accurate a picture of what happened in the programme was presented) and external validity (how generalisable are the findings of the research). The criteria outlined in Section 2.1.1 of Chapter 2 for valid research in child psychiatry are used here as a framework for considering the methodological and practical issues of concern. Because the quantitative outcome findings of Stage 1 of the research are interpreted in conjunction with relevant qualitative findings of Stage 2 concerning outcome, the strengths and limitations of both stages are discussed here together.

### 9.1.1 Degree of control in the research

The degree of control of likely extraneous variables in the research design is an issue pertaining to Stage 1. A control or comparison group was not used in this study. Whilst the absence of a control or comparison group may be viewed as a major limitation, and does clearly indicate the need to exercise caution in interpreting results in terms of the effectiveness of the programme, the issue of employing a control or comparison group needs to be considered in the context of the ethical implications of such an exercise in the given situation (Green & Jacobs, 1998c). As in Sundelin and Hansson's (1999) study, all the families in this study had previously undertaken different types of outpatient or community-based interventions without achieving satisfactory outcomes. Moreover, in some families, Victorian State Government Child Protection Services were involved and had strongly recommended involvement in the AC&FRU programme. In this situation it would not have been deemed ethically correct to randomly place families in either a non-treatment, or a treatment situation that had not assisted in the past, or indeed to delay service as in a waiting list control group. Further, in the current study, the possible option of comparing inpatient families with families on a waiting list engaged in outpatient management, entailed problems with the consistency and variable lengths of outpatient treatment. Nor did the AC&FRU team have the capacity to see families in an ongoing way prior to admission, so that such wait-list families would be engaged in a broad range of outpatient management determined by the referral source and practice of the referrer. Such non-uniformity of treatment would preclude meaningful empirical evaluation.

Of course, as repeatedly noted in Chapter 2, Section 2.2.1, no other study reported in the child psychiatry (0-13 year old) inpatient outcome evaluation literature to date has included a control or comparison group. Target and Fonagy (1996), in the light of the stated ethical, practical and methodological difficulties in carrying out randomised control trials in child and adolescent mental health, suggested that findings from open trials have to be given consideration in evaluation of efficacy. Curry (1991) has also suggested further alternative (multi-programme or multi-treatment) designs discussed in Section 10.3.3 of Chapter 10, but none of these were an option in the practical environment of the AC&FRU programme.

### 9.1.2 Representativeness of the clinical features of the sample

In relation to Stage 1 of this study, the subject sample could be defined as a truly representative clinical group for several reasons. First, the subject population were referred rather than recruited. Secondly, they were treated in a clinical setting rather than non-clinical setting. Thirdly, treatment of a similar duration was undertaken for each family. Finally, each of the 29 families consecutively admitted to the AC&FRU programme over the designated time period, agreed to participate in the study. While, as outlined in Section 7.1 of Chapter 7, due to family composition and CBCL age parameters, varying numbers of cases were available for different measures, the resultant subject numbers were drawn from the entire population of families admitted to the AC&FRU programme between 1995 and 1997. Issues of subject attrition over time points are addressed in Section 9.1.4 below.

Clear criteria for consideration for a family's inclusion and exclusion into the programme as outlined in Section 3.1.1.5 of Chapter 3 was provided. The group of families was notably heterogenous with regard to the diagnoses of family members. Diagnoses for both the IPs and siblings of the IPs included disruptive disorders, anxiety disorders, parent-child relational problems and a range of learning disorders. Mothers were diagnosed with mood disorders, anxiety disorders and chronic schizophrenia, along with relational problems. Fathers' diagnostic status centred solely on relational problems. Such heterogeneity restricts the generalisability of the findings concerning particular diagnostic groups, as it difficult to determine what aspects of the programme worked for which groups. Recommendation of the programme to specific diagnostic population groups therefore cannot be made.

This does not, however, altogether preclude comments that can be made in general terms regarding work with multi-problem treatment resistant families in child psychiatry. As is discussed in Section 9.1.3 below, such heterogeneity, along with comorbidity, are typical of child inpatient populations. Therefore, together with other programmes, such as the Finnish family-oriented child inpatient programmes (Sourander & Piha, 1996) and day patient IFTUs in Sweden (Sundelin, 1999; Sundelin & Hansson, 1999), whose intake populations and treatment approaches were comparable to the AC&FRU programme, useful information regarding the outcomes

of treatment may be drawn. Similarly, further family oriented programmes that may be established in the future could glean important information from this study. In particular, the treatment process information derived from Stage 2 of this research, can be seen as offering valuable implications for other similar programmes. This is taken up further in Chapter 10, Section 10.2, in reference to recommendations regarding specific dimensions of practice in working with multi-problem families in an inpatient or day patient setting.

### 9.1.3 Co-morbidity and natural history of disorder

Co-morbidity issues and the natural history of disorders require consideration in reference to the treatment outcome findings in this research. As noted in other child psychiatry inpatient programmes, the subject population of the AC&FRU programme was notably heterogeneous with typical co-morbidity of disorders experienced by IPs. There was no attempt in this study to limit the population to subjects with a single disorder. Indeed, as both Kazdin (1990) and Mash and Krahn (2000) observed, to do so would make the findings less clinically useful. Therefore, it can be said that the IP subject population in this study (with the inherent heterogeneity and co-morbidity typical of child psychiatry inpatient populations) was representative of the broader group of inpatients, and the presenting co-morbidity did not detract from the findings. Of course, a larger sample size may have allowed comparison of children showing single disorders with those showing co-morbid disorders. As Mash and Krahn observed such a research strategy would aid in disentangling the effects of co-morbidity. However, the fact remains that given the screening criteria for the programme, comorbidity was likely to be the rule rather than the exception in the population referred to the AC&FRU programme.

In addition, the natural history or path or progress of a presenting disorder also requires consideration in reference to the reported outcome findings in this study. While developmental changes may account for some of the noted improvement in functioning, the fact that most of the difficulties presented by the inpatient families were multiply determined, and were of a longstanding and entrenched nature, detracts from the conclusion that this was the sole explanation for the reported positive changes. Conversely, to attribute the improvements in functioning to the inpatient

programme alone, may be overstating its effectiveness. Sleeper effects, as described by Sheerin et al. (1999) and Sourander and Leijala (2002), require consideration. As all the AC&FRU inpatient families had been engaged in outpatient or community based treatment prior to inpatient admission, it is possible that the attempted interventions (often similar in their systemic, multi-modal orientation to inpatient work) were re-visited, and implemented more effectively in the supportive and containing inpatient environment. Further means to disentangle treatment and natural history of disorder effects are required. This is discussed in more depth in Chapter 10, Section 10.4, regarding incorporating mechanisms of therapeutic change in research designs.

#### 9.1.4 Sample size and subject retention and attrition

Despite Stage 1 of the study covering a full two-year period (July 1995 to June 1997), and each of the 29 families consecutively admitted over that time consenting to participate, the resultant sample sizes used in Stage 1 of this study held inherent limitations. It was not possible to secure a larger sample, due firstly to the low yearly throughput in the programme, and secondly due to the closure of the programme in the format under which it was being researched. Furthermore, while 86% of the 29 families completed both the assessment and treatment phases of the programme, the available sample was further reduced through subject attrition due to incomplete data sets.

Nevertheless, in reference to mother-completed data sets across Time 1 and Time 2, while some subjects did not deliver full data sets, very good subject retention rates, were observed for the CBCL Problem Scale reports on IPs (89%, N=24) and on siblings (89%, N=17), and acceptable rates for GHQ-28 self report (79%, N=22), with somewhat less for the CBCL Competency Scale reports for IPs (70%) and siblings (73%) and FAD family evaluation (71%, N=20). These rates are considered to be at least comparable to or better than those in other child psychiatry inpatient or day patient outcome studies, which have reported retention rates of 89% (Dickerson Mayes, Calhoun et al., 2001), and 79% (Sundelin & Hansson, 1999) and 35% (Gavidia-Payne et al., 2003) and 28% (Gerardot et al., 1992).

Father data were more limited and, as explained in Section 7.1.5 of Chapter 7, could not be incorporated into multivariate statistical analyses. This was in part due to fathers being part of the family composition in only 16 of the 29 families admitted; 45% of the families admitted were single parent families. As with the mother-reported data, incomplete data sets were evident for fathers, although father data retention rates were lower. Subject retention rates for father-reported data sets from Time 1 to Time 2, were, as described in Section 7.1.5 of Chapter 7, for the CBCL Problem Scale reports for IPs (67%, N=10), siblings (58%, N=7), CBCL Competency Scale reports for IPs (64%, N=7) and siblings (44%, N=4), GHQ-28 self report (56%, N=9) and FAD family evaluation (38%, N=6).

The lower father retention rates in the study may be suggestive of issues related to the initial degree and ongoing level of engagement of the fathers in the programme. In the two Cassel Hospital Families Unit studies (Healy et al., 1991; Healy & Kennedy, 1993), father data were similarly limited and viewed with concern.

As in Sundelin and Hansson's (1999) research, subject attrition primarily concerned participation in the study, with few families terminating their treatment in the programme. Sundelin and Hansson observed that this points to a problematic reality with which the clinical researcher is faced when collecting information and supervising the research processes. In reference to their own study, Sundelin and Hansson suggested several factors that compromised data collection, such as insufficient routine among the staff concerning collection of information, resistance to participating in the project by some staff, and certain time periods being beset with more pressure and stress. In Stage 1 of the current study, no separate resources were allocated to research, rather this time had to be drawn from the allocated clinical resources. Despite this, a reasonable routine was in place in reference to data collection, particularly for Time 1 and Time 2, and commitment from the AC&FRU team was seen to be good, as evidenced in the 95-96% clinician-reported data completion rate for IPs and siblings. However, in the final year of the data collection, it was clear that changes to the AC&FRU programme were imminent due to funding alterations. Team resources were being focussed elsewhere and several long-term team members resigned from the programme. Data collection became compromised

due to these events, and, in particular, Time 3 data collection could not be actively followed up in all cases.

In reference to Stage 2 of this study, the sample used can be deemed a good representation of the group (former AC&FRU clinicians) under investigation. Ethnographic qualitative research focuses on discovering cultural patterns in human behaviour and describing the perspective of members of the given culture (Gall et al. 1996). In this case, the specific 'cultural' group was the former clinicians of the AC&FRU team, a multidisciplinary group of clinicians collaborating closely with common treatment goals.

For this component of the study, ten of a possible eleven former clinicians of the AC&FRU programme, covering each of the major health disciplines (psychiatry, psychiatric nursing, clinical psychology, and social work) participated in the in-depth semi-structured interviews. This constituted most of the team involved in the programme over the designated time period, who satisfied the criteria as outlined in Chapter 5, Section 5.2. Only two clinicians who satisfied the criteria were not involved in Stage 2. This included one clinician who declined to be involved, and the current researcher. Other team members who were not interviewed included two sessional (less than 0.5 EFT) psychologists, two full-time special education teachers, and two support staff members.

Whilst, ideally, all team members would have been interviewed, pragmatics associated with time expenditure in qualitative research associated with interviewing and subsequent transcribing, coding and analysing of data, prevented exhaustive investigation. It is, however, likely that interviews conducted with every team member may have enhanced the overall picture gained regarding the processes of the AC&FRU programme. In particular, inclusion of the two teachers may have drawn out more detail regarding the educative component of the programme. Additional interviews with the two part-time psychologists, whose primary roles were either individual psychotherapy or psychometric testing rather than family case management responsibilities, may have provided an important, slightly distanced perspective on the role and function of the case management team, and on challenges experienced by both the clinicians and families.



### 9.1.5 Detailed specification of therapy

The practice of the AC&FRU programme is documented in the description of the Unit in Section 3.1.1 of Chapter 3, as well as through the Stage 2 in-depth retrospective interviews conducted with the clinicians involved with the programme, the findings of which are presented in Sections 8.3 and 8.4 of Chapter 8. Detail was provided on the general structure and process of the programme, but not in a highly specific manualised format. The noted heterogeneity of inpatient populations added a further level of complexity with regard to the specifics of treatment, as interventions were therefore seen as needing to be flexibly applied to widely varying situations. Prescribed specifics were not deemed appropriate in this clinical setting. However, certain general components of the family inpatient programme were observed to apply to all families, as reported in Sections 3.1.1.6 and 3.1.1.7 of Chapter 3. These included distinct assessment and treatment phases, management by a designated case management team, parents retaining responsibility for their children, children attending the hospital school, and the implementation of individualised ward-based behavioural programme for the children.

Nevertheless, the underlying theoretical orientation of the programme, as presented in Section 3.1.1.2 of Chapter 3 and Section 8.3 of Chapter 8, which would guide a detailed specification of therapy notably lacked clarity in the programme and hence in this research. Epstein (2004) has identified the need for detailed description of milieu practice to assist in defining the intervention process involved in outcome research. This issue is taken up further in Section 10.3.3 of Chapter 10, regarding methodological recommendations in outcome evaluation research.

### 9.1.6 Measurement

One of the main strengths of this study centred on aspects of measurement, especially in comparison to previously reported studies of family inpatient admission programmes, where no validated quantitative measures had been used. Stage 1 used standardised instruments and covered multiple domains of functioning using multiple

informants. Moreover, the Stage 1 quantitative data were complemented by the Stage 2 qualitative interview analysis.

However, limitations regarding processes of measurement were also observed. In Stage 1, the narrow range of informants and the single measures used across the various domains of functioning, could be seen in this light. In Stage 2, the engagement of clinicians' views alone, rather than also including the families themselves, should also be considered a limitation.

#### 9.1.6.1 Use of standardised instruments

The use of standardised measures (Achenbach CBCL, GHQ-28, and the McMaster FAD) in Stage 1 of this study can be viewed as a clear strength in outcome measurement. Not only do these validated measures provide valuable information, but the findings from these measures, particularly the CBCL Problem Scales, potentially allows for easy integration with other inpatient child psychiatry outcome studies for future meta-analysis.

However, in reference to the use of the AC&FRU's mother-reported CBCL scores for the IP, caution is required in extrapolating these findings as a benchmark for children requiring hospitalisation. As Jones et al. (1988) commented with regard to their normed inpatient sample from the United States, the means and standard deviations have been drawn from a heterogenous group of children with psychiatric disorders, and that averaging across diverse groups of children tends to attenuate the magnitude of scores on individual CBCL subscales. For example, children with high scores on the internalising subscales and low scores on externalising subscales were combined, with children showing the opposite pattern of behaviour problems. Hence, the reporting mean for inpatients probably could under-estimate the score that might be expected from a child in need of inpatient treatment for a specific type of behaviour problem measured by a given subscale (Jones et al.). Therefore, while some generalisation may be made from the findings from this study to other whole inpatient populations, use of these findings as a benchmark next to findings for an individual children may not be an informative exercise.

#### 9.1.6.2 Use of multiple domains of functioning

Attention to multiple domains of functioning, rather than simply child symptomatology, has repeatedly been called for in child psychiatric outcome evaluation (Jensen et al., 1996; Kazdin, 2003; Target & Fonagy, 1996). As remarked on in Chapter 2, Section 2.1.1.8.2, Kazdin (2003) proposed a number of outcome criteria for evaluating treatment effectiveness, encompassing child, parent and family functioning, as well as measures of social impact. Nevertheless, nearly all of the recent child psychiatry inpatient evaluation studies described in Section 2.2.1.2. of Chapter 2, have provided evaluation data on the identified patient alone, and usually employed a single outcome measure (Dickerson Mayes, Calhoun et al., 2001; Gerardot et al., 1992; Sourander, Heikkila et al., 1995; Sourander & Piha, 1998). Only one past child inpatient study (Gavidia-Payne et al., 2003) incorporated the proposed necessary multiple domains of functioning to assess treatment outcome.

A particular strength of this current study, then, was that the evaluation data from Stage 1 covered multiple domains of functioning. These were similar to those addressed in the study by Gavidia-Payne et al. (2003), which incorporated child, parent and family outcome domains. However, in the present study, information was sought from both parents where appropriate, and also concerned a sibling of the IP where possible. To the researcher's knowledge, no other study reported in the child psychiatry inpatient intervention literature has included evaluation data on a sibling of the identified patient as well. This is of particular importance given the systemic influence of most child psychiatry practice, the documented influence of parenting practices on child functioning (Bank et al., 1996), the role of sibling relationships in shaping child development (Dunn, 1983; Dunn, 1992), and the recognition that child-parent-family factors are inter-related in child mental health (Kazdin & Wassell, 2000).

#### 9.1.6.3 Use of multiple informants

In Stage 1 of this study, multiple informants - the parents (mother and father, where available) and the clinicians (primary nurse and case manager) who worked closely with the families - provided information with regard to the childrens' (identified

patient and sibling closest in age to the identified patient) functioning. As Ferdinand et al. (2003) noted, aggregated assessments from multiple informants can provide a comprehensive view of presenting psychopathology.

However, although multiple informants were indeed used to elicit the child data, this did not extend to the children themselves or to their teachers, both of whom would have been valuable sources of information. In addition, multiple informants would have been useful for the parent and family measures as well. Ideally, clinicians would also have completed the McMaster Clinical Rating Scale, the clinicians' parallel version of the McMaster's Family Assessment Device. Whilst this had been in the original plan, it was not carried through due to limited resource availability. Moreover, a clinician version of objective reporting on the parent's general functioning, would have been beneficial.

Finally, in Stage 2, the in-depth interviews conducted with the former clinicians engaged in the programme, could have been extended to include the families involved in the programme as well. Information from the families would have permitted an important comparison between the perceptions of the clinicians and the families regarding their experiences of the programme, providing further useful programme outcome and process evaluative information.

#### 9.1.6.4 Use of multiple measures

While more comprehensive use of multiple informants would have been helpful, so may have been the use of multiple measures in each domain (child, parent and family) of investigation in Stage 1 in this study. As Green and Jacobs (1998c) proposed, measures of change that depend on one perspective, or on only limited aspects of functioning such as behavioural symptoms, are now generally viewed to be inadequate. For the child, the inclusion of a social adaptation measure beyond Achenbach's Competency profile may have been useful.

Moreover, self perception profiles would have afforded valuable information. In reference to the parents' functioning, while the GHQ-28 provided a general mental health profile, given the profile of practical parenting interventions in this study and

other inpatient and day patient child psychiatry programmes, measures related to parenting practices (such as The Parenting Scale) and competency (such as The Parent Sense of Competence Scale) may have been further useful measures to have employed in the evaluation.

Finally, evaluation of the family could also have been extended utilising measures such as those used in Sundelin and Hansson's (1999) study, namely, the self-rated Family Climate Test and Family Relations Scale (FARS), and the observer-rated Clinical Rating Scale-Turbo (CRS-Turbo) and Beavers' Observational System Scale. Moreover, family tasks involving an interview about the family's life and a structured problem-solving task such as 'the Puzzle' could also have been utilised.

#### 9.1.6.5 Complementary quantitative and qualitative stages of research

In the present study, the Stage 1 quantitative outcome data was complemented by the process and outcome evaluation findings from the Stage 2 in-depth qualitative interviews provided by former clinicians involved in the AC&FRU programme. These interviews, which reflected more fully on the theory, practice and outcomes of the programme, provided opportunities for the clinician's perceptions of the workings of the programme and the impact on individuals to be drawn in more detail. By incorporating quantitative and qualitative methodologies, overview and analysis of the process and outcomes of the programme, including strengths and weaknesses, could be provided.

Nevertheless, one concern regarding this current study is that the qualitative data drew on retrospective recall in reference to the AC&FRU programme, rather than the concurrent lived experience. The closure of the programme precluded such an approach.

While other child psychiatry individual admission or day programmes evaluation studies have displayed particular strengths in either quantitative (eg. Sundelin & Hansson, 1999) or qualitative (eg. Chesson, 1996) research design, few studies (eg. Chesson et al., 1997) have incorporated both methodologies. Of note, Chesson et al.'s study concentrated on the qualitative methodology and only utilised a single quantitative outcome measure centred on child symptomatology. Clearly, the practice of including and then integrating

both methodologies remains in its infancy in child psychiatry process and outcome evaluation research. It can be seen as a strength of the present study, and permits enhanced interpretation and discussion of the potential meaning and implications of the findings of each method.

#### 9.1.7 The collection of pre-treatment, post-treatment and follow-up data

A further major strength of the present study is that it appears to be the first study reported in the English language literature concerning child psychiatry family inpatient treatment that provides pre- and post-treatment outcome evaluation data across multiple domains of functioning (child, parent, and family). Even the more sophisticated studies of family oriented day (Sundelin & Hansson, 1999) or inpatient (Sourander & Piha, 1996) programmes, have been restricted in their scope of outcome data.

As noted in Sections 1.3.5 of Chapter 1 and 2.2.3.1 of Chapter 2, while a number of other family admission programmes have been presented in the literature, formal evaluation within a sound methodological framework has been notably absent. All the programmes reviewed in the literature provided descriptions regarding their programmes, and some provided anecdotal case studies including linking the discussed theory to practice, as in London's Marlborough Family Day Unit (Cooklin et al., 1983), Melbourne's Travancore Child and Family Centre (Bornstein et al., 1985) and Redbank House in Sydney (Siegel & Whitmont, 1990).

Some early efforts to evaluate programmes were made, as reviewed in Chapter 2, Section 2.2.3.1. Dydyk et al. (1989), from Thistletown Centre for Children in Toronto, claimed programme effectiveness base on a reduction in necessary bed-days. Other programmes conducted retrospective questionnaire evaluations based on responses by families and staff, at the Children's Psychiatric Research Unit in Ontario (Johnson & Savage, 1967) and Redbank House in Sydney (Churven & Durrant, 1983), and by families and outside professionals as shown in London's Marlborough Family Day Unit (Cooklin et al., 1983). Other evaluations using more empirically sound research design have been planned but not carried through (Bornstein et al.,

1985; Cooklin et al.; Siegel & Whitmont, 1990; Whitmont, 2001, personal communication).

In reference to the current study, while data relevant to outcome were available for admission (Time 1) and discharge points (Time 2), further longitudinal data was not consistently gathered. As described in Chapter 7, Section 7.1.5, data at six months follow-up (Time 3) had been planned but the resultant small sample size that was archived did not permit further analysis. Ideally, families would be followed up over the long term, not just on symptomatology outcome measures, but also on a range of social measures indicative of adaptation or otherwise, taking into account any ongoing intervention. This would have provided a more complete picture regarding the effectiveness of the inpatient family admission, and the influence of any subsequent interventions.

#### 9.1.8 Potential for bias within the research design

Potential sources of bias within this study also require consideration. These sources centre on the non-independent status of the present researcher, dual roles held by each of the clinicians as both clinicians and raters, as well as the dual role played by several of the clinicians as researchers as well.

First, in Stage 1 of the study, three of the twelve clinicians reporting on child functioning, were members of the AC&FRU research team who planned the original study. These clinicians, in their dual roles as researchers and clinicians would have been aware of the purpose of Stage 1 of the study. Of note, however, drawn from the detail provided in the patient information sheet and consent forms, it is important to comment that the remaining nine clinicians, as well as the families themselves, would also have been clearly aware of the purpose of the study.

Secondly, also in Stage 1 of the study, an independent rater, external to the AC&FRU programme, was not available to participate in the CBCL rating of child functioning. Rather, each of the AC&FRU clinicians, held the dual roles of clinician and rater. The clinicians who were involved in the treatment of the families also reported on child functioning. Whilst this enabled the clinicians to draw on a detailed working

knowledge of the subjects, it could also be viewed as a source of potential bias, in possibly determining ratings that favoured the value of the intervention. In addition, as described above, three of the clinicians held intimate knowledge regarding the study. However, of note, the clinician's score used was a 'combined clinician' score, drawing on responses from both the case manager and the primary nurse for each subject. Therefore, the scores provided by the three clinicians who were involved in the initial study design (and also took on case manager roles), would have been tempered by the primary nurse's scores. Moreover, the clinician-ratings were not the sole rating source for child functioning. Child functioning was also reported on by parents, and proved to be useful source of comparative and complementary data. These points may assist in offsetting the above concerns.

In reference to Stage 2 of the study involving the in-depth clinician interviews, concern regarding the clinicians presenting an overly favourable view of the AC&FRU programme does not seem warranted. The timing of this component of the study, two-and-a-half years after the closure of the programme (and shift to a mainly individual admission format), provided space for more detailed reflection on the programme, and, it may be suggested served to minimise the need to skew comments about the programme in order to protect it. This is further supported by the impression that quite frank responses were offered by the former clinicians in their reflective interviews. Indeed, it appeared that the perceived difficulties and limitations regarding the AC&FRU programme were most freely discussed.

Another potential source of bias in the research lies in the fact that the present researcher held a non-independent status in regard to the AC&FRU programme. The researcher had been a long-term member of the AC&FRU team and a member of the research team that planned the original study. This non-independent status brought both advantages and disadvantages. A disadvantage was the potential for favouring the AC&FRU programme, or other investments of her own, with regard to the programme's practice and perceived outcomes. However, the researcher, in her Nurse Unit Manager role and in the absence of taking on case management responsibilities, did not complete any of the clinician-reported findings for Stage 1 or Stage 2 of the study. Moreover, the researcher resigned from the programme in January 1997, six months prior to closure of the programme, and 12 months prior to the final Time 3



data collection. Whilst the researcher had further contact with some other former team members, this was not on a regular basis during the time before the in-depth reflective interviews were conducted.

Several advantages of the researcher having had close links with the programme under investigation are also observed. First, as seen in the Cassel Hospital's Families Unit studies (Healy et al., 1991; Healy & Kennedy, 1993), this ensured the researcher had a detailed understanding of the work of the programme. Moreover, in the case of the AC&FRU programme, this can be seen to have provided an additional lever into engaging the former clinicians in the in-depth interviews (91% of clinicians approached, consented to participate), and eliciting detailed information. At times, however, a learned short-hand communication between the researcher and clinician may have been enacted in the interview discussions, which could have precluded more comprehensive verbalisation of responses.

A further possible disadvantage of the researcher's non-independent status from the AC&FRU programme, was that a neutral framework from which to explore the features of the programme, was not provided. Of note, however, in nearly all the outcome and process evaluation studies reviewed in Chapter 2, the researchers have had close links with the programme under evaluation. While some studies have included university based researchers as well, in-house clinicians have generally held co-researcher roles. The exception is noted in the qualitative study undertaken at the Royal Aberdeen Hospital in Scotland by the sociologist, Chesson (1996).

In the case of this present study, it is highly probable, that if the researcher had not been in-house, the study would not have been completed, but rather fallen to a similar fate as other research attempted in similar settings. As highlighted above planned family inpatient outcome evaluation studies (as outlined in Section 2.2.3.1 of Chapter 2) proposed for Redbank House in Sydney (Siegel & Whitmont, 1990) and Melbourne's Travancore Child and Family Centre (Bornstein et al., 1985), as well as family day patient programmes (as outlined in Section 2.2.3.3 of Chapter 2) in London's Marlborough Family Day Unit (Cooklin et al., 1983) did not come to fruition.

The main strength of this current research, then, is that it is the only reported English language study addressing a child psychiatry family inpatient programme that has conducted evaluation in a comprehensive manner, incorporating both quantitative (Stage 1) and qualitative (Stage 2) methodologies. A completed pre- and post-test outcome evaluation using empirically validated measures, had not been reported before in the family inpatient English language literature. Further, few programmes in the family or individual inpatient literature had encompassed multiple domains of functioning (child, parent and family) as outcome measures.

Other valuable features of this study included the provision of data for both mothers and fathers, as well as for the sibling closest in age. Moreover, the subject group, while heterogenous, constituted a genuine clinical sample. Standardised instruments (Achenbach CBCL, GHQ-28 and McMaster FAD), with high validity, were used at repeated time intervals. In addition, the Stage 2 qualitative interviews with former AC&FRU clinicians addressing the programme's underlying theory, practice, as well as perceived outcomes, provided important rich complementary data to the Stage 1 quantitative findings. Finally, the generally high subject retention rate in both Stage 1 and Stage 2 of the project further strengthened the validity of the findings.

The limitations of this current study centre on the absence of a control or comparison group, the use of only one clinical setting, the small sample size, and limited father data available for analysis. Moreover, while multiple domains of functioning were addressed, the use of multiple outcome measures, with respect to children, parents and families, was not included. In addition, data collection in reference to follow-up post discharge (Time 3), while originally planned, was found to be only piecemeal.

On balance, considering both strengths and limitations, it is possible to claim generally high internal validity for this study. Any conclusions about the sample are based upon evidence from sound measures, and even-handed reflection on the part of the clinicians. Further, every family in the programme between July 1995 and June 1997 participated in the research. External validity, that is potential to generalise the findings beyond the AC&FRU programme, cannot be claimed, of course. However,

given the strengths of the study, it is certainly possible to use the findings to generate recommendations for consideration in future practice and research in family inpatient treatment, and in other family oriented individual admission and day programmes.

## 9.2 Discussion of the findings regarding the outcomes for the children, the parents, and the families

In the light of the limitations of the research, this section discusses the findings regarding the outcomes for the children, the parents and the families as a whole, in relation to their involvement with the AC&FRU programme. The Stage 1 quantitative outcome findings, as presented in Chapter 7 and summarised in Section 7.5, and the qualitative findings of Stage 2, reviewed in Section 8.5 of Chapter 8, are considered together.

While the findings of the Stage 2 clinicians' qualitative study are complementary to the outcome findings of Stage 1, in that they provide a context for a better understanding of the meaning of the quantitative evaluations, it cannot be claimed that the results of Stage 2 actually explain the Stage 1 findings. However, the clinicians' perceptions regarding the programme's theoretical orientation, practice and outcomes, helps provide a framework from which to explore how the positive outcomes noted from the Stage 1 findings were achieved.

The findings are reviewed and interpreted in the context of other child psychiatry family inpatient, individual inpatient, and day patient programmes that have adopted similar short-term, systemic, multi-modal approaches to therapeutic intervention, and have engaged in some similar aspects of programme evaluation.

### 9.2.1 Outcome findings regarding the children

As summarised in Section 7.5.1 of Chapter 7, in reference to both the IPs and the siblings, an improvement in functioning from Time 1 to Time 2, on each of the CBCL Summary Problem Scales (Total, Internalising and Externalising), was reported by the mothers, fathers and clinicians. Fathers also reported an improvement in functioning for both the IPs and siblings from Time 1 to Time 2, on each of the CBCL

Competency Total and Subscales (Activities, Social, and School) scores. Mothers similarly followed this trend, although they did not report an improvement for the IP's on the Social Subscale, or for the siblings on the School Subscale.

#### 9.2.1.1 Outcome for the IPs

As predicted by Hypothesis 1a, set out in Section 3.2.3.2.1 of Chapter 3, psychopathology in the IP, as perceived by the parents (mothers and fathers) and by the clinicians was less at the time of discharge from the programme (Time 2) than at the time of admission (Time 1), as indicated by scores on the Achenbach CBCL Summary Problem Scales. For each of the CBCL Summary Problem Scales (Total, Internalising and Externalising), mothers and clinicians results reached statistical significance. Whilst fathers' results followed a similar trend, multivariate analysis was not possible due to the small father IP sample size.

On the other hand, Hypothesis 1b was not supported. While mothers identified more psychopathology for the IPs at both Time 1 and Time 2 compared to the clinician's observations, this did not reach statistical significance. Two possible explanations are offered for this finding. First, the AC&FRU programme, due to the limited bed status and modus operandi of the programme did not admit crisis referrals, but rather concentrated on planned admissions. The planned nature of the AC&FRU admissions did not allow for what may be viewed as temporary elevations in symptomatology to be included in the data evaluation. Hence, the hypothesised differences between the mother and clinician scores were not attained. Secondly, as discussed in Chapter 2, Section 2.2.1.3, sleeper effects, such as the accumulated input from the extensive outpatient or community services received prior to admission and culminating in the parents having developed more of an internalised model of psychological functioning, more akin to the clinician's perception of the child.

The reported mean scores at Time 1 in the current study were found to be higher than both the North American (Achenbach, 1991a) and the Australian reported outpatient referred norms (Nolan et al., 1996), although at Time 2 they were found to be more comparable to the Australian referred (outpatient) norms. The higher scores reported at Time 1 in comparison to the Australian referred outpatient norms may reflect the

degree of psychopathology with which the IPs presented in the inpatient setting. All of the inpatient families had prior contact with outpatient and community based services, and were considered to have chronic and multiple problems. It is also possible that the current study sample included more children with externalising difficulties that elevated some scores.

Moreover, the finding that the current inpatient study's results at Time 2 were more comparable to the Australian outpatient norms than at Time 1 requires attention. On discharge from the inpatient programme, all families continued on with outpatient work, whether with the AC&FRU team, the referrer or other mental health providers. Therefore, at discharge, Time 2, the current inpatient study sample would be more likely to resemble the outpatient-referred norm sample. This is of importance, given that the population comprising the outpatient norms had not had prior contact with psychiatric services prior to their referral (Nolan et al., 1996). This situation lends support to the effectiveness of the family inpatient intervention, as reflected in the Achenbach CBCL scores.

With regard to comparison of this study with other studies that have utilised the CBCL as an outcome measure, firstly in the family inpatient outcome evaluation literature, no prior studies have utilised standardised measures, let alone the CBCL. Turning to other child psychiatry inpatient or day patient programmes, two individual child inpatient programmes (Gerardot et al., 1992; Kazdin & Bass, 1988), one family-oriented child inpatient programme (Sourander, Heikkilä et al., 1995; Sourander & Piha, 1998) and one partial hospitalisation programme (Kiser et al., 1996) have utilised the CBCL parent-report of child functioning as an outcome measure. Like the findings from the current study, each of these programmes reported improvements in perceived child functioning across time. However, it is not possible to make direct comparisons of the current study with these other studies due to the differing programme content, length of stay and follow-up periods

In reference to the current study, a number of changes were also reported for the IP by the clinicians in the Stage 2 qualitative in-depth interviews. The main changes - an improvement in the child's ability to relate to self and others, and relief from the blame for and burden of holding the problems in the family - were suggestive of the IPs

undergoing important intrapsychic changes in the context of family inpatient intervention. These changes, descriptively provided through the in-depth interviews, were obviously not captured explicitly in the CBCL responses. However, other more obviously observable changes such as an improvements in both the IP's difficult behaviour and in their school work, were identified in both the CBCL and the in-depth interview responses.

The improvements in the IP reported following family inpatient treatment in the AC&FRU programme are also of note in the context of the limited use of medication in the programme. These findings, like those reported by Sourander, Helenius et al. (1996) in their family oriented individual admission programme, which also did not focus on the use of medication, are impressive in this respect. It can be suggested that these outcomes be viewed as a product of psychotherapeutic input, rather than largely as a response to psychopharmacological intervention. Clearly, further research specifically addressing this variable would be beneficial.

#### 9.2.1.2 Outcome findings for the siblings

As outlined in Chapter 7, Section 7.2.2, drawn from Stage 1 findings, psychopathology in the sibling nearest in age to the IP, as perceived by the parents (mothers and fathers) and by the clinicians, was less at discharge from the programme (Time 2) than at admission (Time 1), as registered by scores on the Achenbach CBCL Summary Problem Scales. This finding, reaching statistical significance for mother and clinician scores, supported Hypothesis 2b regarding the clinician's perceptions of the siblings, but was contrary to Hypothesis 2a for the parents reporting on the siblings.

As indicated by Hypothesis 2a, it was originally expected that over the course of the programme, as the parents became increasingly aware of the significance of the family relationships, they would more clearly identify difficulties for individual family members and rate the sibling with more problems on discharge. Instead, parents reported a borderline clinical or clinical level of psychopathology for the siblings at Time 1, which then reduced to a reported non-clinical level at Time 2.

Several possible reasons are forwarded to explain these findings. First, while all of the inpatient families had prior contact with outpatient or community based services, some of the siblings in these families had been exposed to child psychiatric outpatient work (either through family work or their own individual assessment and/or treatment) prior to engaging in the AC&FRU family inpatient programme. It is likely that the parents had already begun assimilating an understanding of the presenting needs of each family member, including the siblings. This would explain the Time 1 results as reported by the parents for the siblings. Second, the families admitted to the AC&FRU programme typically experienced multiple problems of a longstanding nature. Again, parents would be familiar with the needs of the siblings in this context. Nevertheless, it is of note that in these findings the mothers reported a significant improvement in functioning of the siblings from Time 1 to Time 2, as reported on the Achenbach CBCL Summary Problem Scales, lending further support to the effectiveness of the programme.

The improvements reported by the mothers for the siblings from Time 1 to Time 2 on the Achenbach CBCL Competency Scales were less substantial. First, more difficulties were reported for the siblings at Time 2 on the School scale, whilst the improvements on the Social and Activities scales did not reach statistical significance from Time 1 to Time 2. Only minor improvements were observed. Two reasons are offered in relation to the poorer School result at Time 2. First, as suggested in the original hypothesis, parents may have begun to identify more difficulties of this specific kind for the sibling through the course of the admission. Prior to admission, whilst behavioural difficulties at home may have been apparent to the parents, scholastic issues may not have received as close attention. Alternatively, as described in the Stage 2 findings, one of the challenges identified for the families through the admission was the stipulation that all school-age children (identified patients and siblings) attend the Austin Hospital School. Difficulties with this requirement, which was reflected upon in the in-depth interviews, could have been identified by the mothers as highlighted in poorer school performance.

The perceptions by the clinicians, in both their Achenbach CBCL Summary Problem Scale results for the siblings, and in their Stage 2 interviews examining outcomes and changes in perceptions of the siblings, help to illuminate the experiences of the siblings in the programme. While they described the siblings as having had positive experiences through the course of the admission, some clinicians also characterised the siblings being

challenged by the changes occurring in the family dynamics. This finding is in contrast to the uniformly perceived positive outcomes identified by the clinicians for the IPs.

Clearly, the mixed findings reported for the siblings by both parents and clinicians underscore the need for further exploration and understanding of the processes at work to discover how best to support the sibling through the presenting challenges that a family intervention inevitably incurs. Research over the years showing the importance of sibling relationships in shaping child development (Dunn, 1983; 1992) may shed some light on this. As reviewed by Fagan and Najman (2003), positive sibling interactions can enhance children's prosocial behaviours including empathy, conflict management and co-operation, and protect against the negative impact of adverse family circumstances, while negative sibling interactions may increase childhood behaviour problems. Furthermore, drawing on a systemic theoretical framework, it has been noted by Patterson (1986) and Patterson et al. (1984), that parents of aggressive children often do not adequately monitor and set limits on their children or reinforce prosocial behaviour. This can lead on to a generally coercive family environment. In such a setting, sibling conflict may emerge and eventually lead to, and perpetuate aggressive and antisocial behaviours by all children in the family (Fagan & Najman). Moreover, it has been reported that sibling conflict during early childhood increases low-income boys' externalising behaviour at age six (Garcia et al., 2000). Finally, Fagan and Najman (2003), drawing on CBCL outcome measures found a moderately strong association between paired siblings' aggression and internalising behaviour at age five. Collectively, these findings highlight the importance of including siblings in family-based interventions programmes aimed at reducing child difficulties and increasing adaptive family functioning. They also highlight the importance of including sibling factors in research relating to such programmes.

### 9.2.2 Outcome findings for the mothers and fathers

According to Stage 1 findings, both mothers and fathers perceived improved functioning at discharge from the AC&FRU programme (Time 2) compared to on admission (Time 1), as shown in their self-report responses to the 28-item General Health Questionnaire (GHQ-28). Whilst the mothers' results were statistically substantiated, the fathers' results were not able to be analysed using multivariate statistics due to the small sample



size available at both time periods. However, descriptive statistical findings revealed a similar trend as for the mothers.

Only a few other studies reported in the child psychiatry inpatient literature have incorporated parent variables as outcome measures. That of Gavidia-Payne et al. (2003), recently investigating a Child Inpatient Mental Health Service in Melbourne, Australia, is an exception. Utilising the Parenting Scale (PS), The Parenting Sense of Competence Scale (PSOC) and the Centre for Epidemiological Studies Depression Scale (CES-D), from admission to discharge or four months follow up, significant improvements were found on a number of parent measures including competency, efficacy, and depression, as well as parenting practices. Another exception is Sheerin et al.'s (1999) Irish child inpatient evaluation, which included parents completing Goldberg's 12-item General Health Questionnaire (GHQ-12). However, while Sheerin et al. did not provide findings directly centred on the parent's mental health, they did state that the GHQ-12 findings did not correlate with outcome measures.

As Kazdin and Wasseell (2000) have observed, treatment of the child can also have positive effects on parent and family functioning. Moreover, these concomitant outcomes of child therapy may be important in their own right, insofar as changes such as reduced parent depression and stress as well as improved family functioning are intertwined with child mental health and the quality of family life (Crowley & Kazdin, 1998). This was clearly shown in the recent study by Kazdin and Whitely (2003) which found a parent problem solving (PPS) intervention enhanced therapeutic change for children referred for aggressive and antisocial behaviour, and for their parents, and also reduced barriers that parents experienced during treatment.

While, in Stage 1 of the current study, the GHQ-28 focussed on changes in the parents' physical, psychological, and social functioning, the Stage 2 in-depth interview with the clinicians allowed for a broader and more detailed review of parent functioning, and of changes in perception over the period of the family inpatient admission. The main change perceived by the clinicians for the parents over the course of the programme was an improvement in their understanding of the presenting difficulties in the family. It was considered by clinicians that the parents were better able to identify a range of contributing factors in relation to the presenting difficulties,

to have an increased understanding and empathy for the IP, and in all, became less focussed on the IP being ‘the problem’. The admission also allowed for the parents to develop a different story as parents and as individuals.

How such changes may actually have been effected requires further direct exploration. Although in this study specific mechanisms linked to therapeutic change were not examined, several hypotheses can be proposed, derived from the factors noted to facilitate the benefits of the AC&FRU programme. First, the work undertaken within the therapeutic milieu may be seen to have provided the essential emotional holding (Winnicott, 1965) to allow the parents to explore and grapple with their presenting family difficulties. Second, a major component of the inpatient work for each family centred on the ward-based behavioural management programme. This programme, which involved the nurses working alongside the parents, provided the parents with the all-important hands-on skills to manage many of the presenting family difficulties at a behavioural level, by setting limits, incorporating rewards and consequences, implementing a family routine and the like. Seeing incremental changes at this practical level over the four weeks of the treatment phase of the programme and practising the same at home at the weekends, may have alleviated some of the ongoing stress experienced by parents. Such structuring of the programme can be summarised as having provided the parents with the necessary ongoing support and encouragement to both regain authority in their family, and to explore issues at a deeper level.

### 9.2.3 Outcome of family functioning as reported by the mothers and the fathers

Both mothers’ and fathers’ perceived an improvement in family functioning at discharge from the A&FRU programme (Time 2) compared to on admission (Time 1) as shown in their responses on the McMaster Family Assessment Device (FAD). This was observed across each subscale, apart from a slight decline in functioning on the Affective Responsiveness subscale at Time 2 according to fathers. Whilst the mothers’ results were statistically substantiated, the fathers’ results, due to the small sample size available at both time periods, were not able to be analysed using inferential statistics. Descriptive statistical findings, however, revealed the same trend as for the mothers, with the

abovementioned exception. Given the limited father sample size, the mother data are used here for the point of contrast and comparison with other studies and programmes.

The severity of the difficulties that the families in the AC&FRU programme were experiencing is highlighted when compared with non-clinical families, as well as with other families of children in psychiatric settings. First, the mother-reported FAD findings from Time 1 in this study clearly revealed severe problems in all seven dimensions of family functioning captured by the scale. When compared to mean family scores from non-clinical families (Miller et al., 1986), the severity of these problems was significantly greater for each scale, apart from Affective Responsiveness. Second, when compared to an individual child inpatient setting in Massachusetts, United States of America (Kline, 1995), the findings from the AC&FRU programme were elevated on each subscale measure, apart from Affective Responsiveness and Affective Involvement, where the findings from both studies on admission were highly comparable. Follow-up data were not available in Kline's (1995) study.

Other child psychiatry settings have also utilised the FAD in outcome evaluation studies. First, Kiser et al.'s (1996) evaluation of partial hospitalisation programmes in Memphis, in the United States of America, found that the parents reported improvements in family functioning from on admission to one year follow-up, on each of the FAD subscales. Significant gains (based on paired t-test analysis) on parent-report were noted in the Roles and Behaviour Control subscales. Secondly, while Gavidia-Payne et al.'s (2003) Melbourne-based individual short-term child inpatient programme study did not find statistically significant changes in family functioning, two FAD subscales, again Roles and Behaviour Control, did reveal significant improvement from pre-admission to four months follow-up. In reference to the current study, in the AC&FRU programme, a statistically substantiated improvement was observed from Time 1 to Time 2 in the mother-reported findings. Once more, the Roles and Behaviour Control subscales showed the greatest increase in score, with less improvement indicated on the more affectively laden (Affective Involvement, Affective Responsiveness, Communication) subscales. As Gavidia-Payne et al. suggested, short-term interventions may not be as effective for those areas of child and family functioning that are more complex in nature, which may require

longer term treatment and/or other interventions modalities beyond what could be offered within a brief stay inpatient setting.

In Stage 2 of the present study, the in-depth qualitative interviews with the clinicians highlighted that the main gains perceived to be made by the family related to the acquisition of new skills and knowledge by family members. These skills were related to managing the presenting problems, knowledge about themselves and other family members, and knowledge about the nature or what might be contributing to the problem. Emotional relief, support and the installation of hope for the family were also seen to be provided. Change for the families at a deeper psychological level was also identified by some of the clinicians. These findings suggest hypotheses for future research to explore.

#### 9.2.4 Comparison of mother and father findings on each of the measures

Overall, fathers generally reported fewer difficulties than mothers as recorded on each of the child, parent, and family measures utilised in this study.

First, as reported in Sections 7.2.1 and 7.2.2 of Chapter 7, for both the IPs and the siblings, the fathers reported fewer difficulties on each of the Achenbach CBCL Summary Problem Scales. A less consistent pattern emerged in the reporting of CBCL Competency Scale items. However, due to the very small Time 2 father-reported samples for IPs (N=7) and siblings (N=4), further discussion is restricted. Secondly, when comparing mothers' and fathers' self-reports on the GHQ-28, as documented in Section 7.3.3 of Chapter 7, fathers again consistently self-reported fewer difficulties than the mothers on each of the GHQ-28 subscales at both Time 1 and Time 2. This finding was consistent with the DSM-IV generated diagnostic status of mothers and fathers noted in Sections 6.2.1 and 6.2.2 and summarised in Section 6.4 of Chapter 6. Based on the psychiatrist's assessment, all the mothers in this study were ascribed an Axis I clinical diagnosis disorder, for 81% of the mothers their difficulties also included relational problems, and for 22% of the mothers a personality disorder was diagnosed. Diagnoses for the 16 fathers involved in the study centred solely on relational problems.

Thirdly, with reference to the McMaster FAD findings as outlined in Section 7.4.3 of Chapter 7, comparing mothers and fathers' reports on their perception of their families, fathers consistently reported less pathology at both Time 1 and Time 2 on each of the seven subscales except for Affective Responsiveness. Sawyer et al. (1988), comparing clinic-referred to community families on FAD data, noted the fathers' tendency to identify less pathology, and suggested that fathers may be less aware than mothers or (as in their study) adolescents, of differences in family functioning. In a further study, Sundelin and Hansson (1999) in reference to their Swedish IFTU programme, also observed mothers and fathers to have very different experiences of the family. Father's views of the family were observed to be closer to non-clinical families, suggesting a gender-specific finding. Sundelin and Hansson suggested that the fathers wanted to protect their families by reporting a non-clinical picture, or alternatively that the fathers' knowledge of the family was limited to unproblematic parts of the family's life.

The thrust of the hypotheses in this area of family functioning were supported in the current study. A mechanism was suggested by Clinician H (H40), who reflected that admission to the AC&FRU programme was often an 'eye opener' for the fathers. Fathers were seen to discover more about their families than they had previously been aware. They discovered the stresses and strains experienced by their partners, and in the course of the admission reflected on the role their work played for them in providing relief from the confusion, tension and conflict. Moreover, it may be postulated that fathers tended to focus more on task performance than on the child's or the family's emotional life. Such an orientation on the part of the fathers may assist to explain the disparate mother- and father-reported findings on the CBCL Problem Scale outcomes. Clearly, further investigation regarding the differences in mothers and fathers perceptions of the family functioning is required.

#### 9.2.5 Summary of the discussion of the child, parent and family findings

Despite limitations to the breadth of the research stemming from some design and some data collection problems, the present study demonstrated that some important, desired improvements in child, parent, and family levels of functioning were perceived by many parents in the their course of involvement in the AC&FRU family

admission programme. Given that the assessment and intervention processes were overall systemic in focus and multi-modal in operation, applying family systems theories, it can be suggested that positive changes that ensued at each designated level of functioning, were potentially enhanced by changes occurring at the other levels of functioning as well. The AC&FRU programme intervention yielded desirable outcomes across multiple levels of functioning. The manner in which such changes may have occurred are now discussed in more detail, in the context of the underlying theory and components of practice of the programme, as perceived by the participating clinicians.

### 9.3 Discussion of the findings regarding the theory of the programme

#### 9.3.1 Dimensions of theory within the AC&FRU programme

The theoretical underpinnings of the programme, as experienced by the AC&FRU clinical team, are highly likely to have set a framework critical in facilitating the favourable outcomes of the programme found in Stage 1 of the study.

##### 9.3.1.1 Theory and related principles of practice

Compared to other domains of review in this study, comparatively little was volunteered with regard to the clinicians' conceptualisations of the theory underlying the programme. Whilst some specific commentary regarding theory was made, further reflections regarding the theory were drawn from the clinicians' comprehensive comments in reference to the programme's principles of practice. This finding is comparable to Chesson's (1996) experience with child inpatient staff at the Lowit Unit at the Royal Aberdeen Hospital in Scotland. When asked about the Unit's philosophy and theoretical orientation, most staff responded with applied principles related to everyday routines, rather than to abstract concepts.

Several possible reasons for this finding are forwarded. One explanation for little of the information being provided about the underlying theory of the AC&FRU programme was that the theory had been well integrated into these clinicians' everyday practice. Thus, in these cases, the practice conveyed the theory, rather than

the theory trying to drive the practice. Alternatively, a lack of clarity regarding the underlying theory of the programme may have been in operation. Another, not necessarily alternative, explanation may be that the ability to articulate varying theoretical orientations and their constituents, requires a comprehensive, detailed knowledge regarding the theoretical concepts. It would be fair to comment that a number of team members, while being experienced in their domain of practice, did hold such a comprehensive conceptual understanding.

Drawing on the documents review regarding the AC&FRU programme, outlined above in Chapter 3, Section 3.1.1, in reference to philosophy of the programme, it was noted firstly that a family systems conceptual framework guided the overall practice, closely followed by psychodynamic orientation, and to a lesser extent cognitive behavioural principles (Volk, 1993). The documents secondly noted that a 'multi-modal' assessment and treatment philosophy was utilised, with no one particular theory governing the programme practice (Jenkins et al., 1996; Volk, 1996). The AC&FRU programme 'aimed to improve the 'fit' between the child and the child's interpersonal environment and similarly, between the family and the family's interpersonal environment' (Jenkins et al.; Volk, 1996). Whilst the latter reports did not tie the programme to a particular theoretical orientation, drawing on other information provided in the description of the programme (McLouglin, 1996; Volk, 1996) outlined in Section 3.1.1, it did appear that an underlying systemic influence (involvement of the whole family from intake interview through admission) remained in operation, along with psychodynamic (holding frame of the therapeutic milieu) and cognitive-behavioural practices (assessment phase baseline observations of the family, ward-based programme using positive reinforcement, limit setting and consequences, nursing staff modeling interventions).

Indeed, the Stage 2 clinician interviews indicated some agreement in the team upon the use of diverse theoretical frameworks in the practice of the programme, and an aspiration to integrate these frameworks.

### 9.3.1.2 Integration of several theoretical frameworks within the current study of the AC&FRU programme

Drawing on information provided from the Stage 2 qualitative interviews of the current study, the group of former AC&FRU clinicians indicated that they drew upon multiple theoretical perspectives in their conceptualisation of the presenting family difficulties. First and foremost, they discussed family system principles, closely followed by psychodynamic principles, and what was seen to be an integration of several theoretical frameworks. The other specific theoretical frameworks mentioned included cognitive-behavioural, biopsychosocial and developmental psychological principles, as well as consideration of an individual's psychiatric diagnosis or biological status. These findings are noted to be comparable to the findings from the 1993 AC&FRU questionnaire study (Volk, 1993) which requested the clinicians to rank the theoretical frameworks which guided their practice. This is suggestive that the theoretical orientation of the AC&FRU programme remained relatively stable during the years over which these studies were undertaken. Such a finding may be seen to be influenced by the comparatively stable core group of team members (a four year average with the AC&FRU), a 'handing on' of these work practice principles to clinicians new to the programme, and as outlined in Section 8.2 of Chapter 8 and detailed in Table 34, many of the clinicians having engaged in formal family therapy training, further underlining the family systems focus of the programme.

However, while the AC&FRU programme appeared to allow a certain freedom for the clinicians to use their own individual theoretical orientations, the degree of formal integration of these differing theoretical orientations was unclear.

### 9.3.1.3 The advantages and disadvantages of integrating theoretical models

Indeed, the integration of a number of theoretical orientations can afford a number of advantages, particularly in the work with multi-problem families, however, the manner in which the differing models interact and their overall integration within a programme requires careful consideration. Lebow (1987) and Sugarman (1986) in reference to work with integrative individual and family work, found that such a model can offers an understanding of human complexity permitting treatment



flexibility, specificity, and adaptability to diverse patient populations; enhancing the efficacy of each modality; be tailored to match the therapist's clinical style; and also offers advantages in training, encourages the developing therapist to grapple with complex clinical matters. However, the disadvantages of combining modalities as outlined by Racusin and Kaslow (1994) include the potentially contradictory epistemological foundations of the therapies that may confuse both clinician and family; the use of surplus interventions that may dilute commitment to each modality and/or lead to a failure to appreciate the unique contributions of each modality, resulting in poor empiricism and unnecessary expenditure of resources; and difficulty in monitoring treatments due to the complexities associated with formulation and implementation of effective treatment plans.

Such advantages and disadvantages would potentially be manifold when working with patients in a family inpatient setting. The complexities of working with families with multiple and entrenched difficulties in an inpatient setting, certainly warrants a broad theoretical base. Whilst the place and importance of family systemic thinking as a general understanding in this work has been well documented, the manner in which other theoretical perspectives are implemented and integrated does require careful attention. This is of particular importance in inpatient teams, given that team members are heavily reliant on each other to ensure a co-ordinated treatment approach. Thoughtful theoretical integration would work towards ensuring that confusion does not beset the clinician ensuring clear and focussed working models with the families.

In addition, the place of team structure, roles within the team and ongoing education and supervision are important factors that would support the implementation and ongoing review of a broad-based, integrationist orientation. Team members having the time and clinical support to assimilate differing theoretical perspectives is of utmost importance. As Clinician F reflected, consolidation of learning was difficult, despite having been a team member for several years, in the context of several long-term team members resigning from the team, and in conjunction with imminent changes occurring regarding the funding and the manner in which the programme would be delivered. This points to the probable need for a stable institutional framework supportive of a broad-based approach.

Finally, in discussion of the findings regarding the theory of the AC&FRU programme, it is of interest, to compare the theoretical orientations presented in this study with the theoretical perspectives said to underlie other reported family inpatient or family-oriented programmes. While some programmes have gone through differently articulated theoretical orientations, such as Redbank House from strategic family therapy (Churven & Durrant, 1983) to an eclectic orientation integrating systems, social learning and self-psychology theories (Siegel & Whitmont, 1990); the AC&FRU programme, while having drawn upon multiple theoretical perspectives, seemed to maintain an underlying systemic and psychodynamic focus utilising cognitive behavioural principles.

Stability or variation in each of the respective programmes may be due to a range of reasons. First, the continuity or alternatively, changes in key team members can influence decisions and practices surrounding theoretical orientations. Secondly, some programmes, such as the Cassel Hospital's The Families Unit, psychoanalytic approach, have adhered to a pure theoretical orientation (Coombe, 1996). Thirdly, other programmes embrace developments in thinking within different theoretical perspectives. This was clearly articulated by Sundelin (1999) in Sweden's IFTUs, which drew on multi-systemic therapy, therapeutic communities, as well as the work of the Norwegian flying teams. Fourthly, programmes may alter, theoretically and/or operationally, as a consequence of programme evaluation, whether through accumulated working knowledge of the programme's own or through reported literature from other programmes, or as a consequence of politically driven fiscal pressures. Finally, changes in programmes can be a product of various components of the abovementioned.

#### 9.4 Discussion of the findings regarding the practice of the programme

The following section reviews findings of the practice of the AC&FRU programme as drawn from information regarding the programme as outlined in Section 3.1.1 of Chapter 3, as well as from the Stage 2 qualitative interviews with the former AC&FRU clinicians. These findings assist in understanding the practice processes which may have facilitated the improvements in functioning found in Stage 1 of the study. First, factors perceived to have facilitated the benefits offered by the

programme are addressed. Secondly, factors that may be viewed to have inhibited or limited the gains achieved from the programme are outlined. Possible challenges experienced by the families as inpatients, as well as demands encountered by clinicians in the programme, are explored, along with the interplay between the two, as well as wider systemic concerns. These findings are discussed in the context of reports from other family inpatient, family-oriented day patient and individual child inpatient programmes.

#### 9.4.1 Factors that facilitated the benefits offered by the programme

The main specific factors identified by the former AC&FRU clinicians to have contributed to the benefits offered to the family through their inpatient treatment can be summarised as the structure, comprehensiveness and planning of the treatment programme, which was delivered within a supportive and containing therapeutic milieu.

The AC&FRU clinicians thoroughly articulated the roles and responsibilities within the team. The case management team's role incorporating those of the primary nurse and case manager were very well defined and articulated. Clinicians were also clear regarding other clinicians roles as they took on differing assessment and treatment roles for varying family subsystems. The importance of team structure and clarity regarding roles, responsibility and authority when working with multi-problem families has also been clearly outlined by other authors (Bandler, 1987; Chesson, 1996; Green & Jacobs, 1998b).

The comprehensiveness of the treatment programme was also viewed by the clinicians as a strength of the programme. The value of systemically integrating a range of treatment strategies or as noted by Clinician A in reference to the current study, the AC&FRU programme involved 'a critical mass of investment' in terms of staff and resources which 'hit the system (intervened) at two or three levels minimum'. The importance of such an approach with this population has been increasingly recognised. Kazdin (2000), as discussed in Chapter 1, Section 1.1.5, suggested that an integrationist or 'broad-based' treatment package drawn from a range of treatments

that have been empirically validated, may be indicated for clinical problems that are multiply determined, protracted, and resistant to other forms of treatment. In addition, Fonagy et al. (2002) described an emergent 'pan-theoretical' model in child psychiatry, which combines biological, systems, cognitive-behavioural, and psychodynamic perspectives. Indeed, such approaches have also been effectively utilised in other family oriented child psychiatry programmes (Sourander & Piha, 1996; Sundelin & Hansson, 1999).

Moreover, the place and importance of planning was clearly highlighted in the AC&FRU programme. Other programmes reported in the literature – family inpatient (Byrne & Jones, 1998; Dydyk et al., 1989) family-oriented day patient (Sundelin & Hansson, 1999) family-oriented child individual admission (Sourander & Piha, 1996; Sourander & Leijala 2002) and individual child admission programmes (Gavidia-Payne et al., 2003; Ney et al., 1988) also utilised comprehensive planning in their programmes. Commonalities in all these programmes were the pre-admission, during admission and post discharge planning, along with involvement with external agencies. Such programmes impressed as viewing themselves as systemically incorporated within a broader ongoing treatment context for the child and the family. While some programmes gave due attention to such planning procedures in reference to findings of outcome evaluation (Gavidia-Payne et al.; Ney et al.), to date the impact of planning as a process variable in outcome evaluation has not been explored in the literature.

The place of planning is also acknowledged in the structure and containment provided within an effective therapeutic milieu setting. This is particularly important when working intensively with multi-problem families within a short time period. In the AC&FRU programme, utilising the model of the parents remaining in charge of their family throughout the admission, with the psychiatric nurses working alongside them, such structure and containment provided can be likened to Winnicott's (1965; 1972) notion of emotional 'holding'. In the setting of generally cohesive team functioning, as Schenider and Cohen (1998) observed, such structure and containment provides an essential boundary in which extreme feelings and behaviours could be tested and different ways of being explored. Indeed, Churven and Durrant's (1983) parent-

reported findings of family treatment at Sydney's Redbank House, similarly perceived the main instrument of change as the 24 hour support and guidance offered by the nursing staff through the milieu setting, again reflecting the importance of emotional holding afforded through structure and containment.

Finally, overlapping with the specific factors facilitating benefits as discussed above, various non-specific factors (Frank & Frank, 1991), centring on the therapeutic relationship, were also likely to be at play. Given the often multiply determined, protracted and entrenched difficulties encountered, the AC&FRU clinicians appeared to extensively utilise these all-important non-specific factors in their therapeutic work with families, integrating these with an essential understanding of family systems mechanisms underlying the difficulties. They worked at addressing the difficulties at a number of different levels simultaneously. The utilisation of non-specific therapeutic factors, as well as a systemic understanding and working approach, can be viewed to be powerful agents of change in the treatment of families in the AC&FRU programme. This is evidenced by the reflections of the clinicians in the Stage 2 interviews in their observations that one of the main strengths of the programme was the holding frame provided by the supportive therapeutic milieu, which incorporated all elements of the traditional non-specific factors.

#### 9.4.2 Factors that limited the benefits offered by the programme

Underlining the systemic nature of this work, the factors considered to limit the benefits to be gained from the AC&FRU programme could be seen as multifaceted and clearly interlinked. They included a range of potential difficulties that families may experience as inpatients, challenges encountered by the clinicians in their work practice, and the interplay between the family and treating team systems.

##### 9.4.2.1 Potential difficulties and challenges experienced by the families as inpatients

The potential challenges or difficulties that families may have experienced as inpatients, as perceived by clinicians, are drawn from Chapter 8, Sections 8.5.5 and

8.5.6, presented in Tables 47 and 48. In summary, the main difficulties and challenges were perceived as arising when the families did not have the necessary psychological resources to deal with the programme in the format in which it was presented, or when protective issues were active.

It can be assumed that for any family to be involved in an inpatient treatment programme such as AC&FRU programme, would be extremely challenging and demanding. To be uprooted and placed in an unfamiliar environment with a group of professionals with whom the entire family is expected to work closely and effectively with for five days a week for up to a six week period, would take considerable psychological mindedness and tenacity. Indeed, the importance of psychological resources to productively engage in such a programme was noted by Bornstein et al. (1985) in their clinical experience with Melbourne's Travancore Child and Family Centre. Bornstein et al. stipulated that inpatient family intervention would be contraindicated for a family that would experience the inpatient process as too emotionally threatening, as could be noted at assessment in highly defensive behaviour. This could be seen, for example, in cases in which the parents have a great need to focus the family's problem on a particular child, and to avoid giving attention to their own serious marital or personal problems. Serious psychopathology in at least one parent may also be indicated (Bornstein et al.), although of course this was a demographic of the AC&FRU programme as documented in the findings. In further reference to the AC&FRU programme, Clinician H reflected that the family needed to be able to say, 'I'm here in order to get my family working better, at the same time I'm under the microscope (but) I know this is happening for my benefit than for any other persecutory reason'.

Limitations regarding the benefits afforded to the family by the AC&FRU programme were also noted when families accepted the admission based on a strong recommendation by Victorian State Government Child Protection Services. This was also noted in McLoughlin's (1996) review of the AC&FRU programme. Statutory involvement of Protection Services provided a distinct set of challenges for the treating team and the family. Several factors are proposed here as likely to lie behind these challenges. First, the family's acceptance of admission was not such a free

decision to seek help, but, rather, was overshadowed by a strong recommendation. In the consequent absence of the family's clear ownership of their admission, the relationship the team established with the family, viewed by the clinicians to be the cornerstone of the therapeutic work, was seen to be compromised in comparison to work with families without statutory involvement. In addition, McLoughlin commented that it was often found that involvement of a statutory body, overall, generated much discussion within the team, and the need for close inter-agency collaboration often brought forth further challenges, particularly in the more complex cases, and particularly regarding further planning.

The demandingness of the AC&FRU programme, in hand with the psychological resources required to actively engage with it, was clearly highlighted in Stage 2 of the present study, for example in the difficulties many parents were observed to have in effectively participating in therapeutic physical holding of their child, required for out-of-control or dangerous behaviour in the child. As reported in Table 48 and reviewed in Section 8.5.6 of Chapter 8, over half of the clinicians in this study perceived this to be a particular difficulty for the families. Sourander, Ellila, et al. (2002) proposed that in the context of general heightened social awareness of physical and sexual abuse, a natural ambivalence may be enacted if the physical holding intervention is construed as abuse or punishment. In the experience of the AC&FRU programme, as documented by McLoughlin (1996), many of the parents had themselves experienced childhood physical and sexual abuse, which may have further impeded their effectively engaging in the practice of therapeutic physical holding. As Clinician C, in the current study, commented in reference to the practice, 'I think parents needed to separate out their own pain from their kid's pain, to be able to take charge'.

In all, these above examples regarding factors that potentially limited the benefits of the programme for the families, culminated in what may be described as a lack of shared goals, and lack of a shared language between the family and the AC&FRU treating team. The efficacy of treatment for any individual or family cannot be assessed without attention to the quality of the fit between prospective patient's life circumstances and capacities and the treatment modality offered (Target & Fonagy, 1996). In the case of AC&FRU programme, the patient's life circumstances would

include the family's capacity for psychological mindedness, the preparedness of all family members to attend and participate in the programme, and the social and emotional supports available to the family post discharge. It is not surprising that the AC&FRU programme appeared to be more accessible for certain families than others, as well as more effective for some families than for others, as suggested by the findings of Stage 1 of this research.

#### 9.4.2.2 Challenges experienced by the clinicians in the programme

As outlined in Section 8.4.3 of Chapter 8, and summarised in Table 42, a number of difficulties or challenges were reported by the clinicians in their work with the AC&FRU programme. Many of these had also been identified by other child psychiatry inpatient individual admission and full family admission programmes. While some were similarly identified as issues for the families (such as Protection Services involvement and therapeutic physical holding), and were addressed above in 9.4.2.1, others, centering on the nature and management of this clinical work and associated team dynamics, are discussed below .

##### 9.4.2.2.1 The nature of the clinical work and associated team dynamics

As noted in Sections 1.2.6 and 1.3.7 of Chapter 1, clinical work involving children and families with problems that are multiply determined, protracted and resistant to other forms of treatment, is highly demanding. Several main points, drawn from the qualitative findings in Chapter 8, Section 8.4.3, regarding the clinicians' perceptions of team relationships within the work practice, as summarised in Table 42, warrant discussion.

First, the AC&FRU clinicians reported that the very nature of the clinical work created issues and tensions within their work practice. While containment of aggression and verbal working through of issues of aggression in the family were key objectives, not all instances of such behaviour could be prevented. In particular, the observation of abuse and emotional neglect, and witnessing or actually being a recipient of aggression and violence from the family, created significant tensions in team members. Similarly, Bandler (1987) at the Cassel Hospital in London, and



Byrne and Jones (1998) in their work with families who abuse at the Park Hospital for Children in Oxford, noted that parents abusing their children aroused the strongest feelings and greatest anxiety in staff. Observing, nursing and intervening on a daily basis in a grossly dysfunctional parent-child relationship, and being a witness to emotional abuse or neglect, can be extremely painful for team members (Byrne & Jones). Destructive forces in the parent are seen at their most unrestrained in an inpatient setting, and children are recognised as helpless victims of situations they cannot comprehend or control. These experiences can test the staff's capacity of work together to the utmost (Bandler)

Secondly, difficulties in relations between team members were also viewed as influenced, in part, by these challenging experiences. Britton's (1981) notion of the treating team members unwittingly re-enacting or mirroring family relationships as a response to family dynamics, was described by some of the AC&FRU clinicians. This was considered to be a 'parallel process' in operation, reflecting transference and countertransference psychodynamics, which potentially contributed to the understanding of the issues for and tensions within the team.

However, as Winship (1995) observed, team dynamics within inpatient settings also have a life of their own. While not suggesting that these issues are totally separate from the dynamics activated through transference and countertransference in relation to the family, to attribute them solely to the same, would not give due credit to team members' own intrapersonal and interpersonal contributions, as well as those drawn from group (inpatient treating team, wider treating team) and organisational (institution to which the programme is affiliated) psychodynamic processes. Challenging interactions can be seen as flowing from a number of different, although overlapping, individual and group (family, inpatient treating team, wider treating team, organisation) sources (Hinshelwood, 1987).

Previous research in child and family psychiatry inpatient settings has repeatedly reported inter-staff tensions (Chesson, 1996; Churven & Cintio, 1983). As in the current study, these tensions have been noted to often fall on the line between the direct care/ward-based/milieu staff and the other clinicians within the team. Section 8.4.3 of Chapter 8, records that a number of AC&FRU clinicians noted

interdisciplinary rivalry. While issues could be observed across disciplines, most often this was reported between the nurses as a group, on one hand, and other clinical team members, on the other. A range of reasons for this, such as mutual envy of the others' role (nurses having more involvement with the children, other clinicians engaging in more formal therapeutic work such as in the role of case manager or family therapist) were offered. Indeed, while the clear role definition, along with the structure of the programme was viewed as a strength in the family treatment offered by the AC&FRU, it impressed that some team members experienced this as professionally restrictive.

In the Child Inpatient Unit at Royal Aberdeen Hospital in Scotland, Chesson (1996) tensions among multidisciplinary team members were also noted. Some of the discord was attributed to differences in hours worked, status and pay. Other differences were apparently tied to the amount of direct contact or therapeutic input with the children. In summary, direct care staff felt left with the array of daily, pressing, presenting issues, while other team members came and went. In the experience of the AC&FRU, Clinician A described a similar situation, wherein the nurses would 'feel like the diggers and the officers would come and visit'. A further parallel between the experience of an employed father and a home duties mother was also noted by Clinician A.

Again, Churven and Cintio (1983), in the experience of Sydney's Redbank House family inpatient programme, noted a 'vigorous ongoing dialectic in staff meetings', between what was described as the 'devious, manipulative' family therapists and 'open, honest and confronting' direct care staff' (p.195). The said conflict was in part seen to be a product of differing principles of practice in operation within the programme. On the one hand, direct care staff worked within therapeutic community principles which emphasised openness and equality, whereas strategic family therapy staff utilised non-insight oriented directives to alter patterns of behaviour.

Whilst the origins of these above outlined conflicts and tensions within child psychiatry treating teams may vary, their management, along with any associated psychodynamics must become the focus of attention.

#### 9.4.2.2.2 Management of the clinical work and associated team dynamics

The current research has underlined a feature noted elsewhere, that given the nature of the clinical work and associated team dynamics, it is essential that management practices are put in place that can assist in the ongoing work with such issues. In Chapter 1, Sections 1.2.4 (multidisciplinary inpatient team structure and functioning) and 1.2.7 (the role of clinical supervision and staff sensitivity groups in inpatient practice) reviewed and outlined some of the necessary management components previously documented (Green & Jacobs, 1998b; Winship, 1995). These are now revisited in the light of the clinicians' perceptions of the experience of the AC&FRU programme, and this information compared with that emerging from other child psychiatry individual and family inpatient programmes.

Structure was viewed by the A&CFRU clinicians as a particular strength of the programme and could mostly be seen as providing containment for both the families and the team. The perceived structure of the AC&FRU programme took a number of forms, as described in Section 8.4.3 (roles and functions within the AC&FRU team), with both external and internal features.

Within this structure, while outcomes regarding team issues and tensions were perceived by half of the clinicians as positive or constructive, several other clinicians felt that resolution of issues was not always achieved. While a number of forums and structures were noted to be available to discuss issues for the team members, several team members identified problems regarding these structures and forums. As Bandler (1987) suggested if these feelings are left to develop, strains and tensions can build to an intolerable extent, leaving workers to feeling helpless, alone and unable to work together, thereby impacting on effective work with families. However, she offered, if these strains can be understood, processed and managed, the possibility of working usefully with the family remains open.

In the experience of The Families Unit at the Cassel Hospital in London, regular forums and structures for understanding, processing and managing the work were seen as essential (Bandler, 1987). These included regular reviews, where all staff working with the family were present, as well as smaller meetings, where parents,

children, or individuals were the main focus. As each staff member was responsible for specific pieces of work, overall progress for the family could not be monitored, or overall understanding gleaned, without the opportunity to look at and integrate different aspects of the work. Bandler commented that strains in working together could not be understood or held without such forums. Because of the emotional strain of working with the families, the importance of the primary workers with a family to have a chance to talk about their reactions to the patients and to each other was underscored. Such reactions provided clues as to the nature of the family's disturbance, and when understood, could be used to further the treatment.

Byrne and Jones (1998), in their work with the Residential Family Unit at the Park Hospital for Children in Oxford, also described the process of weekly clinical supervision. This forum, for the parent-child therapists (direct care staff), was viewed as an 'opportunity for emotional and psychological support, a distillation process for refining the assessments, and a process of exploration of the dynamics of the parent-child relationship, as evidenced both in the use the parents make of the child and of the therapists, and in the therapist's countertransference' (p.301).

Sourander and Piha (1996) reporting on the family oriented individual child admission programmes in Finland, explained that the aim of clinical supervision sessions was to strive to understand the intrafamilial origins of family problems at the family/ward boundary and between staff members. They noted that as staff members on a child psychiatric ward experience unpleasant, anxiety-provoking, and confusing emotions (Embling, 1993, cited in Sourander & Piha, 1996), it is necessary to experience some of the chaos and confusion the patients are feeling in order to understand and help them. From a psychodynamic perspective, these emotional reactions reflect the inner world and life situations of the patients. It is important that the clinical supervisor keeps the major focus on the level of the extended therapeutic system (Sourander & Piha).

Overall, the present study has confirmed and extended the discussion in the literature of central team dynamics.

The discussion of the findings in this chapter leads on to a range of implications for theoretical development concerning family systems, family-oriented practice and for research on family interventions, the subject matter of the next, concluding chapter.

## CHAPTER 10

### CONCLUSION: IMPLICATIONS OF THE FINDINGS

As discussed in Chapter 1, the treatment in child psychiatry of families with multiple problems who have proven in the past through outpatient interventions to be treatment resistant, present as a major therapeutic challenge. Full family inpatient admission has been one therapeutic option offered to such families. While this intervention has been employed within several services around the world, formal programme outcome and process evaluation had not been reported in the English language literature.

Although a number of important empirical limitations were inherent in this piece of research, some valuable information also emerged. From the discussion of the findings of this research, in relation to literature discussing other family admission and family oriented day programmes, as well as child psychiatry individual admission programmes, certain implications for relevant theory emerge. Further, recommendations concerning specific dimensions of clinical practice in working with multi-problem families, as well as future research directions, can be made on the basis of the present findings. This chapter first discusses the theoretical implications of the research, then goes on to outline implications for practice. Finally, implications for future research are presented.

#### 10.1 Theoretical implications of the study

##### 10.1.1 Broad-based theoretical orientation in working with multi-problem families

It is suggested, on the basis of the findings of Stage 2 of the current study, that the theoretical orientation underpinning work with multi-problem, treatment resistant families in a child psychiatry setting, needs to be wide ranging and integrative. Only such theoretical scope can encompass and potentially provide a better handle on the difficulties such families bring to the clinical setting. In the main, drawing on several theoretical frameworks has been recognised in other family inpatient programmes (Bornstein et al., 1985; Byrne & Jones, 1998; Combrinck-Graham, 1985; Ravnsborg,

1982; Siegel & Whitmont, 1990), as well as in family-focussed inpatient and day patient programmes (Cooklin et al., 1983; Sourander & Piha, 1996; Sundelin & Hansson, 1999).

Similarly, within the broader context of child psychiatry, Fonagy et al. (2002, p.394) recently described an emergent 'pan-theoretical model' of intervention which draws its inspiration from a combination of biological, systems, cognitive-behavioural, and psychodynamic principles. Again, Green and Jacobs (Green & Jacobs, 1998a; Jacobs and Green, 1998), in their comprehensive review of individual child psychiatry inpatient treatment, along with that what was offered within a traditional milieu setting, demonstrated the need to utilise an integrated theoretical model in residential treatment. This was described as a 'biopsychosocial' or 'holistic' approach (Jacobs & Green, 1998, p.425) that draws on the medical model, psychological treatments (such as cognitive behavioural, psychodynamic, group), and educational assessments, within a systemic framework.

As shown above, the value of utilising multiple theoretical perspectives in child psychiatry, particularly in working with multi-problem families, has been increasingly recognised. However, the manner in which these theoretical perspectives are integrated, requires greater attention. As shown in the current study (reviewed in Section 9.3.1 of Chapter 9), a clearly outlined and understood integration of theoretical frameworks may have proven more beneficial in the practice of the AC&FRU programme. Such detail can assist in the general running of the programme providing a short-hand common language in which the team can communicate as they work towards a common goal, providing each family with a more inclusive, tailored treatment package addressing their specific needs.

Two questions thus arise. What would such an integrated theoretical framework look like? What would be the necessary theoretical components of such a framework when working with multi-problem families? The following sections considers these questions.

### 10.1.2 Toward an integrated theoretical framework in working with multi-problem families

A broad-based or integrated theoretical framework, employed in work with multi-problem families, would incorporate individual functioning, family systems functioning and the wider treating team (outpatient professional network) into both the overall conceptualisation of the presenting difficulties, and into decision-making concerning the interventions offered to the family. The findings of Stage 2 suggest that important components of an integrated theoretical framework would include an underlying general systems based orientation, psychodynamic understanding, developmental perspective, and behavioural principles. Furthermore, such an integrated framework would need to be squarely placed within the context of the medical system in which child psychiatry is grounded. Thus psychiatric diagnoses, biological status and general biopsychosocial factors would need to be accounted for.

First, the importance of an underlying general systems based theoretical framework was repeatedly drawn upon in the family inpatient and family oriented work with multi-problem families, as outlined in Sections 1.3.5 and 1.3.6 of Chapter 1 above. A systemic orientation can be purposefully applied to focussed work in the treatment setting. A systems-based understanding draws on concepts from different family therapy schools to help formulate alternative, constructive, ‘understandings’ of presenting difficulties (Sundelin, 1999). For instance a structural approach addresses the important interconnectedness between family organisation and individual well-being (Minuchin, 1974), a systemic orientation points to family myths and the system of meaning and their relation to individual perception of reality (Boscolo et al., 1987), while the narrative perspective attends to the individual script (the story about oneself) embedded within the family script (White & Epston, 1990).

However, within a systemic theoretical framework, it is important that focussed work in the treatment setting, potentially drawing on a range of family therapy interventions, would occur in the context of the broader (professional and community) system. Of the studies reviewed in this thesis, Sourander and Piha (2000) have come closest to alluding to a fully explicit systemic model. Integrating both their outcome findings and lived experience of family oriented child inpatient work, Sourander and



Piha articulated a treatment model linking child psychiatric inpatient treatment with the professional outpatient network. The child, the family, and the ward community together are seen as an extended therapeutic system. The ward subsystem interacts with both the family system and the professional network. The practical implications of this model, observed in both the AC&FRU programmes and some other family programmes (eg. Sourander & Piha, 1996), was the importance placed on meetings (sometimes termed 'network meetings'), which include all those involved with the presenting problem (for example family, grandparents and/or other relatives, teacher, social worker, outpatient therapist) both prior to admission and during the course of treatment. The importance such meetings is discussed further in Sections 10.2.4 and 10.2.5 below, in reference to collaborative work with the family and external agencies, particularly in the context of discharge planning and facilitating the transition back into the community.

Next, the place of psychodynamic understanding in working with families embedded in such dysfunction has also been frequently observed and utilised. The treating facility does not need to operate within a dedicated psychoanalytic framework such as The Cassel Hospital in London (Coombe, 1996; Kennedy et al., 1987), to integrate psychodynamic concepts and understanding in their work practice. As noted in many of the family treatment programmes, the presenting difficulties, including issues of physical and sexual abuse, often span the generations (Byrne & Jones, 1998; Healy et al., 1991; McLoughlin, 1996). For the team to have a conceptual understanding of the quality of family members' internal object relations, can assist in planning in reference to the treatment modality choice and general approach to psychotherapeutic work. In addition, as observed in the the AC&FRU programme as well as Sweden's IFTU's programme (Sundelin, 1999), the functioning of the milieu setting drew upon psychodynamic concepts of 'containing' and 'holding'. Moreover, as discussed in Sections 1.2.6 and 1.3.7 of Chapter 1 work with families with chronic, multi-layered difficulties inevitably gives rise to transference and countertransference issues. Psychodynamic principles can assist the clinical team to make sense of the arising conflicts. In addition, a psychodynamic theoretical understanding, drawing on concepts of group and organisational processes is of value in working with the wider health system, especially in the context of significant changes in health care delivery and the inherent competing demands of a socio-cultural, political and financial nature.

A developmental theoretical orientation which incorporates the concepts of individual development, the family life cycle, and contextual factors also requires consideration in relation to a broad-based, integrated approach to treatment of multi-problem families. As Davidson et al. (2001) described, an individual developmental approach which considers how the family nurtures and supports individual development, sets limits and teaches internal self-control, fosters early socialisation efforts, facilitates achievement and success, and facilitates independence/selfhood and individuation. Family life cycle issues include how the family prepared for and negotiated the events of the life cycle, identifying unanticipated or unique challenges the family has encountered (illness, unemployment). Finally, contextual factors encompass how the family's socioeconomic status, cultural and religious perspective affected their children. In addition, recent significant events such as school changes, remarriages, moving house are taken into consideration. The place of the family in the larger community, in terms of isolation or inter-relation, is also taken into account by context (Davidson et al.).

The employment of behavioural principles are similarly viewed as crucial in an integrated model of treatment delivery to multi-problem families. In all of the child individual admission inpatient settings as reviewed in Section 2.2.1.2 of Chapter 2, and in a number of the family inpatient and family oriented day programme settings, behavioural principles were utilised. Stage 2 of the current study revealed that behavioural principles were predominately used within the milieu setting in relation to children's behavioural management programmes, and in practical parenting work. Such findings have been reported in other practical literature. For example, Morris and Jacobs (1998) noted that behavioural principles are most clearly presented in the parenting work, and that for some parents, an initial cognitive behavioural approach opens up the possibility of addressing well-defended areas of experience for future individual psychodynamic work.

Finally, it would be important that an integrated framework for the treatment of multi-problem families also draws upon the general biopsychosocial theoretical orientation, and incorporates the medical and psychiatric systems in which child psychiatry is firmly grounded.

The literature relevant to the present research has provided important windows to seeing how such integrationist thinking may operate overall. Important here are frameworks such as attachment theory (Ainsworth et al., 1978; Bowlby, 1969; Bowlby, 1973; Bowlby, 1980), which draws upon psychodynamic, cognitive and biological theories to address aspects of the parent-child relationship, and Josephson's (2002) description of a contemporary approach to family therapy which focuses on the integration of systemic, psychodynamic/developmental, and behavioural perspectives, as reviewed in Section 1.1.4.4.2 of Chapter 1. However, it is clear that the routine integration of the proposed abovementioned theoretical frameworks in the treatment of multi-problem families remains an enterprise yet to be fully examined and achieved.

## 10.2 Practical implications of the study: Specific dimensions of practice in working with multi-problem families

As the current research findings have indicated, the AC&FRU programme was successful in certain key desired outcomes for the particular families, and it is therefore considered that the programme has implications for effective treatment of multi-problem families. In particular, Stage 2 of the research served as a basis for identifying what elements or factors that may be deemed critical to the development of the overall framework and structure for service delivery to such families, whether in family inpatient or family-oriented day programme or family-oriented individual inpatient settings. The notion of such structural issues as being critical can be seen as derived from the theories of Winnicott (1965; 1971), which suggest the value of an emotional holding environment for both the families and the clinicians that can work towards facilitating change.

The usefulness of a broad-based intervention for multi-problem families and the means of implementing such a framework in child psychiatry settings is reviewed below. Then the critical factors, drawn from the broad-based theoretical intervention, regarded as having implications for practice, are outlined. These factors may helpfully be described as internal and external structures. The external structures include the engagement of an experienced multidisciplinary team, comprehensive and coherent programme planning and structure (including pre-admission, admission and

post discharge) and ensuring that the family and external agencies are collaborative partners throughout the treatment process. However, these external structures cannot be optimally operationalised without also integrating with them certain internal structures, to effectively manage the inherent emotional complexity and demandingness of this work. Such internal structures include clinical supervision, staff sensitivity groups, ongoing professional development and team building practices. These specific dimensions of practice related to working with multi-problem families are discussed below.

#### 10.2.1 The value of a broad-based intervention

The findings from this current study indicated the value of the AC&FRU short-term, intensive, broad-based family inpatient intervention for multi-problem families. As reviewed in Section 1.3.2 of Chapter 1, family inpatient treatment programmes can provide a number of important treatment opportunities and specific advantages over other modes of intervention. These include diffusing the focus on the referred child, and adopting a broader family systems approach to the difficulties, creating an opportunity for intensive and comprehensive assessment of the presenting difficulties, which can lead onto the development of intense therapeutic relationships between family members and clinicians, and providing peer support for both the parents and the children (Brendler, 1987; Byrne & Jones, 1998; Comrinck-Graham et al., 1982; Siegel & Whitmont, 1990). Moreover, in reference to the cost associated with full family admission, Byrne and Jones attested to the economic advantages of having an experienced multidisciplinary team concentrated in the one setting, enabling a more accurate conclusions about the presenting difficulties to be drawn. The costs associated with inpatient family treatment can be balanced against the usual alternative costs of longer individual child admission and prolonged involvement by multiple agencies (Bornstein et al., 1985), as well as the possibility of repeated individual admissions.

While the advantages of utilising a broad-based intervention for multi-problem families from within a family inpatient setting, have been comprehensively outlined above, this is not necessarily the only option for such a programme.

Psychiatric service delivery needs to be considered in the context of the challenges, brought by social, economic and political developments, particularly the push towards accountability of treatment effectiveness, combined with pressures to minimise costs (Green & Jacobs, 1998a). Such consideration makes identifying effective treatment options for multi-problem, treatment resistant families, a further challenge. However, as Leventhal and Zimmerman (2004) observed, despite these pressures, child psychiatry has a clinical and ethical obligation to provide a full continuum of services to meet the needs of all children and their families. Given this situation, and given that previous research has shown that these families typically do not respond to outpatient interventions alone, an intensive family-oriented inpatient or day patient treatment format may be viewed as the preferred treatment options for this population.

First, in reference to child inpatient treatment generally, Green and Jacobs (1998a) contended that well functioning inpatient environments can indeed provide the most powerful response to some of the most complex and challenging difficulties presenting in child mental health. For example, interventions from the behavioural level to medication can be best introduced and monitored in an inpatient setting. Indeed, as Jacobs and Green (1998) observed, in the absence of inpatient services, a proportion of cases (such as those drawn from multi-problem families) would remain quite unresponsive to outpatient interventions, leading to unrelieved distress for some very disturbed children. Also, it is likely that more problems would present for education and social services, and other authorities. Difficulties for this group would be likely to escalate rather than resolve over time, with long-term morbidity and burden on services into adulthood more likely. Such concerns may include alcohol and drug abuse, self harm, personality difficulties, ongoing behavioural difficulties, antisocial problems and issues related to parenting their own children. This can be viewed as a high price to society for the failure of early intervention (Jacobs & Green).

However, as the politics and economics of mental health delivery have placed emphasis on more community-based interventions (Jensen & Whittaker, 1989), consideration of services other than inpatient treatment, but that incorporate the features of the AC&FRU family admission programme (as outlined in Section 3.1.1 of Chapter 3, and discussed in Section 9.4.1 of Chapter 9) warrant consideration. Features, such as short-term, intensive, multi-impact intervention, layered planning with a clear family focus have also been noted in the Finnish child inpatient programmes (Sourander, Heikkila et al., 1995; Sourander & Piha, 1996), the Swedish IFTUs day treatment facilities (Sundelin & Hansson, 1999) and the Marlborough Family Day Unit in London (Cooklin et al., 1983; Asen, 1988). These programmes, which have serviced a similar target longstanding, multi-problem family population are reviewed in Section 1.3.6 of Chapter 1. In the case of Finnish and Swedish programmes, short-term successes have been proven. Such programmes may be viewed as clear contenders as examples of intermediary programmes between full family admission and systemically based outpatient treatment.

However, regardless of whether individual child inpatient, family inpatient or family-oriented day patient approaches adopted, Sourander and Leijala (2002) based on their research and clinical experience for this population, recommended that short-term child psychiatry intervention, should be seen as a pathway to further assistance rather than a complete form of intervention. In this context, the importance of discharge planning and active follow-up have been repeatedly underscored. This is discussed further in Section 10.2.4 below.

### 10.2.3 Engagement of an experienced multidisciplinary team

In line with adopting a broad-based theoretical orientation, the practical implications of such an approach call for experienced clinicians, who are both familiar with a range of theoretical orientations and therapeutic techniques, and who are able to manage the demands of working intensively with multi-problem families. The clinical and economic advantages of engaging experienced clinicians drawn from a multidisciplinary base are reviewed above in Section 10.2.1. Concentrating resources in the one setting allows a clinical picture regarding the presenting difficulties to be

more accurately drawn, and treatment options more readily employed in a more integrated manner. However, as Kazdin (2000) observed, these skills may require extensive training to ensure the delivery of high quality, integrated treatment. Therefore, such resources would be viewed as specialist, tailored for working with multi-problem families, and depending on the programme involved, these resources may be required up to 24 hours a day, seven days a week (full-time inpatient programme). Therefore, it is important that the multidisciplinary treating team is comprised of experienced, emotionally mature clinicians and support staff that can engage with others, act as mentors for less experienced clinicians and be reflective regarding their practice in an ongoing manner.

#### 10.2.4 Comprehensive and coherent programme planning and structure

Along with engaging an experienced multidisciplinary team, comprehensive and coherent programme planning can provide the necessary structure or holding frame required when working with multi-problem families. Programme planning takes in pre-admission, during admission and post-discharge goals. As well as the provision and maintenance of a supportive and containing therapeutic milieu, due attention must be paid to aftercare to facilitate the transition from inpatient treatment to the community. Such planning and structure can prove to be containing for both the families and the treating team.

The place and importance of such planning was clearly highlighted in the AC&FRU programme, as outlined in Section 3.1.1 of Chapter 3, and other family inpatient (Byrne & Jones, 1998; Dydyk et al., 1989) family-oriented day patient (Sundelin & Hansson, 1999), family-oriented child individual admission (Sourander & Piha, 1996; Sourander & Leijala 2002) and individual child admission programmes (Gavidia-Payne et al., 2003; Ney et al., 1988). Each of these programmes drew on clearly documented procedures and planning. Such programmes impressed as viewing themselves as systemically incorporated within a broader ongoing treatment context for the child and the family.

A number of these programmes used a pre-determined period of inpatient treatment (Byrnes & Jones, 1998; Dydyk et al., 1989; Gavidia-Payne et al., 2003; Ney et al., 1988; Siegel & Whitmont, 1990; Sourander & Piha, 1996; Sundelin & Hansson, 1999). Ney et al. observed that this can assist to concentrate staff effort and maximise family and community involvement. With all parties being aware of length of commitment, psychotherapeutic attachment and subsequent separation issues can be managed in a planned manner, building upon experience. Moreover, particularly with short-term interventions, links with the community can be well maintained. As noted in the current study in Section 3.1.1.3. of Chapter 3 and Section 6.1 of Chapter 6, for the most part, the AC&FRU programme had a planned two week assessment period and four week treatment phase. Reviewing the other family oriented inpatient and day patient programmes that have more recently engaged in research, similar time periods to Ney et al.'s study, often along with pre-admission and follow-up work were observed (Gavidia-Payne et al.; Sourander & Piha; Sundelin & Hansson).

The provision and maintenance of a supportive and containing therapeutic milieu further facilitates the necessary holding required for therapeutic treatment with multi-problem families. As outlined in Section 1.2.5 of Chapter 1, the therapeutic milieu of a child inpatient setting can be viewed as the central nexus of the programme (Gunderson, 1978, cited in Crouch, 1998). The overall aim of the inpatient milieu is to provide a structured and consistent environment designed to allow the child to establish a sense of security, to promote interactions leading to the child developing satisfying interpersonal relationships, and to provide meaningful activities (Sourander, Helenius et al., 1995). These aims are extended to the whole family in family inpatient treatment.

Puotiniemi et al.'s (2001; 2002) research into the resources of, and factors associated with, the coping of parents with a child in psychiatric inpatient care, indicated that a range of support (emotional, instrumental and financial) assisted in the general coping of parents. The manner in which the AC&FRU family inpatient programme was set up with a case management team assigned to each family, and with 24 hour nursing staff back up throughout their admission, ensured that the parents felt well-supported and were provided the necessary containment to facilitate change.



The importance of discharge or aftercare planning has been repeatedly observed for the transfer and generalisation of treatment gains to the child and family's everyday environment. The earlier generation of child inpatient outcome evaluation studies (Blotcky et al., 1984; Pfeiffer & Strezlecki, 1990) observed that the positive results of treatment were often obviated by difficulties in the transition from inpatient treatment into the community. Moreover, the more recent group of child inpatient outcome studies, reviewed in Section 2.2.1.2 of Chapter 2, similarly revealed ongoing difficulties at follow-up. While patients improved from admission to discharge or follow-up, a large percentage often remained in the borderline or clinical range of functioning. These findings underline the importance of carefully considering post-discharge follow-up arrangements, and linking together the inpatient or day patient programme with outpatient and/or community resources.

A number of measures may be implemented to aid in aftercare or discharge planning. As is outlined in the Section 10.2.5 below, looking at the roles of the parents and families, treating professionals and other agencies, and the interfaces of these three, may assist in facilitating the transition from the inpatient setting into the community. In addition, as Cafferty and Leichtmen (2001) suggested, bringing resources that will be utilised post discharge into the treatment programme can also aid the child and family's transition back into the community. However, given the longstanding, multiply determined and often entrenched nature of the presenting family difficulties, it is important that the short-term inpatient or day patient family-oriented treatment is conceptualised as one step in a longer intervention, one that must be followed by a range of supportive mechanisms following discharge.

#### 10.2.5 The family and other agencies as collaborative partners in therapy

Drawing on an underlying general systems based theoretical orientation, it is essential that the family and other agencies involved with the family are also clearly identified as collaborative partners in the treatment process. Whilst the complexity of difficulties facing multi-problem families (and often their extended therapeutic system) will present significant therapeutic challenges for the inpatient or day patient treating team, finding avenues for engagement and maintaining this engagement, with

both the family and external professional and community agencies is crucial to productive collaborative intervention.

First, in reference to collaborating with the family, establishing and maintaining an effective therapeutic alliance between the unit staff, the child and the parents, may be seen as the cornerstone of such collaborative work. In a number of reviews of inpatient child psychiatry programmes, it has been stated that treatment is more likely to be effective, if the family is positively engaged with the programme (Blotcky et al., 1984; Cornsweet, 1990; Green et al., 2001; Pfeiffer, & Strezelecki, 1990). In addition, in the few individual child admission qualitative evaluation studies reviewed in Section 2.2.2.1 of Chapter 2, each gave due recognition to the importance of the parents' experience and perception in relation to the treatment of their child. This was observed in Puotinemi et al.'s (2001; 2002) exploration of parent resources and coping factors associated with a child in inpatient care, in Scharer's (1999; 2000) analysis of the relationship that develops between the parents and the nurses, in Demmitt and Joanning's (1998) overall review of the parents' experience of the inpatient process, in parents' perceived outcomes of their child's inpatient experience as noted by Bradley and Clarke (1993) and Chesson et al. (1997).

How can this model of collaboration with the families be incorporated into clinical practice? While a guiding systemic theoretical frame of full family admission may assist in this process, as shown in the present study, as well as in other family inpatient programmes (Churven & Durrant, 1983; Johnson & Savage, 1967), difficulties between the collaborating parties can arise, whereby collaboration towards a common goal is compromised. In other words, a stated systemic theoretical orientation does not necessarily seamlessly equate with partnership and effective collaboration in treatment. Along with a guiding theoretical framework, what also may be deemed necessary to facilitate this important process, is attention to the roles, attitudes and expectations of all parties.

Collaboration between clinicians and the family is central. In the experience of the AC&FRU programme, staff were mindful of being careful not to take over the parenting role, but rather to work actively alongside the parents, modelling where

necessary, but respecting and supporting their efforts. In addition, the family returned home each weekend to practice new interventions, and ways of being together, and thereby could assess their developing skills and broader understanding of the presenting difficulties while maintaining important links to their community, the wider system. For team members to work effectively in this mode of practice, ongoing education, guidance and de-briefing where necessary, were required. Of note, this model of working, adopted by the AC&FRU and other family inpatient or family oriented day patient programmes, is not necessarily familiar to most individual inpatient settings.

Recently, Cafferty and Leichtmen (2001) and Leichtmen and Leichtmen (2001a), drawn from their work with an adolescent inpatient population, recognised the need to revise clinical roles and reorient attitudes of staff towards being more actively inclusive in their work with families. This call for increased parental involvement was also identified in Demmitt and Joanning's (1998) qualitative study. According to the parents interviewed, they wanted to be more involved in goal setting and decision making for their child, found family therapy to be useful in addressing family issues and family-staff conflicts, and underscored that regular communication was essential between the staff and parents, but felt most communication had to be initiated by the parents. At a very practical level, Leichtmen (2001) suggested that rather than use family visits as rewards, the family's involvement needs to be actively integrated into the programme, in planning, decision making and general participation.

Moreover, Chesson (1996) called for further research to explore how staff attitudes, education, training and philosophies affect the therapeutic relationship, and hence the degree of collaborative partnership in the treatment process. The exploration and review, where required, of attitudinal positions, of all clinicians in the multidisciplinary team, with regard to the patient population, may further aid in the move towards the families being viewed and worked with as partners in collaborative treatment. This may also be taken up in ongoing professional development as recommended and reviewed in Section 10.2.6, below.

However, as noted in the current research, the families' attitudinal position and general expectations can also impact on the degree of effective collaborative work

As presented in Section 8.5.5 of Chapter 8, regarding factors that limited the benefits of the programme included the lack of collaboration. This referred to the possibility of a disparate agenda developing between the parents and the team, was noted when parents wanted the nurses to be responsible for the children, when the family sought a prescribed solution to their difficulties, when the family was not being ready to work on the presenting difficulties, particularly shown in the father not being available to engage in the programme in an ongoing manner. Pre-admission work, with both the family and the referring agency, regarding the aims, expectations and the manner in which the given programme functions, along with clear criteria regarding admission with attention to families which may not benefit from the process, are also recommended.

In reference to collaboration with other agencies, an example of difficulties in collaboration between the treating team, the family and other agencies was provided in the current study, in their work with families with involvement from Protection Services as outlined in Section 9.4.2.1 of Chapter 9. Rather, than excluding such families from service, further review of the manner in which the treating team can engage and work with both the family and the involved agencies appeared to be indicated. The work undertaken with 'abusing families' at London's Park Hospital for Children (Byrne & Jones, 1998) may provide some pointers in this direction. While similar in planning structure to the AC&FRU, as Jones (1997) outlined, the Park Hospital for Children programme placed major emphasis on a risk management process. In this process, the risk matrix is broken down into manageable domains which include parental, parent-child, child, family abuse acts, social setting and professional systems. This enabled the many factors, positive and negative, to be weighed and counterbalanced during decision-making and risk management, and was noted to have been a useful framework for communication and liaison with other professionals. In addition, further attention to the manner in which inpatient team liaise with the wider treating team including a range of external agencies is indicated.

In all, as Armbruster et al. (2002) noted, professionals and families need to work together in relationships of respect and mutual support in all aspects of planning, programme development, service delivery and evaluation. It is important the families have a lead voice, as well as choice, in decisions regarding treatment plans for their

children. The challenge is to operationalise this inclusive model in both training and practice.

#### 10.2.6 Clinicians incorporating internal processing structures into clinical practice

The abovementioned, important external structures (engagement of an experienced multidisciplinary team, comprehensive and coherent programme planning and structure, and collaboration with the family and wider system) related to the recommended specific dimensions of practice in working with multi-problem families, cannot be optimally operationalised without also integrating into clinical practice, important internal structures, to effectively manage the inherent emotional complexity and demandingness of this work. Such internal structures include clinical supervision, staff sensitivity groups, ongoing professional development and team building practices.

First, acknowledging the clear challenges of working intensively with multi-problem families as outlined in Section 1.3.7 of Chapter 1, in reference to team dynamics related to transference and countertransference issues, clinical supervision (whether this is on an individual, group and/or team basis) is an essential structure to have in place. The experience of the AC&FRU team and other inpatient family treatment or family oriented programmes (Bandler, 1987; Sourander & Piha, 1996), suggest ideal characteristics of team supervision. A supervisor would ideally be appointed who is external to the team and treating facility, who is familiar with the programme's theoretical and practical orientation and case complexity, and who can incorporate a psychodynamic understanding of group processes, as well as systemically focussing on the extended therapeutic system.

Secondly, along with clinical supervision, staff sensitivity meetings are suggested as another important internal structure to integrate into clinical practice. As discussed in Section 1.2.7 of Chapter 1, not all staff issues can be, or should be, linked to the experience of working with the patient or family. Staff, in their own right, have their own interpersonal conflicts to work through. A staff sensitivity group is a forum in which such interpersonal material can be addressed (Winship, 1995). If both clinical

supervision and staff sensitivity group are utilised by the team, an important cross-over of experience would be likely. Staff sensitivity groups should offer a supervisory learning experience, and a group supervision process should foster an atmosphere of sensitivity to the needs and feelings of their colleagues. However, in order to ensure that the boundaries of these two approaches are not blurred unnecessarily, it is important that the group supervisor has experience and training in facilitating staff sensitivity groups and clinical group supervision (Winship).

A further internal structure recommended in work with multi-problem families, is ongoing professional development for all team members. Given that a broad-based integrated theoretical orientation is recommended, it is important that the treating team of the particular setting work together to understand how the various theoretical orientations coalesce to provide an effective, dynamic, inclusive and collectively informed treatment programme. For the less experienced clinicians, and those new to the treating team, it is essential that support and training is provided to assist them to assimilate different theoretical orientations and treatment modalities along with a self-reflective position into their working practice. As noted in the practice of the AC&FRU team, newer team members understandably found the learning curve to be steep, and drew on the knowledge of more experienced clinicians in the team, as well as engaging in formal education such as family therapy training.

Finally, activities that promote team building and increased team cohesion, such as social events, are a further internal structure recommended to be integrated into team practice. It is important that all work teams have the opportunity to join together in an atmosphere that is social and not work focussed. This is crucial when the nature of the work requires constant emotional processing and holding of complexities of human nature. Some lightness needs to intervene and can serve to revitalise the practice of the team. Such support, education and training is then reflected in the ongoing work practice. As Byrne and Jones (1998) observed, the therapeutic milieu created by cohesive and well-supported teamwork invariably enhances the treatment that is provided.

## 10.3 Methodological implications of the study for future research

### 10.3.1 Developing a research culture within the clinical setting

As Shirk (2001) observed, from a service perspective, one of the major challenges of our time involves the implementation of empirically supported treatment in clinical settings. For the child psychiatry research methodology recommendations, reviewed above in Section 2.1.1 of Chapter 2, to be actively considered, it is necessary to facilitate a research culture within the clinical setting. Jacobs and Green (1998d) noted that generating a research culture, particularly within an inpatient unit is at best a gradual task. Drawing from the experience of this current study and other research literature, combined with developments in the field of psychotherapy and research, several recommendations are made to facilitate this process.

First, clarity regarding research role ownership and where possible, sharing of the research task is essential. In reviewing the enormous effort required in combining both clinical and research leadership within an inpatient unit, Riddle (1989) suggested that the roles be divided between a clinical director and a research director on the unit. Also emphasised was the importance of engaging the nursing team from the earliest stages of the project, to facilitate an ownership of the research task. Where possible, however, to reduce problems of clinical bias, the use of non-clinical staff in formal data collection was suggested. As Jacobs and Green (1998) noted, this enables the research and clinical tasks to be separated and requires fewer research skills of clinical staff. Moreover, it is essential that resources are allocated not just for the programme service delivery but also adequate resources are provided for evaluation of programmes. Finally, as observed by Curry (2004), successful partnerships between university departments and child inpatient units have demonstrated the use of combining the resources of both settings to attain both practical and meaningful data. Such partnerships can reduce the burden of the research enterprise on the inpatient staff and provide supportive collaboration between the university and inpatient team.

Secondly, it is important to facilitate making outcome assessment routine within an inpatient setting. Moore and O'Connor (1991) recommended that a standardised component of evaluative research be built into normal clinical practice. Many

inpatient units use a standardised assessment procedure in any case, and unit staff certainly have at hand the clinical information needed to respond to such procedures. Therefore this information could be readily tapped for research purposes and assist in the assimilation of a research oriented attitude into the clinical setting (Jacobs & Green, 1998; Moore & O'Connor) and the individual's clinical practice. As Curry (2004) most recently observed, a range of assessment methods that are widely accepted and easily administered are now becoming available for use in child inpatient research. As observed in Chapter 2, Section 2.2.2, parent-completed, clinician-completed and child self-report rating scales, as well as structured interviews have been employed in a number of child inpatient outcome evaluation studies. Other measures that have been used more commonly with an outpatient population may also in some circumstances be utilised in an inpatient setting to assess treatment outcome.

Thirdly, pooling of data through the usage of multi-site research methodologies that targets specific childhood disorders can assist in focusing child inpatient research attention. As discussed in Chapter 2, Section 2.1.5.2, the tension between the complexity of variables generated in child inpatient outcome research and the comparatively small number of patients treated on inpatient units, is further compounded by multivariate statistical designs needing large numbers to analyse the data (Green & Jacobs, 1998b). If many units use standardised assessment routinely as part of their assessment, pooling of these data from different units may address this issue (Blanz & Schmidt, 2000). The problem of low numbers can be minimised by careful selection of the focus of studies, robust designs that highlight change versus no change, and well chosen measures (Blanz & Schmidt; Jacobs & Green, 1998). As Curry (2004) observed, methodologies have been developed to conduct such multi-site research. Such an undertaking would however require a more integrated research culture among child psychiatry inpatient clinicians (Jacobs & Green), such as that reported by the Finnish multi-centre studies conducted by Sourander and colleagues (Sourander et al., 1995; Sourander & Piha, 1998).

Finally, as Imrie and Green (1998) summarised, a more integrated research culture would assist child psychiatry to look towards the emergence of critical mass of research centres, the development of shared conceptual approaches and instruments, the gradual accumulation of partial but interlocking studies, and an unfolding of



consensus of knowledge. When research is meaningful and well integrated into the clinical culture, it can promote self-observation and evaluation of interventions that will make us more consistent with our theories and more aware of the values clinicians impose in the context of those theories (Cornsweet, 1990).

### 10.3.2 Viewing outcome as a longitudinal, multi-dimensional phenomenon

In planning research, a longitudinal design which gives close attention to pre-treatment, post-treatment and follow-up data (preferably over a number of time intervals) is important. Pre-treatment data provide baseline information in the case of single subject design and assist in demonstrating group equivalency (Peterson & Bell-Dolan, 1995) and the type and severity of problems under investigation (Durlak et al., 1995). Post-treatment data are critical in determining the treatment effect, while follow-up data are needed to provide evidence of maintenance of treatment effects (Peterson & Bell-Dolan). As shown in the child inpatient studies reviewed and summarised in Sections 2.2.1.2 and 2.2.1.3 of Chapter 2, maintenance of treatment effects can be difficult to establish due to factors such as resilience, the natural recovery (or maturational) process (Salzer, 1996), and sleeper effects (Sheerin et al., 1999; Sourander & Leijala, 2002), as well as other specific treatment, individual and family variables, and mechanisms of therapeutic change (Kazdin & Nock, 2003).

In addition to a longitudinal research design, it is essential to incorporate the use of multiple informants, as well as the use of multiple measures and attention to multiple domains of functioning. The use of multiple informants (parents, teacher, child and clinician), providing parallel and complementary information is viewed as desirable. The noted low rate of agreement among informants highlights the importance of drawing on multiple perspectives to build a detailed, well articulated picture of the presenting difficulties and outcomes (Ferdinand et al., 2003). It would be useful for parent data collection to include, where possible, both parents. To date, the majority of child psychiatry inpatient studies have focussed on mother-reporting only in reference to the child. Input from fathers has been strikingly limited. Moreover, the paucity of information available comparing parent and clinician (Garcia et al., 2002; Rey et al., 1999) and parent and child (Chesson et al., 1997) perceptions could be redressed.

Indeed, comparison of parent and child views on outcomes, and comparing these further with clinicians' views, would assist in informing and directing therapeutic practice.

A comprehensive range of measures to assess outcome is also considered to be necessary. It is important that these measures are well-standardised and validated. In addition, it is essential that multiple domains of functioning - child, parent and family functioning - as well as measures of social impact are incorporated into outcome measures (Kazdin, 2003). Child functioning includes symptomatology, impairment, prosocial competence, and academic functioning. Parent and family functioning can incorporate dysfunction, contextual issues such as stress and quality of life, and conditions that promote adaptation such as family relations and organisation. Finally, social impact measures should include school activities, attendance and truancy, and service usage such as reduction in special services and hospitalisations (Kazdin).

Using multiple informants and measures across multiple domains of functioning would also assist in exploring possible mechanisms of therapeutic change.

### 10.3.3 Use of both quantitative and qualitative methodologies

To fully address the multi-dimensionality inherent in child psychiatry, and in particular in work with treatment resistant multi-problem families, both quantitative and qualitative research methodologies could be effectively utilised. Whilst quantitative methodologies have improved considerably and have begun to incorporate the multidimensional nature of child psychiatry, as reviewed in Sections 2.2.2 and 2.2.3 of Chapter 2, limited qualitative evaluations have been conducted to date.

In reference to quantitative methodology, and in the light of the ethical and design difficulties associated with RCTs in child psychiatry (Blotcky et al., 1984; Epstein, 2004; Target & Fonagy, 1996), the use of other experimental designs requires active consideration. Curry (1991) suggested the options of a between-programme design (comparing a well-defined mode of treatment with an alternative programme offering a different treatment), a within-programme design (where a single programme experiments with two or more alternative treatments within its own setting) and finally an across-programme design (where for instance day and community-based

treatments could be compared with inpatient treatments). These designs warrant consideration in respect to child psychiatry inpatient outcome evaluation.

As commented on in Sections 2.1.2, 2.1.3 and 2.1.4 of Chapter 2, much can be learned from qualitative studies. Qualitative studies may shed light on factors that can either facilitate or inhibit the efficacy of interventions, as well as play a role in quality improvement within inpatient settings. Feedback from children, parents and clinicians in reference to treatment can assist in identifying barriers to improvement that can be addressed by the treating team. Individual semi-structured interviews (rather than the mailed out surveys or questionnaires which dominated the child and family inpatient qualitative studies reviewed in Sections 2.2.2 and 2.2.3 of Chapter 2), conducted prior to treatment, during treatment, at discharge and at follow up could provide valuable information regarding family members' expectations, experience and perceived outcomes of treatment. The therapeutic experience of children and families could then be better conceptualised, and further understanding developed regarding possible mechanisms of therapeutic change.

A further methodological implication for future research is the inclusion of more detailed, qualitative descriptions of the therapeutic underpinnings involved in the creation and maintenance of a therapeutic inpatient environment (Epstein, 2004). Over the years, research emphasis has shifted away from explicit detail regarding the inpatient programme's treatment philosophy and intervention, towards studies of treatment outcome (Epstein). The need for a detailed specification of therapy is particularly important in the changing inpatient setting which incorporates a range of therapies within a milieu setting. In the absence of this information, there is no way of knowing how the theory was put into practice in any given setting. The provision of a more detailed specification of therapy is also important in aiding the exploration of mechanisms of therapeutic change within a given setting, and is crucial when involving a comparison group. For example, programmes that operate as multi-modal with a clear underlying family-oriented systemic focus, could be compared to more traditional inpatient settings which tend to utilise pharmacological interventions more so. In summary, as Epstein observed, in the absence of a precise description of the type of treatment provided and its theoretical underpinnings, the findings of such an evaluation have clear limitations.

In the current study, positive effects of treatment were found from admission to discharge for families engaged in the AC&FRU programme. However, as noted in the clinicians reflections drawn from the Stage 2 in-depth interviews, it was evident that some families benefited more than others from the programme. Therefore, it would be important in any future research to investigate differences between these groups of families and to identify their distinguishing features. Healy and Kennedy's (1993) study, undertaken through the Families Unit at the Cassel Hospital in London has begun some of this work.

Of course, one of the factors contributing to differential rates of improvement could be related to the mechanisms of therapeutic change that are inherent in the programme. Kazdin and Nock (2003) underscored the need to delineate mechanisms of therapeutic change (understanding how psychotherapy works), to assist in maximising treatment effects and ensuring that critical features of therapy are generalised to clinical practice. To date, researchers have paid limited attention to the processes involved in therapy that account for or contribute to therapeutic change (Imrie & Green, 1998; Kazdin, 2000; Sundelin, 1999). Further work is needed in the field as a whole to examine the mechanisms through which child, parent and family changes occur, and the timing and sequence of changes over the course of treatment, and the long-term implications for parent and family changes on child functioning (Kazdin & Wassell, 2000).

As Kazdin and Nock (2003) contended, within research design, two main questions need to be actively explored in this connection. What processes or characteristics within the child, parent or family can be mobilised to foster therapeutic change? What events, processes, activities, and tasks in treatment can foster therapeutic change? However, there is not likely to be a single mechanism or a technique, and two children or two families in the same treatment conceivably could respond for different reasons. The relationship between process measurements and outcome allow clinicians to see how their efforts affect their patients, and hence can provide indicators regarding the directions of child inpatient treatment (Imrie & Green, 1998).

Implied by the findings of the present study, as well as other research on the more recent past, certain mechanisms of therapeutic change are proposed and discussed below. Whilst, primarily relevant to the inpatient setting, they could be applied to a range of child psychiatry treatment settings – inpatient, day patient or outpatient. The proposed variables are investigation of the therapeutic process (quality of the ward environment and milieu functioning, and the therapeutic alliance between the family and the treating team), the impact of programme planning and structure including aftercare planning and follow-up management, and the inter-relationship between child, parent and family variables. While each of these is addressed individually below, considerable overlap between the variables is noted. Moreover, the value of assessing interactions between the different proposed mechanisms of therapeutic change is also noted.

#### 10.4.1 The quality of the ward environment and milieu functioning

Imrie and Green (1998) suggested that it is important to review the quality of the environment and the milieu functioning (ward atmosphere) in order to determine which components or characteristics of inpatient treatment are effective. Measurement of process may be achieved by investigating both staff and patient perceptions of the unit milieu along a number of different dimensions. For instance, inpatient unit staff readily identify when the unit rapidly shifts from a ‘treatment’ environment to ‘containment’ (Green & Jacobs, 1998d). Likewise in the current study, Clinician J indicated, ‘the more volatile cases raised everybody’s anxiety and made collaboration more difficult’.

Imrie and Green have aimed to capture these more transient fluctuations in milieu functioning by investigating some of the influences on these fluctuations such as staff numbers, skill mix, patient characteristics and ward events; and linked these to consequences such as morale and patient attitudes and behaviour. The relationships between process measurements and outcome allow the clinicians to see how their efforts affect their patients. This in turn may provide indicators for future directions of the inpatient work (Imrie & Green).

#### 10.4.2 The therapeutic alliance between the family and the treating team

A further process variable that could be studied in future child psychiatry outcome research is the therapeutic alliance between the family (child, parents and family) and the treating team.

To date, only limited exploration regarding the therapeutic alliance process in child psychiatry has occurred to date. As reviewed above in Chapter 2, Section 2.2.2, only a couple of studies have been reported in the literature. Scharer (1999; 2000) in reference to the relationship that develops between the nurses and parents, found that therapeutic engagement was enhanced when the nurses responded with reassurance and caring, and the relationship was influenced by respective expectations and nursing routines. Puotiniemi et al. (2001; 2002) in their exploration of parental resources and coping factors associated with having a child in psychiatric inpatient care, found that if the parents feel supported and are coping better with the presenting difficulties within the family, then other members/subsystems of the family (including the referred child) may be in a better position to cope also. This links in with Kazdin and Whitley's (2003) study which found the treatment of parental stress enhanced therapeutic change among children, and with findings from the current study, which suggested that the improvements noted in each of the domains of child, parent and family functioning could be seen to be potentially interlinked.

A couple of measures, reported in the literature, have been developed in relation to therapeutic alliance within a child psychiatric setting. Kroll and Green (1998) developed an instrument to measure staff perceptions of family engagement to the unit, while Imrie and Green (unpublished, cited in Imrie & Green, 1998) developed a measure of child relationship to the ward. Both these measures may be reviewed further and potentially utilised in exploring issues related to therapeutic alliance.

Moreover, Chesson (1996) noted there was a need for a greater understanding of inpatient processes. For example, factors promoting and inhibiting (patient) child-staff interactions. The importance of personal qualities of staff, their interaction with each other as well as their capacity to form a therapeutic culture is considered to be a basic building block of inpatient treatment.

#### 10.4.3 The impact of programme planning and structure

Programme planning and structure including pre-admission, admission and aftercare planning, may also be explored as a possible mechanism of therapeutic change. The place and importance of structure and planning within a clinical team has been repeatedly acknowledged. Such a framework assists in providing the necessary holding and containing function required particularly in an inpatient setting when working with multi-problem families. In the current study, drawn from the Stage 2 in-depth interviews with AC&FRU clinicians, the structure and planning were identified as one of the main facilitating factors regarding the effectiveness of the programme. Similarly, Gavidia-Payne et al. (2003) in their Melbourne-based study as reviewed in Chapter 2, Section 2.2.1.2, suggested that the positive outcome findings may be accounted for by features of the case management such as co-ordination with referrers and careful planning at discharge, combined with outpatient treatment following discharge.

Moreover, the place of a set period of inpatient treatment could also be explored. Ney et al. (1988) utilised set admission periods in their inpatient practice and argued that such planning assisted in concentrating staff effort and served to maximize family and community involvement in the treatment process. In the current study noted in the current study (reviewed in Section 3.1.1.3. of Chapter 3 and Section 6.1 of Chapter 6), families admitted to the AC&FRU were generally offered an initial two weeks assessment period which if recommended could then be followed on by a four week treatment phase. Such set periods, it could be argued, facilitated both staff and patients engaged in the therapeutic process.

A further consistent finding reported in past literature is that outpatient treatment following discharge substantially increases the likelihood of continued improvement in child behaviour and functioning (Cornsweet, 1990; Green et al., 2001; Pfeiffer & Strezelecki, 1990). Several of the more recent studies also comment on this (Sourander et al., 1995; Sourander, Helenius, & Piha, 1996).

Furthermore, in reference to mechanisms of therapeutic change, the length of follow-up and the potential for 'sleeping effects' to be activated during the follow-up period, also require exploration in future outcome evaluation work. Possible pathways of 'sleeping

effects' (benefits that accrue to the child and family but only manifest later on in symptom improvement) include providing future professionals with an in-depth understanding of the child and family, enabling the child and family to have some internalised model of psychological functioning and the need for containment and understanding, and/or providing skills for future conflict resolution (Sheerin et al., 1999).

#### 10.4.4 The inter-relationship between child, parent and family variables

Finally, in reference to mechanisms of therapeutic change, in relation to future areas of research exploration, the inter-relationship between child, parent and family variables clearly warrants further attention. As shown in Section 2.2.1 of Chapter 2, outcome evaluation of child inpatient psychiatry has typically focussed on child outcome, largely to the exclusion of other potentially inter-related domains of functioning such as parent, sibling and family. When reporting on child functioning, mother-reported data has predominately been utilised, with father-reported data being notably under-represented. When studies, from other child psychiatry settings have included father-reported data (Sawyer et al., 1988; Sundelin & Hansson, 1999), clear discrepancies between father and mother perceptions have been observed. This was also noted in the current study as outlined in Section 9.2.4 of Chapter 9. Similarly, despite the repeated recognition that family dysfunction potentially impacts on all family members, sibling data also have not featured in the child psychiatry literature in an ongoing and informed manner. Further research specifically addressing these variables (child, sibling, parent and family) and their potential inter-relationship may further assist in determining mechanism of therapeutic change.

Insofar as child, parent, and family functioning are interrelated, reductions in child difficulties might influence parent and family functioning (Kazdin & Wassell, 2000). Child disorders are often associated with parent, family, and contextual factors, with parent and child influences recognised to be reciprocal, bidirectional, and interdependent (Bell & Harper, 1977; Deater-Deckard, 1998). Puotiniemi et al. (2001; 2002), in their exploration of parental resources and coping factors associated with having a child in psychiatric inpatient care, found that when the parents feel supported and are coping better with the presenting difficulties within the family, then other members/subsystems of the family (including the referred child) may also be in a better



position to cope with stress. This links in with Kazdin and Whitley's (2003) study which found the treatment of parental stress enhance therapeutic change among children. Moreover, in the current study, as suggested in Section 9.2.5 of Chapter 9, the positive changes perceived at each designated level of functioning (child, parent and family), were potentially enhanced by positive changes occurring at other levels of functioning.

As Kazdin and Wassell (2000) speculated, it is possible that the scope of the benefits of child treatment has been underestimated. The changes in parent and family functioning, are not only clinically relevant and important in their own right, but are also likely to reflect important contextual changes that could, in turn, directly influence child functioning and the maintenance of therapeutic changes. The findings of both Stage 1 and Stage 2 of the present study do suggest a resonating multiple concordance of interaction between such factors.

## 10.5 Conclusion

The research reported by this thesis examined the issue of whole family intervention with multi-problem families, beginning with a review of the relevant treatment approaches, and of empirical studies of outcome and process of a range of child psychiatric interventions, including individual child admission, family inpatient admission and family-oriented day patient programmes. The research progressed to an empirical study of a particular whole family inpatient programme, and a retrospective qualitative study of the experience of the clinicians who delivered the programme. It was found that the outcomes of the programme were beneficial to the families involved in several ways, and the reflections of the clinicians upon the work they each contributed to the team afforded some insights into possible process factors in both positive and negative outcomes.

The largely favourable outcomes of this unique programme give rise to a wide range of implications that go beyond family inpatient work. Although this programme, in its dedicated family inpatient treatment format, was discontinued before the evaluation was completed, the research has established the potential value of such an intervention and provides a measure of encouragement to the field to revisit many of the principles elucidated in the implications discussed in this last chapter.

## REFERENCES

- Abroms, G., Fellner, C., & Whitaker, C. (1971). The family enters the hospital. *American Journal of Psychiatry*, 10, 1363-1370.
- Achenbach, T. (1978). The Child Behaviour Profile: I. Boys aged 6-11. *Journal of Consulting & Clinical Psychology*, 46, 478-488.
- Achenbach, T. (1991a). *Manual for the Child Behaviour Checklist/4-18 and 1991 Profile*. Burlington, Vermont: University of Vermont Department of Psychiatry.
- Achenbach, T. (1991b). *Manual for the Youth Self-Report and 1991 Profile*. Burlington, Vermont: University of Vermont Department of Psychiatry.
- Achenbach, T. (1991c). *Manual for the Teacher's Report Form and 1991 Profile*. Burlington, Vermont: University of Vermont Department of Psychiatry.
- Achenbach, T. (1995). Diagnosis, assessment, and co-morbidity in psychosocial treatment research. *Journal of Abnormal Child Psychology*, 23(1), 45-56.
- Achenbach, T., & Edelbrock, C. (1983). *Manual for the Child Behaviour Checklist and Revised Child Behaviour Profile*. Burlington: University of Vermont, Department of Psychiatry.
- Achenbach, T., Hensley, V., Phares, V., & Grayson, D. (1990). Problems and competencies reported by parents of Australian and American children. *Journal of Child Psychology and Psychiatry*, 31(2), 265-286.
- Achenbach, T., McConaughy, S., & Howell, C. (1987). Child/adolescent behaviours and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin*, 101, 213-232.
- Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment*. New Jersey: Erlbaum.

American Psychiatric Association (APA). (1980). *Diagnostic and statistical manual of mental disorders* (3<sup>rd</sup> ed.). Washington, DC: Author.

American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed.). Washington, DC: Author.

Anderson, T. (1991). *The reflecting team: Dialogues and dialogues about dialogues*. New York: W. W. Norton.

Anderson, T. (1993). On a roller coaster: A collaborative language system approach to therapy. In S. Friedman (Ed.), *The new language of change: Constructive collaboration in psychotherapy*. New York: Guilford Press.

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implication for clinical theory. *Family Process*, 27, 371-393.

Anderson, H., & Goolishian, H. (1990). Beyond cybernetics: Comments on Atkinson and Health's 'Further thoughts on second-order family therapy.' *Family Process*, 29, 157-163.

Armbruster, P., Chock, U., Tanner, E., & Holmes, S. (2002). Parent work. In M. Lewis (Ed), *Child and adolescent psychiatry. A comprehensive textbook*. (3<sup>rd</sup> ed.). (pp. 1055-1065). Philadelphia: Lippincott, Williams & Wilkins.

Armbruster, P., & Fallon, T. (1994). Clinical, sociodemographic and systems risk factors for attrition in a children's mental health clinic. *American Journal of Orthopsychiatry*, 64, 577-585.

Arnold, L., & Estricher, D. (1985). *Parent-child group therapy: Building self-esteem in a cognitive behavioural group*. Lexington MA: Lexington Books, D.C. Heath & Co.

Asen, K. (1988). The Marlborough Family Day Unit. *Bulletin of the Royal College of Psychiatrists*, 12, 88-90.

- Asen, E. (2002). Multiple family therapy. An overview. *Journal of Family Therapy*, 24(1), 3-16.
- Baker, P. (1988). The future of residential treatment for children. In C. Schaefer & A. Swanson (Eds), *Children in residential care. Critical issues in treatment*. (pp.1-16). New York: Van Nostrand Reinhold.
- Bandler, D. (1987). Working with other professionals in an in-patient setting. *Journal of Child Psychotherapy*, 13(2), 81-89.
- Bank, I., Patterson, G., & Reid, J. (1996). Negative sibling interaction patterns as predictors of later adjustment problems in adolescent and young males. In G. Brody (Ed.), *Sibling relationships: Their causes and consequences*. (pp. 197-230). New Jersey: Ablex.
- Banks, M. (1983). Validity of the General Health Questionnaire in a young community sample. *Psychological Medicine*, 13, 349-353.
- Banks, M., Clegg, C., Jackson, P., Kemp, N., Stafford, E., & Wall, T. (1980). The use of the General Health Questionnaire as an indicator of mental health in occupational studies. *Journal of Occupational Psychology*, 53, 187-194.
- Barker, C., Pistrang, N., & Elliot, R. (2002). *Research methods in clinical psychology. An introduction for students and practitioners*. (2<sup>nd</sup> ed). West Sussex: John Wiley & Sons Ltd.
- Barkley, R. (1996). Attention-deficit/hyperactivity disorder. In E. Mash & R. Barkley (Eds.), *Child psychopathology*. (pp. 63-112). New York: Guilford.
- Barnes, J., Stein, A., & Rosenberg, W. (1999). Evidence-based medicine and evaluation of mental health services: methodological issues and future directions. *Archives of Diseases of Childhood*, 80(3), 280-285.

- Barnett, R., Docherty, J., & Frommelt, G. (1991). A review of psychotherapy research since 1963. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(1),
- Bartunek, J., & Louis, M. (1996). *Insider/outsider team research*. California: Sage Publications.
- Becvar, D., & Becvar, R. (1988). *Family therapy. A systemic integration*. Boston: Allyn & Bacon.
- Bell, R., & Harper, L. (1977). *Child effects on adults*. New York: Wiley.
- Bettleheim, B. (1949). Milieu therapy: indications and illustrations. *Psychoanalytic Review*, 36, 54-68.
- Bettleheim, B. (1960). *The informed heart*. New York : Free Press.
- Bettleheim, B. (1967). *The empty fortress*. New York: Free Press.
- Bhatti, R., Janakiramaiah, N., & Channabasavanna, S. (1980). Family psychiatric ward treatment in India. *Family Process*, 19, 193-200.
- Bickman, L., Guthrie, P., Foster, E., Lambert, E., Summerfelt, W., Breda, C., & Helfinger, C. (1996). *Evaluating managed mental health services: The Fort Bragg experiment*. New York: Plenum Press.
- Bird, H., Canino, G., Rubio-Stipec, M., Gould, M., Ribera, J., Sesman, M., Woodbury, M., Hueretas-Goldman, S., Pagan, A., Sanchez-Lacay, A., & Moscoso, M. (1988). Estimates of the prevalence of childhood maladjustment in a community survey in Puerto Rico: The use of combined measures. *Archives of General Psychiatry*, 45, 1120-1126.

- Blanz, B., & Schmidt, M. (2000). Practitioner review: Preconditions and outcome of inpatient treatment in child and adolescent psychiatry. *Journal of Child Psychology & Psychiatry*, 41, 703-712.
- Blotcky, M., & Dimperio, T. (1991). Outcome of inpatient treatment. *Journal of the American Academy of Child & Adolescent Psychiatry*, 30(3), 507.
- Blotcky, M., Dimperio, T., & Gossett, J. (1984). Follow-up of children treated in psychiatric hospitals A review of studies. *American Journal of Psychiatry*, 141(12), 1499-1507.
- Bond, L., Nolan, T., Adler, R., & Robertson, C. (1994). The Child Behaviour Checklist in a Melbourne urban sample. *Australian Psychologist*, 29(2), 103-109.
- Bornstein, D., Belcher, N., Buamgartner, S. (1985). Family admission policy in a child psychiatric unit. *Australian & New Zealand Journal of Psychiatry*, 19, 61-70.
- Boscolo, L. (1993). *The times of time. A new perspective in systemic therapy and consultation*. New York: Norton & Company.
- Boscolo, L., Cecchin, G., Hoffman, L., & Penn, P. (1987). *Milan family therapy. Conversations in theory and practice*. New York: Basic Books.
- Bowen, M. (1960). A family concept of schizophrenia. In D. Jackson (Ed.), *The aetiology of schizophrenia*. New York: Basic Books.
- Bowlby, J. (1969). *Attachment and loss: Volume 1. Attachment*. New York: Basic Books.
- Bowlby, J. (1973). *Attachment and loss: Volume 2. Separation: Anger and anxiety*. New York: Basic Books.
- Bowlby, J. (1980). *Attachment and loss. Volume 3. Loss: Sadness and depression*. New York: Basic Books.

Bradley, E., & Clark, B. (1993). Patients characteristics and consumer satisfaction on an inpatient child psychiatric unit. *Canadian Journal of Psychiatry*, 38, 175-180.

Brady, E., & Kendall, P. (1992). Comorbidity of anxiety and depression in children and adolescents. *Psychological Bulletin*, 3, 244-255.

Britton, R. (1980). Re-enactment as an unwitting professional response to family dynamics. In S. Box, B. Copley, J. Magagna, & E. Moustaki (Eds.), *Psychotherapy with families: An analytic approach*. (pp. 48-58). London: Routledge & Kegan Paul.

Brendler, J. (1987). A perspective on the brief hospitalisation of whole families. *Journal of Family Therapy*, 9, 113-130.

Brendler, J., & Combrinck-Graham, L. (1986). The treatment of hospitalised families of young children. *Family Therapy Collections*, 18, 85-95.

Breuer, J., & Freud, S. (1895/1955). Case histories. In J. Strachey (ed. and trans.), *The standard edition of the complete works of Sigmund Freud* (Vol. 2). London: Hogarth Press.

Brown, J. (1991). Family involvement in the residential treatment of children: A systemic perspective. *Australian & New Zealand Journal of Family Therapy*, 12(1), 17-22.

Byng-Hall, J. (1973). Family myths used as defence in conjoint family therapy. *British Journal of Psychology*, 46, 239-250.

Byng-Hall, J. (1979). Re-editing family mythology during family therapy. *Journal of Family Therapy*, 1, 103-106.

Byng-Hall, J. (1995a). Creating a secure family base: some implications of attachment theory for family therapy. *Family Process*, 34, 45-58.

Byng-Hall, J. (1995b). *Rewriting family scripts: Improvisation and systems change*. New York: Guildford Press.

Byng-Hall, J. (1998). Evolving ideas about narrative: re-editing and re-editing of family mythology. *Journal of Family Therapy*, 20, 133-141.

Byrne, G., & Jones, D. (1998). Severe breakdown in the parenting of infants. In J. Green & B. Jacobs (Eds), *Inpatient child psychiatry. Modern practice, research and the future*. (pp.297-306). London: Routledge Kegan.

Cafferty, H., & Leichtman, M. (2001). Facilitating the transition from residential treatment into the community. II. Changing social work roles. *Residential Treatment for Children and Youth*, 19(2), 13-26.

Callias, M. (1992). Evaluation of interventions with children and adolescents. In D. Lane & A. Miller (Eds), *Child and adolescent therapy* (pp. 39-64). Buckingham, England: Open University Press.

Caron, C., & Rutter, M. (1991). Comorbidity in child psychopathology: Concepts, issues and research strategies. *Journal of Child Psychology and Psychiatry*, 32, 1063-1080.

Carr, A. (2000). *Family therapy. Concepts, process and practice*. Chichester: John Wiley & Sons.

Charmaz, K. (1991). *Good days, bad days: The self in chronic illness and time*. New Jersey: Rutgers University Press.

Chesson, R. (1996). Dimensions of therapeutic input. A research study. In R. Chesson & D. Chisholm, (Eds.), *Child psychiatric units: at the crossroads*. (pp. 196-223). London: Jessica Kingsley.



Chesson, R., Harding, L., Hart, C., & O'Loughlin, V. (1997). Do parents and children have common perceptions of admission, treatment and outcome in a child psychiatric unit? *Clinical Child Psychology and Psychiatry*, 2(2), 251-270.

Chiesa, M., Drahorad, C., & Rocco, M. (1998). The inpatient treatment of families suffering from severe psychiatric pathologies at the Cassel Hospital. (Italian). *Interazione*, 2, 23-37. (abstract only)

Churven, P., & Cintio, B. (1983). An application of strategic family therapy to a residential child and family psychiatry service: Redbank House. *Australian & New Zealand Journal of Psychiatry*, 17, 191-195.

Churven, P., & Durrant, M. (1983). The admission of the whole family in a child psychiatry setting: A follow-up study. *Australian Journal of Family Therapy*, 4(3), 153-158.

Cohen, M. (1995). The triggers of heightened parental uncertainty in chronic life-threatening childhood illness: A process analysis. *Research in Nursing and Health*, 18, 39-48.

Combrinck-Graham, L. (1985). Hospitalisation as a therapeutic intervention in the family. In R. Ziffer (Ed.), *Adjunctive techniques in family therapy*. (pp. 99-124). Grune & Stratton.

Combrinck-Graham, L. (1990). Developments in family systems theory and research. *Journal of the American Academy of Child & Adolescent Psychiatry*, 29(4), 501-512.

Combrinck-Graham, L., Gursky, E., & Brendler, J. (1982). Hospitalisation of single-parent families of disturbed children. *Family Process*, 21, 141-152.

Cooklin, A., Miller, A., & McHugh, B. (1983). An institution for change: developing a family day unit. *Family Processes*, 22, 453-467.

- Coombe, P. (1996). The Cassel Hospital, London. *Australian & New Zealand Journal of Psychiatry*, 30, 672-680.
- Cordell, A., & Allen, S. (1997). Integration of therapeutic approaches in working with children. *The Journal of Psychotherapy & Research*, 6(1), 45-58.
- Cornsweet, C. (1990). A review of research on hospital treatment of children and adolescents. *Bulletin of the Menninger Clinic*, 54, 64-77.
- Creswell, J. (1994). *Research designs: Qualitative and quantitative approaches*. California: Sage Publications.
- Crijnen, A., Achenbach, T., & Verhulst, F. (1999). Problems reported by parents of children in multiple cultures: The Child Behaviour Checklist Syndrome constructs. *American Journal of Psychiatry*, 156(4), 569-574.
- Crouch, W. (1998). The therapeutic milieu and treatment of emotionally disturbed children: Clinical application. *Clinical Child Psychology and Psychiatry*, 3(1), 115-129.
- Crowley, M., & Kazdin, A. (1998). Child psychosocial functioning and parent quality of life among clinically referred children. *Journal of Child & Family Studies*, 7, 233-251.
- Curry, J. (1991). Outcome research on residential treatment: Implications and suggested directions. *American Journal of Orthopsychiatry*, 61(3), 348-357.
- Curry, J. (2004). Future directions in residential treatment outcome research. *Child & Adolescent Clinics of North America*, 13, 429-440.
- Dadds, M. (1995). *Families, Children, and the Development of Dysfunction*. London: Sage Publications.
- Davidson, B., Quinn, W., & Josephson, A. (2001). Assessment of the family. Systemic and developmental perspectives. *Child & Adolescent Clinics of North America*, 10(3), 415-429.

Deater-Deckard, K. (1998). Parenting stress and child adjustment: some old hypotheses and new questions. *Clinical Psychology Science & Practice*, 5(3), 314-332.

Demmitt, A., & Joanning, H. (1998). A parent-based description of residential treatment. *Journal of Family Psychotherapy*, 9(1), 47-66.

deShazer, S. (1985). *Keys to solution in brief therapy*. Los Angeles: Tarcher.

deShazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: W. W. Norton.

deShazer, S. (1991). *Putting differences to work*. New York: W. W. Norton.

Diamond, G., Serrano, A., Dickly, M., & Sonis, W. (1996). Current status of family-based outcome and process research. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(1), 6-16.

Dickerson Mayes, S., Calhoun, S., Krecko, V., Vesell, H., & Hu, J. (2001). Outcome following child psychiatric hospitalisation. *The Journal of Behavioural Health Services & Research*, 28(1), 96-103.

Dickerson Mayes, S., Krecko, V., Calhoun, M., Vesell, H., Schuch, S., & Toole, W. (2001). Variables related to outcome following child psychiatric hospitalisation. *General Hospital Psychiatry*, 23, 278-284.

Diekstra, R. (1995). Depression and suicidal behaviours in adolescence: Sociocultural and time trends. In M. Rutter (Ed.), *Psychosocial disturbances in young people*. Cambridge: Cambridge University Press.

Dunn, J. (1983). Sibling relationships in early childhood. *Child Development*, 54, 787-811.

- Dunn, J. (1992). Sisters and brothers: current issues in developmental research. In F. Boer & J. Dunn (Eds.), *Children's sibling relationships*. (pp. 1-17). New Jersey: Lawrence Erlbaum.
- Durlak, J., Wells, A., Cotton, J., & Johnson, S. (1995). Analysis of selected methodological issues in child psychotherapy research. *Journal of Clinical Child Psychology*, 24, 141-148.
- Dwivedi, K. (1998a). Group work in child mental health services. In K. Dwivedi (Ed.), *Group work with children and adolescents. A Handbook*. (pp.290-306). London: Jessica Kingsley.
- Dwivedi, K. (1998b). Introduction. In K. Dwivedi (Ed), *Group work with children and adolescents. A Handbook*. (pp.1-13). London: Jessica Kingsley.
- Dwivedi, K. (1998c). Conceptual frameworks. In K. Dwivedi (Ed), *Group work with children and adolescents. A Handbook*. (pp.28-45). London: Jessica Kingsley.
- Dydyk, B., French, G., Gertsman, C., & Morrison, N. (1982). Admission of whole families. *Canadian Journal of Psychiatry*, 27, 640-643.
- Dydyk, B., French, G., Gertsman, C., Morrison, N., & O'Neill, I. (1989). Admitting whole families: An alternative to residential care. *Canadian Journal of Psychiatry*, 34, 694-699.
- Edelbrock, C. (1985). Child Behaviour Rating Form. *Psychopharmacology Bulletin*, 21, 835-837.
- Edelbrock, C. & Achenbach, T. (1980). A typology of child behaviour profile patterns. Distribution and correlates for disturbed children aged 6-16. *Journal of Abnormal Child Psychology*, 8, 441-470.

- Epstein, R. (2004). Inpatient and residential treatment effects for children and adolescents: A review and critique. *Child & Adolescent Clinics of North America*, 13(2), 411-428.
- Epstein, N., Baldwin, L., Bishop, D. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy*, 9, 171-180.
- Epstein, N., & Bishop, D. (1981). Problem-centred systems therapy of the family. In A. Gurman & D. Kniskern (Eds.), *Handbook of family therapy*. (pp. 444-482). New York: Brunner/Mazel.
- Ertmer, P. (1997). Common qualitative research designs. In P. Leedy (Ed), *Practical research. Planning and design*. (6th ed.). (pp.155-172). New Jersey: Merrill.
- Eysenck, H. (1952). The effects of psychotherapy: an evaluation. *Journal of Consulting Psychology*, 16, 319-324.
- Fahlberg, V. (1990). *Residential treatment: a tapestry of many therapies*. Indianapolis: Perspectives Press.
- Fagan, A., & Najman, J. (2003). Association between early childhood aggression and internalising behaviour for sibling pairs. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(9), 1093-1100.
- Ferdinand, R., Hoogerheide, K., van der Ende, J., Visser, J., Koot, H., Kasius, M., & Verhulst, F. (2003). The role of the clinician: Three year predictive value of parents', teachers, and clinicians' judgement of childhood psychopathology. *Journal of Child Psychology & Psychiatry & Allied Disciplines*, 44(6), 867-876.
- Ferholt, J. (2002). Psychodynamic parent psychotherapy: Treating disorders in parenting and in the parent-child relationship. In M.Lewis (Ed), *Child and adolescent psychiatry. A comprehensive textbook*. (3<sup>rd</sup> ed.) (pp. 1065-1077). Philadelphia: Lippincott, Williams & Wilkins.

Fiese, B., & Bickman, N. (1998). Qualitative inquiry: An overview for paediatric psychology. *Journal of Pediatric Psychology*, 23(2), 79-86.

Fitzpatrick, R., & Boulton, M. (1994). Qualitative methods for assessing health care. *Quality in Health Care*, 3, 107-113.

Flaskas, C. (1996). Understanding the therapeutic relationship: using psychoanalytic ideas in the systemic context. In C. Flaskas & A. Perlesz (Eds), *The therapeutic relationship in systemic therapy*. London: Karnac Books.

Flaskas, C. (1997). Engagement and the therapeutic relationship in systemic therapy. *Journal of Family Therapy*, 19(3), 263-282.

Folkart, L. (1964). The role of the child psychotherapist in an in-patient setting. *Journal of Child Psychotherapy*, 1, 44-54.

Fonagy, P., Target, M., Cottrell, D., Phillips, J., & Kurtz, Z. (2002). *What works for whom? A critical review of treatments for children and adolescents*. New York: The Guilford Press.

Framo, J. (1976). Family of origin as a therapeutic resource for adults in marital and family therapy: You can and should go home again. *Family Process*, 15, 193-210.

Framo, J. (1981). The integration of marital therapy sessions with family of origin. In A. Gurman & D. Kniskern (Eds.), *Handbook of family therapy*. (pp.133-158). New York: Brunner/Mazel .

Framo, J. (1992). *Family-of-origin therapy: An intergenerational approach*. New York: Brunner/ Mazel.

Frank, J., & Frank, J. (1991). *Persuasion and healing: A comparative study of psychotherapy*. (3<sup>rd</sup> ed.) Baltimore: John Hopkins University.

Freemantle, N., & Maynard, A. (1994). Something rotten in the state of clinical and economic evaluations? *Health Economics*, 3, 63-67.

Freud, A. (1946). *The psycho-analytical treatment of children*. London: Imago Publishing.

Fuller, M. (1995). More is less: Increasing access as a strategy for managing health care costs. *Psychiatric Services*, 46(10), 1015-1017.

Gall, M., Borg, W., & Gall, J. (1996). *Educational research: An introduction*. New York: Longman.

Garcia, R., Josphe, T., Turk, J., & Basu, R. (2002). A comparison of parent and therapist ratings of outcome in a child mental health clinic. *Child & Adolescent Mental Health*, 7(4), 168-172.

Garton, A., Zubrick, S., & Silburn, S. (1995). The Western Australian child health survey: A pilot study. *Australian & New Zealand Journal of Psychiatry*, 29, 48-57.

Gavidia-Payne, S., Littlefield, L., Hallgren, M., Jenkins, P., & Coventry, N. (2003). Outcome evaluation of a statewide child inpatient mental health unit. *Australian & New Zealand Journal of Psychiatry*, 37(2), 204-211.

Gerardot, R., Thyer, B., Mabe, P., & Poston, P. (1992). The effects of psychiatric hospitalisation on behaviourally disordered children: A preliminary evaluation. *The Psychiatric Hospital*, 23, 2, 65-68.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Doubleday.

Goldenberg, I., & Goldenberg, H. (1996). *Family therapy. An overview.* (4<sup>th</sup> ed.). California: Brooks/Cole Publishing Company.

Goldberg, D. (1972). *The detection of psychiatric illness by questionnaire.* London: Oxford University Press.

Goldberg, D., Gater, R., Sartorius, N., Ustun, T., Piccinelli, M., Gureje, O., & Rutter, C. (1997). The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychological Medicine*, 27, 191-197.

Goldberg, D., & Hillier, V. (1979). A scaled version of the general health questionnaire. *Psychological Medicine*, 9, 139-145.

Goldberg, D., & Williams, P. (1988). *A user's guide to the General Health Questionnaire.* Berkshire: NFER-Nelson.

Goldfried, M., & Wolfe, B. (1996). Psychotherapy practice and research. Repairing a strained alliance. *American Psychologist*, 51(10), 1007-1016.

Goren, S. (1979). A systems approach to emotional disorders of children. *Nursing Clinics of North America*, 14(3), 457-465.

Graetz, B. (1991). Multidimensional properties of the General Health Questionnaire. *Social Psychiatry & Psychiatric Epidemiology*, 26, 132-138.

Graham, P. (2000). Treatment interventions and findings from research: bridging the chasm in child psychiatry. *British Journal of Psychiatry*, 176, 414-419.

Green, J., & Jacobs, B. (1998a). Current challenges. In J. Green & B. Jacobs (Eds.), *Inpatient child psychiatry, modern practice, research and the future.* (pp.3-8). London: Routledge.



Green, J., & Jacobs, B. (1998b). Current practice: A questionnaire survey of in-patient child psychiatry in the United Kingdom. In J. Green & B. Jacobs (Eds.), *Inpatient child psychiatry, modern practice, research and the future*. (pp.9-21). London: Routledge.

Green, J., & Jacobs, B. (1998c). Methodological issues and future directions for inpatient research. In J. Green & B. Jacobs (Eds.), *Inpatient child psychiatry, modern practice, research and the future*. (pp.339-346). London: Routledge.

Green, J., Kroll, L., Imrie, D., Frances, F., Begum, K., Harrison, L., & Anson, R. (2001). Health gains and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40(3), 325-333.

Grunebaum, H., Weiss, J., Hirsch, L., & Barret, J. (1963). *The baby on the ward*. *Psychiatry*, 26, 39-53.

Haley, J., & Hoffman, L. (1967). *Techniques of family therapy*. New York: Basic Books.

Hallstrom, A. (1991). Multiple impact family therapy. A family treatment model in a rural area. *Nordic Journal of Psychiatry*, 45, 287-297. (English abstract only, Swedish paper).

Hallstrom, A. (1992). Multiple impact family treatment. Long-term evaluation by means of tailored target criteria. *Nordic Journal of Psychiatry*, 46, 245-256. (English abstract only, Swedish paper).

Hanrahan, G. (1986). Beginning work with families of hospitalised adolescents. *Family Process*, 25, 391-405.

Harter, S. (1982). The perceived competence scale for children. *Child Development*, 53, 87-97.

Harter, S., & Pike, R. (1981). *Teacher's Rating Scale of Child's Actual Competence and Social Acceptance*. Denver: University of Denver.

Healy, K., & Kennedy, R. (1993). Which families benefit from inpatient psychotherapeutic work at the Cassel Hospital? *British Journal of Psychotherapy*, 9(4), 394-404.

Healy, K., Kennedy, R., & Sinclair, J. (1991). Child physical abuse observed. Comparison of families with and without history of child abuse treated in an in-patient family unit. *British Journal of Psychiatry*, 158, 234-237.

Henao, S. (1985). A systems approach to family medicine. In S. Henao & N. Grose (Eds.), *Principles of family systems in family medicine*. New York: Brunner Mazel.

Henggeler, S., & Borduin, C. (1990). *Family therapy and beyond: A multisystemic approach to treating the behaviour problems of children and adolescents*. California: Brooks/Cole.

Henggeler, S., Rowland, M., Halliday-Boykins, C., Sheidow, A., Ward, D., Randall, J., Pickrel, S., Cunningham, P., & Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalisation of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42, 543-551.

Henggeler, S., Rowland, M., Randall, J., Ward, D., Pickrel, S., Cunningham, P., Miller, S., Edwards, J., Zealberg, J., Hand, L., & Santos, A. (1999). Home-based multisystemic therapy as an alternative to the hospitalisation of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38(11), 1331-1339.

Henggeler, S., Schoenwald, S., & Pickrel, S. (1995). Multisystemic therapy: bridging the gap between university and community-based treatment. *Journal of Consulting & Clinical Psychology*, 5, 709-717.

Hensley, V. (1988). Australian normative study of the Achenbach Child Behaviour Checklist. *Australian Psychologist*, 23(3), 371-382.

Herbert, M. (2001). Clinical formulation. In T. Ollendick (Ed), *Child and adolescent clinical formulations and treatment. Comprehensive clinical psychology*. Vol. 5. (pp. 25-55). Oxford: Elsevier Science Ltd.

Hildebrand, J., Jenkins, J., Carter, D., Lask, B. (1981). The introduction of a full family orientation in a child psychiatric in-patient unit. *Journal of Family Therapy*, 3, 139-152.

Hinshelwood, R. (1987). *What happens in groups*. London: Free Association Press.

Hoagwood, K., & Rupp, A. (1995). Mental health service needs, use and costs for children and adolescents with mental disorders and their families: Preliminary evidence. *Psychiatric Times*, March, 62-63.

Hoffman, L. (1981). *The foundations of family therapy*. New York: Basic Books.

Hollingshead, A. (1975). *Four-factor index of social status*. New Haven: Yale University Department of Sociology.

Hudson, A. (2001). Applied behaviour analysis. In T. Ollendick (Ed), *Child and adolescent clinical formulations and treatment. Comprehensive clinical psychology*. Vol. 5. (pp. 107-147). Oxford: Elsevier Science Ltd.

Imrie, D. & Green, J. (1998). Research into efficacy and process of treatment. In J. Green & B. Jacobs (Eds), *Inpatient child psychiatry, modern practice, research and the future*. (pp.333-338). London: Routledge.

Ireland, L., & Hollway, I. (1996). *Qualitative health research with children. Children & Society*, 10, 155-164.

Jacobs, B. (1998). Behavioural and cognitive therapies. In J. Green & B. Jacobs (Eds), *Inpatient child psychiatry, modern practice, research and the future*. (pp.110-123). London: Routledge.

Jaffa, T. (1995). *Adolescent psychiatry services*. British Journal of Psychiatry, 166, 306-310.

Jenkins, P., McLoughlin, A., Evans, H., Volk, D., & Littelfield, L. (1995). *Research project proposal: An evaluation of inpatient family psychiatric treatment*. Application presented to the Child & Adolescent Mental Health Service Innovative Project Grants. Child & Adolescent Mental Health Service, Austin & Repatriation Medical Centre, Melbourne, Victoria, Australia.

Jensen, P., Hoagwood, K., Petti, T. (1996). Outcomes of mental health care for children and adolescents: II. Literature review and application of a comprehensive model. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(8), 1064-1077.

Jensen, J., & Whittaker, J. (1989). Partners in care: Involving parents in children's residential treatment. In R. Lyman, S. Prentice-Dunn, & S Gabel (Eds.), *Residential and in-patient treatment of children and adolescents*. (pp.207-227). New York: Plenum Press.

Johnson, D., & Savage, M. (1967). The admission of mother and child: An approach to family therapy. *Canadian Psychiatric Association Journal*, 12, 409-411.

Jones, D. (1996). Management of the sexually abused child. *Advances in Psychiatric Treatment*, 2, 30-45.

Jones, D. (1997). Treatment of the child and the family where child abuse or neglect has occurred. In R. Helfer, R. Kempe, & R. Krugman (Eds), *The battered child*. (5th ed.). (pp.521-542). Chicago: University of Chicago Press.

Jones, M. (1991). Measuring outcomes. In K. Wellls & D. Biegel (Eds), *Family preservation services: research and evaluation*. Sage focus editions. Vol. 129. (pp.159-186). California: Sage Publications.

Jones, R. (1995). Why do qualitative research? *British Medical Journal*, 311, 2.

Jones, R., Latkowski, M., Kircher, J., & McMahon, W. (1988). The Child Behaviour Checklist: Normative information for inpatients. *Journal of the American Academy of Child & Adolescent Psychiatry*, 27(5), 632-635.

Josephson, A. (2002). Family therapy. In M. Lewis (Ed.), *Child and adolescent psychiatry. A comprehensive textbook*. (pp.1036-1054). Philadelphia: Lippincott Williams & Wilkins.

Kahn, M. (1986). The self and the system: Integrating Kohut and Milan. In J. Hansen & S. Sugarman (Eds.), *The interface of individual and family therapy*. (pp.50-64). Rockville MD: Aspen.

Kazdin, A. (1990). Premature termination from treatment among children referred for antisocial behaviour. *Journal of Child Psychology and Psychiatry*, 31, 415-425.

Kazdin, A. (1993). Treatment of conduct disorder: Progress and directions in psychotherapy research. *Development and Psychopathology*, 5, 277-310.

Kazdin, A. (1995). Scope of child and adolescent psychotherapy research: Limited sampling of dysfunctions, treatments, and client characteristics. *Journal of Clinical Child Psychology*, 24(2), 125-140.

Kazdin, A. (1997). Parent management training: Evidence, outcomes and issues. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, 1329-1356.

Kazdin, A. (1998). Conduct disorder. In R. Morris & T. Kratchowill (Eds.), *The practice of child therapy*. (3<sup>rd</sup> ed.). (pp.199-230). Boston: Allyn & Bacon.

Kazdin, A. (2000). *Psychotherapy for children and adolescence: Directions for research and practice*. New York: Oxford University Press.

Kazdin, A. (2003). Psychotherapy for children and adolescents. *Annual Review of Psychology*, 54, 253-276.

Kazdin, A., & Bass, D. (1988). Parent, teacher, and hospital staff evaluations of severely disturbed children. *American Journal of Orthopsychiatry*, 58(4), 512-523.

Kazdin, A., Bass, D., Ayers, W., & Rodgers, A. (1990). The empirical and clinical focus of child and adolescent psychotherapy research. *Journal of Consulting & Clinical Psychology*, 58, 729-740.

Kazdin, A., & Nock, M. (2003). Delineating mechanisms of change in child and adolescent therapy; Methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry*, 44(8), 1116-1129.

Kazdin, A., Siegel, T., & Bass, D. (1990). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behaviour. *Journal of Consulting & Clinical Psychology*, 60, 733-747.

Kazdin, A., & Wassell, G. (2000). Therapeutic changes in children, parents, and families resulting from treatment of children with conduct problems. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(4), 414-442.

Kazdin, A., & Whitley, M. (2003). Treatment of parental stress to enhance therapeutic change among children referred for aggressive and antisocial behaviour. *Journal of Consulting and Clinical Psychology*, 71(3), 504-515.

Keepers, T. (1987). Group treatment of children. Practical considerations and techniques. In P. Keller & S. Heyman (Eds.), *Innovations in clinical practice* 6. (pp. 165-175). Sarasota: Professional Resource Exchange.

Keith, D., & Whitaker, C. (1981). Play therapy: a paradigm of work with families. *Journal of Marital and Family Therapy*, 6, 243-254.

Kennedy, R. (1987). Work of the day. Aspects of work with families at the Cassel Hospital. In R. Kennedy, A. Heyman, & L. Tischler (Eds.), *The family as in-patient. Families and adolescents at the Cassel Hospital*. (pp. 27-48). London: Free Association Books.

Kennedy, R., Heyman, A., & Tischler, L. (1987). *The family as in-patient. Families and adolescents at the Cassel Hospital*. London: Free Association Books.

Kiser, L., Millsap, P., Hickerson, S., Heston, J., Nunn, W., Pruitt, D., & Rohr, M. (1996). Results of treatment one year later: Child and adolescent partial hospitalisation. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(1), 81-90.

Klein, M. (1932). *The psychoanalysis of children*. London: Hogarth Press.

Kline, P. (1995). An exploratory investigation of family functioning for child inpatients: Implications for practice. *Child & Adolescent Social Work Journal*, 12(6), 423-434.

Knapp, M. (1997). Economic evaluations and interventions for children and adolescents with mental health problems. *Journal of Child Psychology and Psychiatry*, 38(1), 3-25.

Kolko, D. (1992). Short-term follow-up of child psychiatric hospitalisation: Clinical description, predictors, and correlates. *Journal of the American Academy of Child & Adolescent Psychiatry*, 31(4), 719-727.

Kovacs, M., & Lohr, W. (1995). Research on psychotherapy with children and adolescents: An overview of evolving trends and current issues. *Journal of Abnormal Child Psychology*, 23(1), 11-29.

Korner, S. (1988). Family therapists and children: a case of neglect? *Psychotherapy in Private Practice*, 6, 101-113.

- Krahn, G., Hohn, M., & Kime, C. (1995). Incorporating qualitative approaches into clinical child psychology research. *Journal of Clinical Child Psychology*, 24(2), 204-213.
- Kroll, L., & Green, J. (1997). The therapeutic alliance in child inpatient treatment: Development and initial validation of a family engagement questionnaire. *Clinical Child Psychology and Psychiatry*, 2(3), 431-447.
- Kurtz, Z., Thornes, R., & Wolkind, S. (1995). *Services for the mental health of children and young people in England: Assessment of needs and unmet need*. London: South West Thames.
- Kymissis, P. (1997). Group therapy. *Child & Adolescent Psychiatric Clinics of North America*, 6(1), 173-184.
- Larner, G. (2000). Towards a common ground in psychoanalysis and family therapy: on knowing not to know. *Journal of Family Therapy*, 22, 61-82.
- Lebow, J. (1987). Integrative family therapy. An overview of major issues. *Psychotherapy: Theory, Research, and Training*, 24, 584-594.
- Leichtman, M. (2001). Facilitating the transition from residential treatment into the community. III. Changing roles of nursing and child care staff. *Residential Treatment for Children and Youth*, 19(2), 27-38.
- Leichtman, M. & Leichtman, M. (2001a). Facilitating the transition from residential treatment into the community. I. The problem. *Residential Treatment for Children and Youth*, 19(1), 21-27.
- Leichtman, M., & Leitchman, M. (2001b). Facilitating the transition from residential treatment into the community. IV. Making use of community resources. *Residential Treatment for Children and Youth*, 19(3), 43-52.



Lerner, R. (1991). Changing organism-context relations as the basic process of development: a developmental contextual perspective. *Developmental Psychology*, 27, 27-32.

Leventhal, B., & Zimmerman, D. (2004). Preface. Residential treatment. *Child & Adolescent Clinics of North America*, 13, xv-xvii.

Logan, S. (1997). Quantitative versus qualitative methods (editorial). *Child Care Health Development*, 23, 283-285.

Luepnitz, D. (1988). *The family interpreted. Psychoanalysis, feminism and family therapy*. United States of America: Basic Books.

Luepnitz, D. (1997). Feminism, psychoanalysis and family therapy: reflections on telos. *Journal of Family Therapy*, 19, 303-317.

Lynch, M., Steinberg, D., Ounsted, C. (1975). Family unit in a children's psychiatric hospital. *British Medical Journal*, 2, 127-129.

MacGregor, R. (1962). Multiple impact psychotherapy with families. *Family Process*, 1, 15-29.

Madanes, C. (1984). *Behind the one-way mirror. Advances in the practice of strategic therapy*. San Francisco: Jossey-Bass.

Magagna, J. (1998). Psychodynamic psychotherapy in the in-patient setting. In J. Green & B. Jacobs (Eds.), *Inpatient child psychiatry, modern practice, research and the future*. (pp.124-142). London: Routledge.

Main, T. (1958). Mothers with children in a psychiatric hospital. *Lancet*, 2, 845-847.

Malone, C. (1983). Family therapy and childhood disorder. In L. Grinspoon (Ed.), *Psychiatry update: The American Psychiatric Association Annual Review*. (pp.228-248). Washington DC: American Psychiatric Press.

- Martin, G., Rozanes, P., Pearce, C., & Allison, S. (1995). Adolescent suicide, depression and family dysfunction. *Acta Psychiatrica Scandinavia*, 92, 336-344.
- Mash, E., & Krahn, G. (2000). Research strategies in child psychology. In M. Hersen & R. Ammerman (Eds.), *Advanced abnormal child psychology*. (2<sup>nd</sup> ed.). (pp. 101-130). New Jersey: Lawrence Erlbaum Associates.
- Massey, O., & Murphy, S. (1991). A study of the utility of the Child Behaviour Checklist with residentially placed children. *Evaluation Programme Planning*, 14, 319-324.
- McCellan, J., & Werry, J. (2003). Evidence-based treatments in child and adolescent psychiatry. An inventory. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(12), 1388-1400.
- McLoughlin, A. (1996). *Families in crisis: A review of admission of a child psychiatry facility*. Unpublished Master's thesis: La Trobe University, Melbourne, Victoria, Australia.
- McMahon, R. (1999). Parent training. In S. Russ, T. Walker, & T. Ollenduck et al (Eds.), *Handbook of psychotherapies with children and families. Issues in clinical child psychology*. (pp. 154-182). New York: Kluwer Academic/Plenum.
- Miles, M., & Huberman, A. (1994). *An expanded sourcebook. Qualitative data analysis*. (2<sup>nd</sup> ed.). London: Sage Publications.
- Miller, I., Epstein, N., Bishop, D., & Keitner, G. (1985). The McMaster Family Assessment Device: Reliability and validity. *Journal of Marital and Family Therapy*, 11, 345-356.
- Miller, I., Kabacoff, R., Epstein, N., Bishop, D., Keitner, G., Baldwin, L., & van der Spuy, H. (1994). The development of a clinical rating scale for the McMaster Model of Family Functioning. *Family Process*, 33, 53-69.

Minuchin, S. (1974). *Families and family therapy*. Cambridge: Harvard University Press.

Minuchin, S., & Fishman, C. (1981). *Family therapy techniques*. Cambridge: Harvard University Press.

Moffitt, T., Caspi, A., Dickson, N., Silva, P., & Stanton, W. (1996). Childhood-onset versus adolescent-onset antisocial problems in males: natural history from ages 3 to 18 years. *Developmental Psychopathology*, 9, 399-424.

Moore, L., & O'Connor, T. (1991). A psychiatric residential centre for children and adolescents: A pilot study of its patients' characteristics and improvement while resident. *Child Care Health Development*, 17(4), 235-242.

Morris, K., & Jacobs, B. (1998). Some cognitive-behavioural approaches to parenting used in children's in-patient settings. In J. Green & B. Jacobs (Eds.), *Inpatient child psychiatry, modern practice, research and the future*. (pp.322-333). London: Routledge.

Nakhla, F., Folkart, L., Webster, J. (1969). Treatment of families as in-patients. *Family Process*, 8, 79-86.

Natham, P., & Gorman, J. (1998). Treatments that work – and what convinces us they do. In P. Nathan & J. Gorman (Eds.), *A guide to treatments that work*. (pp. 3-25). New York: Oxford University Press.

Ney, P., Adam, R., Hanton, B., & Brinidad, E. (1988). The effectiveness of a child psychiatric unit: A follow-up study. *Canadian Journal of Psychiatry*, 33, 793-799.

Nolan, T., Bond, L., Adler, R., Littlefield, L., Marriage, K., Mawdsley, A., Salo, R., & Tonge, B. (1996). Child Behaviour Checklist classification of behaviour disorder. *Journal of Paediatrics & Child Health*, 32(5), 405-411.

O'Hanlon, W., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy*. New York: W.W. Norton.

Olson, D. (1986). Circumplex model VII: validation studies and FACES III. *Family Process*, 25, 337-351.

Parry-Jones, W. (1995). The future of adolescent psychiatry. *British Journal of Psychiatry*, 166, 299-305.

Patterson, G. (1986). The contribution of siblings to training for fighting: a microsocial analysis. In D. Olweus, J. Block & M. Radke-Yarrow (Eds.), *Development of antisocial and prosocial behaviour. Research, theories and issues*. (pp. 235-262). Orlando: Academic Press.

Patterson, G., Dishion, T., & Bank, L. (1984). Family interaction: a process of deviancy training. *Aggressive Behavior*, 10, 253-267.

Pedder, J. (1986). Reflections on the theory and practice of supervision. *Psychoanalytic Psychotherapy*, 2, 1-12.

Peterson, L., & Bell-Dolan, D. (1995). Treatment outcome research in child psychology: Realistic coping with the 'ten commandments of methodology'. *Journal of Clinical Child Psychology*, 24(2), 149-162.

Pfeiffer, S. (1989). Follow-up of children and adolescents treated in psychiatric facilities. *Psychiatric Hospital*, 20, 15-20.

Pfeiffer, S., Strzelecki, S. (1990). Inpatient psychiatric treatment of children and adolescents: A review of outcome studies. *Journal of the American Academy of Child & Adolescent Psychiatry*, 29(6), 847-853.

Puotiniemi, T., Kyngas, H., & Nikkonen, M. (2001). Factors associated with the coping of parents with a child in psychiatric inpatient care. *International Journal of Nursing Practice*, 7(5), 298-305.

Puotiniemi, T., Kyngas, H., & Nikkonen, M. (2002). The resources of parents with a child in psychiatric inpatient care. *Journal of Psychiatric and Mental Health Nursing*, 9(1), 15-22.

Racusin, G., & Kaslow, N. (1994). Child and family therapy combined: Indications and implications. *The American Journal of Family Therapy*, 22(3), 237-246.

Ravnsborg, I. (1982). The inpatient care of families at Vikersund. In F. Kaslow (Ed.), *The international book of family therapy*. (pp. 275-290). New York: Brunner/Mazel.

Redl, F. & Wineman, D. (1951). *Children who hate*. Illinois: Free Press.

Redl, F., & Wineman, D. (1952). *Controls from within*. Illinois: Free Press.

Reid, S., & Kolvin, I. (1996). Group therapy for children and adolescents. In M. Garralda (Ed.), *Managing children with psychiatric problems*. (pp. 68-84). London: BMJ Publishing Group.

Rey, J., Plapp, J., & Simpson, P. (1999). Parental satisfaction and outcome: A 4-year study in a child and adolescent mental health service. *Australian and New Zealand Journal of Psychiatry*, 33, 22-28.

Riddle, M. (1989). Research on a children's psychiatric inpatient service. *Journal of the American Academy of Child & Adolescent Psychiatry*, 28(1), 42-46.

Roberts, J (1978). There's more to child abuse than spotting bruises. *Community Care*, June 28, 29-30.

Rosenhan, D. (1973). On being sane in insane places. *Science*, 179, 250-258.

Roth, A., & P. Fonagy (1996). *What works for whom. A critical review of psychotherapy research*. New York: The Guilford Press.

Russ, S. (2001). Play therapy. In T. Ollendick (Ed), Children and adolescents: *Clinical formulation and treatment. Comprehensive Clinical Psychology*. Vol. 5. (pp. 221-243). Oxford: Elsevier Science Ltd.

Salzer, M. (1996). Interpreting outcome studies. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(11), 1419.

Sawyer, M., Sarris, A., Baghurst, P., Cross, D., & Kalucy, R. (1988). Family Assessment Device: Reports from mothers, fathers and adolescents in community and clinic families. *Journal of Marital and Family Therapy*, 14, 287-296.

Scharer, K. (1999). Nurse-patient relationship building in child psychiatric units. *Journal of Child & Adolescent Psychiatric Nursing*, 12(4), 153-167.

Scharer, K. (2000). Admission: a crucial point in relationship building between parents and staff in child psychiatric units. *Issues in Mental Health Nursing*, 21(8), 723-744.

Scharff, D., & Scharff, J. (1987). *Object relations family therapy*. New Jersey: Aronson.

Schneider, S., & Cohen, Y. (1998). Potential space in milieu therapy with children and adolescents. *Therapeutic Communities*, 19(2), 81-88.

Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., Prata, G. (1978). *Paradox and counterparadox*. New York: Jason Aronson.

Shaw, M. (1998). Childhood, mental health and the law. In J. Green & B. Jacobs (Eds.), *Inpatient child psychiatry, modern practice, research and the future*. (pp.349-362). London: Routledge.

Sheerin, D., Maguire, R., & Robinson, J. (1999). A 15-month follow-up study of children admitted to a child psychiatric inpatient unit. *Irish Journal of Psychological Medicine*, 16(3), 97-103.

Shirk, S. (2001). The road to effective child psychological services. Treatment process and outcome research. In J. Hughes & A. La Greca (Eds.), *Handbook of psychological services for children and adolescents*. (pp.43-59). New York: Oxford University Press.

Siegel, L., & Whitmont, S. (1990). A systemic approach to family hospitalisation. *Family Systems Medicine*, 8(3), 251-263.

Silburn, S., Zubrick, S., Garton, A., Gurrin, L., Burton, P., Dalby, R., Carlton, J., Shepherd, C., Lawrence, D. (1996). *Western Australian Child Health Survey: Family and Community Health*. Perth, Western Australia: Australian Bureau of Statistics and TVW Telethon Institute for Child Health Research.

Skygger, A. (1981). An open-systems, group analytic approach to family therapy. In A. Gurman & D. Kniskern (Eds.), *Handbook of family therapy*. (pp. 39-84). New York: Brunner/Mazel.

Sourander, A., Ellila, H., Valimäki, M., & Piha, J. (2002). Use of holding, restraints, seclusion and time-out in child and adolescent psychiatric in-patient treatment. *European Child & Adolescent Psychiatry*, 11, 162-167.

Sourander, A., Heikkilä, T., Leijala, H., Heinisuo, A., Helenius, H., & Piha, J. (1995). Follow-up of short-term child psychiatric inpatient treatment. *Nordic Journal of Psychiatry*, 49(2), 95-101.

Sourander, A., Helenius, H., Leijala, H., Heikkilä, T., Bergroth, L., Piha, J. (1996). Predictors of outcome of short-term child psychiatric inpatient treatment. *European Child & Adolescent Psychiatry*, 5, 75-82.

Sourander, A., Helenius, H., & Piha, J. (1995). Parent and teacher reports of problem behaviours in child psychiatric inpatients: Cross informant correlations on admission and at 5 months follow up. *Child Psychiatry and Human Development*, 26, 85-95.

- Sourander, A., Helenius, H., & Piha, J. (1996). Child psychiatric short-term inpatient treatment: CGAS as follow-up measures. *Child Psychiatry and Human Development*, 27(2), 93-104.
- Sourander, A., & Leijala, H. (2002). The clinical course of children treated in a short-term inpatient programme. *Child Psychiatry and Human Development*, 33(1), 75-88.
- Sourander, A., Leijala, H., Lehtila, A., Kanerva, A., Helenius, H., & Piha, J. (1996). Short-term child psychiatric inpatient treatment. Place of residence as one-year outcome measure. *European Child & Adolescent Psychiatry*, 5, 38-43
- Sourander, A., & Piha, J. (1996). A short-term family-oriented, child and adolescent psychiatric inpatient treatment program. *Family Process*, 35, 103-111.
- Sourander, A., & Piha, J. (1998). Three-year follow-up of child psychiatric inpatient treatment. *European Child & Adolescent Psychiatry*, 7(3), 153-162.
- Sourander, A., & Piha, J. (2000). A model for change at the outpatient-inpatient interface in child psychiatry. *Clinical Child Psychology and Psychiatry*, 5(1), 97-103.
- Stroul, B., & Friedman, R. (1996). *A system of care for children and adolescents with severe emotional disturbance*. Washington DC: National Technical Assistance Center for Child Mental Health.
- Subotsky, F. (1992). Psychiatric treatment for children – the organization of services. *Archives of the Disabled Child*, 67(7), 971-975.
- Sugarman, S. (1986). Individual and family therapy: an overview of the interface. In J. Hansen & S. Sugarman (Eds.), *The interface of individual and family therapy*. (pp.1-16). Aspen: Rockville MD.
- Sundelin, J. (1999). A systems-oriented model for description of intensive family therapy units. *Nordic Journal of Psychiatry*, 53(3), 223-229.



Sundelin, J., & Hansson, K. (1999). Intensive family therapy: A way to change family functioning in multi-problem families. *Journal of Family Therapy*, 21(4), 419-2001.

Tannen, D., & Wallat, C. (1987). Interactive frames and knowledge schemas in interaction. Examples from a medical examination/interview. *Social Psychology Quarterly*, 50, 205-216.

Target, M., & Fonagy, P. (1996). The psychological treatment of child and adolescent psychiatric disorders. In A. Roth, & P. Fonagy (Eds). *What works for whom. A critical review of psychotherapy research*. (pp. 263-320). New York: The Guilford Press.

Target, M., & Fonagy, P. (2001). Psychodynamic psychotherapy. In T. Ollendick (Ed.), *Children and adolescents: Clinical formulation and treatment. Comprehensive Clinical Psychology*. Vol. 5. (pp. 245-266). Oxford: Elsevier Science Ltd.

Taylor, A., Wilson, D., Dal Grande E., Ben-Tovim, D., Elzinga, R., Goldney, R., MacFarlane, A., Cheok, F., & Kirke, K. (2000). Mental health status of South Australian population. *Australian & New Zealand Journal of Public Health*, 24(1), 29-34.

Tenant, C. (1977). The General Health Questionnaire: A valid index of psychological impairment in Australian populations. *Medical Journal of Australia*, 2, 392-394.

Tesch, R. (1994). The contribution of a qualitative method: Phenomenological research. In M Langenbach, C. Vaughn, & L. Aagaard (Eds.), *An introduction to educational research*. (pp. 143-157). Massachusetts: Allyn & Bacon.

Towle, P., & Schwarz, J. (1987). The Child Behaviour Checklist as applied to archival data: Factor structure and external correlates. *Journal of Clinical Child Psychology*, 16, 69-79.

Verhulst, F., & Koot, H. (1992). *Child psychiatric epidemiology. Concepts, methods and findings*. California: Sage.

Vitulano, L., & Tebes, J. (2002). Child and adolescent behaviour therapy. In M.Lewis (Ed.), *Child and adolescent psychiatry. A comprehensive textbook*. (3<sup>rd</sup> ed.). (pp. 998-1013). Philadelphia: Lippincott, Williams & Wilkins.

Volk, D. (1993). *A systems approach analysis of parents' and clinicians' perceptions of children's behaviour*. Unpublished Postgraduate thesis. La Trobe University, Melbourne, Victoria, Australia.

Volk, D. (1996). Family admission programme. *Australia's Third International Psychiatric Nursing Conference. Contemporary Psychiatric Nursing Practice: Action, Autonomy, Accountability. Proceedings of the Conference*. Melbourne: Royal Melbourne Institute of Technology.

Watson, J., & Rayner, R. (1920). Conditioned emotional reactions. *Journal of Experimental Psychology*, 3, 1-14.

Weiss, H., & Greene, J. (1992). An empowerment partnership for family support and education programs and evaluations. *Family Science Review*, 5, 131-148.

Weisz, J., Donberg, G., Han, S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Clinical and Consulting Psychology*, 63(5), 688-701.

Weisz, J., Weiss, B., Alicke, M., & Klotz, M. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology*, 55, 542-549.

Werneke, U., Goldberg, D., Yalcin, I., & Ustun, T. (2000). The stability of the factor structure of the GHQ. *Psychological Medicine*, 30(4), 823-829.

Whitaker, C., & Olsen, E. (1971). The staff team and the family square off. In G. Abrams & N. Greenfield (Eds.), *The new hospital psychiatry*. (pp. 67-81). New York: Academic Press.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton.

White, J., Moffitt, T., Earls, F., Robins, L., & Silva, P. (1990). How early can we tell? Pre-school predictors of boys' conduct disorder and delinquency. *Criminology*, 28, 507-533.

S. Whitmont (personal communication, August 2001)

Winnicott, D. (1965). *The maturational process and the facilitating environment: Studies in the theory of emotional development*. London: Hogarth Press.

Winnicott, D. (1971). *Playing and reality*. London: Tavistock.

Winship, G. (1995). The unconscious impact of caring for acutely disturbed patients: A perspective on supervision. *Journal of Psychiatric and Mental Health Nursing*, 2, 227-231.

World Health Organization (1978). *International classification of diseases: Clinical descriptions and diagnostic guidelines*. (9<sup>th</sup> ed.). Geneva: Author.

Yates, B. (1994). Toward the incorporation of costs, cost-effectiveness analysis and cost-benefit analysis into clinical research. *Journal of Consulting and Clinical Psychology*, 62(4), 729-736.

Zilbach, J. (1986). *Young children in family therapy*. New York : Brunnel/Mazel.

Zilbach, J., Berger, E., & Gass, C. (1972). The role of the young child in family therapy. In C. Sager & H. Kaplan (Eds.), *Progress in group therapy*. (pp. 385-399). New York: Brunner/Mazel.

Zubrick, S., Silburn, S., Garton, A., Burton, P., Dalby, R., Carlton, J., Shepherd, C., & Lawrence, D. (1995). *Western Australian Child Health Survey: Developing health and wellbeing in the nineties*. Perth, Western Australia: Australian Bureau of Statistics and Institute for Child Health Research.

Zubrick, S., Silburn, S., Gurrin, L., Tech, H., Shepherd, C., Carlton, J., & Lawrence, D. (1997). *Western Australian Child Health Survey: Education, Health and Competence*. Perth, Western Australia: Australian Bureau of Statistics and TVW Telethon Institute for Child Health Research.

## CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

For office use only  
ID #

Please Print

CHILD'S FULL NAME	FIRST	MIDDLE	LAST	<b>PARENTS' USUAL TYPE OF WORK</b> , even if not working now. <i>(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)</i>  FATHER'S TYPE OF WORK: _____  MOTHER'S TYPE OF WORK: _____  THIS FORM FILLED OUT BY: <input type="checkbox"/> Mother (full name) _____ <input type="checkbox"/> Father (full name) _____ <input type="checkbox"/> Other—full name & relationship to child: _____
EX	AGE		ETHNIC GROUP OR RACE	
<input type="checkbox"/> Boy <input type="checkbox"/> Girl				
TODAY'S DATE		CHILD'S BIRTHDATE		
Mo. _____ Date _____ Yr. _____		Mo. _____ Date _____ Yr. _____		
GRADE IN SCHOOL		Please fill out this form to reflect <i>your</i> view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on page 2.		
NOT ATTENDING SCHOOL <input type="checkbox"/>				

**Please list the sports your child most likes to take part in.** For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

**Compared to others of the same age, about how much time does he/she spend in each?**

Don't Know	Less Than Average	Average	More Than Average
------------	-------------------	---------	-------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**Compared to others of the same age, how well does he/she do each one?**

Don't Know	Below Average	Average	Above Average
------------	---------------	---------	---------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**Please list your child's favorite hobbies, activities, and games, other than sports.** For example: stamps dolls, books, piano, crafts, cars, singing, etc. (Do *not* include listening to radio or TV.)

☐ None

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

**Compared to others of the same age, about how much time does he/she spend in each?**

Don't Know	Less Than Average	Average	More Than Average
------------	-------------------	---------	-------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**Compared to others of the same age, how well does he/she do each one?**

Don't Know	Below Average	Average	Above Average
------------	---------------	---------	---------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**Please list any organizations, clubs, teams, or groups your child belongs to.**

☐ None

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

**Compared to others of the same age, how active is he/she in each?**

Don't Know	Less Active	Average	More Active
------------	-------------	---------	-------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**Please list any jobs or chores your child has.** For example: paper route, babysitting, making bed, working in store, etc. (Include *both* paid and unpaid jobs and chores.)

☐ None

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

**Compared to others of the same age, how well does he/she carry them out?**

Don't Know	Below Average	Average	Above Average
------------	---------------	---------	---------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Please Print

- I. 1. About how many close friends does your child have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more  
(Do not include brothers & sisters)
2. About how many times a week does your child do things with any friends outside of regular school hours?  
(Do not include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

- |   | Worse                    | About Average            | Better                   |   |
|---|--------------------------|--------------------------|--------------------------|---|
| a. Get along with his/her brothers & sisters? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Has no brothers or sisters |
| b. Get along with other kids?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |
| c. Behave with his/her parents?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |
| d. Play and work alone?                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |   |

VII. 1. For ages 6 and older—performance in academic subjects. ☐ Does not attend school because \_\_\_\_\_

Check a box for each subject that child takes

- |                                       | Falling                  | Below Average            | Average                  | Above Average            |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Reading, English, or Language Arts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. History or Social Studies          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Arithmetic or Math                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Science                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. _____                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. _____                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. _____                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., etc.

2. Does your child receive special remedial services or attend a special class or special school? ☐ No ☐ Yes—kind of services, class, or school: \_\_\_\_\_

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons: \_\_\_\_\_

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe: \_\_\_\_\_

When did these problems start? \_\_\_\_\_

Have these problems ended? ☐ No ☐ Yes—when? \_\_\_\_\_

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe: \_\_\_\_\_

What concerns you most about your child? \_\_\_\_\_

Please describe the best things about your child: \_\_\_\_\_

Below is a list of items that describe children and youth. For each item that describes your child **now or within the past 6 months**, please circle the 2 if the item is **very true or often true** of your child. Circle the 1 if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

**Please Print**

**0 = Not True (as far as you know)    1 = Somewhat or Sometimes True    2 = Very True or Often True**

1 2	1.	Acts too young for his/her age	0	1	2	31.	Fears he/she might think or do something bad
1 2	2.	Allergy (describe): _____	0	1	2	32.	Feels he/she has to be perfect
		_____	0	1	2	33.	Feels or complains that no one loves him/her
1 2	3.	Argues a lot	0	1	2	34.	Feels others are out to get him/her
1 2	4.	Asthma	0	1	2	35.	Feels worthless or inferior
1 2	5.	Behaves like opposite sex	0	1	2	36.	Gets hurt a lot, accident-prone
1 2	6.	Bowel movements outside toilet	0	1	2	37.	Gets in many fights
1 2	7.	Bragging, boasting	0	1	2	38.	Gets teased a lot
1 2	8.	Can't concentrate, can't pay attention for long	0	1	2	39.	Hangs around with others who get in trouble
1 2	9.	Can't get his/her mind off certain thoughts; obsessions (describe): _____	0	1	2	40.	Hears sounds or voices that aren't there (describe): _____
2	10.	Can't sit still, restless, or hyperactive	0	1	2	41.	Impulsive or acts without thinking
2	11.	Clings to adults or too dependent	0	1	2	42.	Would rather be alone than with others
2	12.	Complains of loneliness	0	1	2	43.	Lying or cheating
1 2	13.	Confused or seems to be in a fog	0	1	2	44.	Bites fingernails
1 2	14.	Cries a lot	0	1	2	45.	Nervous, highstrung, or tense
1 2	15.	Cruel to animals	0	1	2	46.	Nervous movements or twitching (describe): _____
1 2	16.	Cruelty, bullying, or meanness to others	0	1	2	47.	Nightmares
2	17.	Day-dreams or gets lost in his/her thoughts	0	1	2	48.	Not liked by other kids
2	18.	Deliberately harms self or attempts suicide	0	1	2	49.	Constipated, doesn't move bowels
2	19.	Demands a lot of attention	0	1	2	50.	Too fearful or anxious
2	20.	Destroys his/her own things	0	1	2	51.	Feels dizzy
2	21.	Destroys things belonging to his/her family or others	0	1	2	52.	Feels too guilty
2	22.	Disobedient at home	0	1	2	53.	Overeating
2	23.	Disobedient at school	0	1	2	54.	Overtired
2	24.	Doesn't eat well	0	1	2	55.	Overweight
2	25.	Doesn't get along with other kids				56.	Physical problems <b>without known medical cause</b> :
2	26.	Doesn't seem to feel guilty after misbehaving	0	1	2	a.	Aches or pains ( <b>not</b> stomach or headaches)
2	27.	Easily jealous	0	1	2	b.	Headaches
2	28.	Eats or drinks things that are not food — <b>don't</b> include sweets (describe): _____	0	1	2	c.	Nausea, feels sick
		_____	0	1	2	d.	Problems with eyes ( <b>not</b> if corrected by glasses) (describe): _____
2	29.	Fears certain animals, situations, or places, other than school (describe): _____	0	1	2	e.	Rashes or other skin problems
		_____	0	1	2	f.	Stomachaches or cramps
2	30.	Fears going to school	0	1	2	g.	Vomiting, throwing up
			0	1	2	h.	Other (describe): _____

**Please see other side**

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

1

1	2	57.	Physically attacks people	0	1	2	84.	Strange behavior (describe): _____
1	2	58.	Picks nose, skin, or other parts of body (describe): _____					_____
				0	1	2	85.	Strange ideas (describe): _____
1	2	59.	Plays with own sex parts in public					_____
1	2	60.	Plays with own sex parts too much	0	1	2	86.	Stubborn, sullen, or irritable
1	2	61.	Poor school work	0	1	2	87.	Sudden changes in mood or feelings
1	2	62.	Poorly coordinated or clumsy	0	1	2	88.	Sulks a lot
1	2	63.	Prefers being with older kids	0	1	2	89.	Suspicious
1	2	64.	Prefers being with younger kids	0	1	2	90.	Swearing or obscene language
1	2	65.	Refuses to talk	0	1	2	91.	Talks about killing self
1	2	66.	Repeats certain acts over and over; compulsions (describe): _____	0	1	2	92.	Talks or walks in sleep (describe): _____
								_____
1	2	67.	Runs away from home	0	1	2	93.	Talks too much
1	2	68.	Screams a lot	0	1	2	94.	Teases a lot
				0	1	2	95.	Temper tantrums or hot temper
1	2	69.	Secretive, keeps things to self	0	1	2	96.	Thinks about sex too much
1	2	70.	Sees things that aren't there (describe): _____	0	1	2	97.	Threatens people
				0	1	2	98.	Thumb-sucking
				0	1	2	99.	Too concerned with neatness or cleanliness
				0	1	2	100.	Trouble sleeping (describe): _____
1	2	71.	Self-conscious or easily embarrassed					_____
1	2	72.	Sets fires					_____
1	2	73.	Sexual problems (describe): _____	0	1	2	101.	Truancy, skips school
				0	1	2	102.	Underactive, slow moving, or lacks energy
				0	1	2	103.	Unhappy, sad, or depressed
				0	1	2	104.	Unusually loud
1	2	74.	Showing off or clowning	0	1	2	105.	Uses alcohol or drugs for nonmedical purposes (describe): _____
1	2	75.	Shy or timid					_____
1	2	76.	Sleeps less than most kids	0	1	2	106.	Vandalism
1	2	77.	Sleeps more than most kids during day and/or night (describe): _____	0	1	2	107.	Wets self during the day
				0	1	2	108.	Wets the bed
1	2	78.	Smears or plays with bowel movements	0	1	2	109.	Whining
1	2	79.	Speech problem (describe): _____	0	1	2	110.	Wishes to be of opposite sex
				0	1	2	111.	Withdrawn, doesn't get involved with others
				0	1	2	112.	Worries
1	2	80.	Stares blankly				113.	Please write in any problems your child has that were not listed above:
1	2	81.	Steals at home					
1	2	82.	Steals outside the home	0	1	2		_____
1	2	83.	Stores up things he/she doesn't need (describe): _____	0	1	2		_____
				0	1	2		_____



# APPENDIX II : CBCL SAMPLE SCORED PROFILE

## 1991 Child Behavior Checklist Profile Parent-Reported Competence - Girls Aged 6-11

File				T Score
69-1	8.0	8.5	6.0	1-55
-1	7.5	7.5		1- 10#
-1	7.0	7.0	5.5	1- 08SB1AFM
50-1				1-50
-1	6.5	6.5		1- In the file:
-1	6.0			1- 08SB1AF.M
31-1		6.0	5.0	1-45
-1	5.5	5.5		1- Girl Age: 6
-1	###	5.0		1-
16-1	4.5		4.5	1-40 Date Filled:
-1	4.0	4.5		1- 05/21/98
-1	3.5	4.0	4.0	1-
7-1				1-35 Filled out by:
-1	2.5	3.0	3.5	1- Others:
-1	2.0	###		1-
2-1			3.0	1-30 Card: 01
-1	1.5	2.0	###	1- Agency:
-1		1.5	2.0	1-
1-1	1.0		1.5	1-25 Total 10.0
-1	0.5	1.0	1.0	1- Total T 30 ++
-1		0.5	0.5	1-
-1	0.0	0.0	0.0	1-20

### Activities

### Social

### School

+ Borderline  
++ Clinical Ran

0.0 I.A. # of sports

1.0 I.B. Mean of participation  
& skill in sports

1.0 II.B. Mean of participation  
& skill in activities

2.0 IV.A. # of jobs

1.0 B. Mean job quality

5.0 Total

42 T Score

0.0 III.A. # of organizations

1.0 B. Mean of participa-  
tion in organizat'ns

0.0 V.1. # of friends

1.0 2. Frequency of contact  
with friends

0.3 VI.A. Behavior with others

0.0 B. Behavior alone

2.5 Total

31 T Score

0.3 VII.1. Mean performance

1.0 2. Special class

1.0 3. Repeated grade

0.0 4. School problems

2.5 Total

28 T Score

Broken lines =

borderline clinical range

### = plotted score

Total Score for each scale is rounded to nearest 0.5.

### Indicates the score was not computed due to missing data.

On Activities and Social Scales, if one item is missing,  
the mean of the other items is substituted.

Not scored on competence scale  
0.0 II.A. # of other activities

Copyright 1991  
by T.M. Achenbach  
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University of Vermont  
1 South Prospect St.  
Burlington, VT 05401-3456

## 1991 CBCL Profile - Girls 4-11

Internalizing			1991 CBCL Profile - Girls 4-11			Externalizing		T Score	
17	27		15	13	21	24	39	1-	ID# 08SB1AFM
17	26					23	37	1-	IN:08SB1AF.M
16					20			1-	95 Girl AGE: 6
16	25		14	12	19	21	35	1-	DATE FILLED:
15	24		13	11	18	20	34	1-	05/21/97
	23					19	33	1-	90 BY: Other
14	22		12	10	17	18	32	1-	CARDS 02,03
	21				16	16	31	1-	AGENCY
13	12		11	9			30	1-	85
	11	20			15	14	29	1-	
12			10	8	14	13	27	1-	# ITEMS 61
	18					12		1-	80 TOTSCORE 74
11	9		***	7	13	10	25	1-	TOT T 73+
10	16		8	6	12	9	24	1-	INTERNAL 29
	8				11		23	1-	75 INT T 76+
FILE- ***	***	15	7	5		7	22	1-	EXTERNAL 18
	14				10	6	21	1-	EXT T 64+
18	6	***	6	4	***	***	20	1-	70 ++ Clinical
	5	11		3	8	4	17	1-	+ Borderline
	10		5		7				
93				2			16	1-	65 OTHER PROBS
	4	8			6		15	1-	1 5. ActOppSex\$
	3	7	4		5	3	***	1-	0 6. BM Out
84								1-	60 0 15.CruelAnim
	2	6		***	4		11	1-	0 18.HarmSelf
	3	5	3			2	10	1-	1 24.NotEat
69							9	1-	55 0 28.EatNonFood
	2	4			3		8	1-	0 29.Fears
		3	2		2	1	7	1-	1 30.FearSchool
50	0-1	0	0-2	0-1	0	0-1	0	0-6	1 36.Accidents
	I	II	III	IV	V	VI	VII	VIII	1 44.BiteNail
	WITHDRAWN	SOMATIC COMPLAINTS	ANXIOUS/ DEPRESSED	SOCIAL PROBLEMS	THOUGHT PROBLEMS	ATTENTION PROBLEMS	DELINQUENT BEHAVIOR	AGGRESSIVE BEHAVIOR	1 47.Nightmares
1 42.Rather BeAlone	0 51. Dizzy	1 12.Lonely	1 1. Acts Young	1 9. Mind Off	1 1. Acts Young	1 26.NoGuilt	2 3. Argues	0 53.Overeat	
1 65.Won't Talk	1 54. Tired	1 14.Cries	2 11.Clings	0 40.Hears Things	1 8. Concen- trate	0 39.BadCompan	0 7. Brags	0 56h.OtherPhys	
1 69.Secretive	1 56a.Aches	1 31.FearDoBad	1 25.NotGet Along	0 66.Repeats Acts	0 10.Sit Still	1 63.PrefOlder	2 19.DemAttn	0 59.SexPrtsP\$	
	1 56b.Headaches	1 32.Perfect	2 38.Teased	0 70.Sees Things	0 13.Confuse dream	0 67.RunAway	1 20.DestOwn	0 60.SexPrtsM\$	
2 75.Shy	1 56c.Nausea	1 33.Unloved	1 48.Not Liked	0 80.Stares*	1 17.Day-dream	1 81.StealHome	1 22.DisbHome*	0 76.SleepLess	
0 80.Stares	0 56d.Eye	2 35.Worthless	0 55.Over- Weight*	0 84.Strange Behav	1 41.Impulsv	0 82.StealOut	1 23.DisbSchl	0 77.SleepMore	
2 88.Sulks	1 56e.Skin	1 45.Nervous			0 90.Swears	0 96.ThnkSex**	2 27.Jealous	0 78.SmearBM	
0 102.Underactive	1 56f.Stomach	0 52.Guilty			0 101.Truant	0 105.AlcDrugs	0 37.Fights	0 79.SpeechProb	
	7 TOTAL	2 71.SelfConsc	2 62.Clumsy		1 45.Nervous	0 106.Vandal*	0 57.Attacks	0 83.StoresUp	
0 103.Sad	73 T SCORE	1 89.Suspicious	0 64.Prefers Young	0 85.Strange Ideas	1 46.Twitch*		0 68.Screams	0 91.TalkSuicid	
2 111.Withdrawn		0 103.Sad			1 61.Poor School		0 74.ShowOff	0 92.SleepWalk	
		1 112.Worries	9 TOTAL	1 TOTAL	5 TOTAL		1 86.Stubborn	0 98.ThumbSuck	
9 TOTAL		13 TOTAL	79 T SCORE	58 T SCORE	2 62.Clumsy	70 T SCORE	0 87.MoodChng	0 99.TooNeat	
73 T SCORE		70 T SCORE			0 80.Stares		0 93.TalkMuch	0 100.SleepProb	
					9 TOTAL		1 94.Teases	1 107.WetsSelf	
					70 T SCORE		1 95.Temper	1 108.WetsBed	
							0 97.Threaten	1 109.Whining	
							0 104.Loud	0 110.WshOpSex\$	
							13 TOTAL	- 113.OtherProb	

# The scaled GHQ

## GENERAL HEALTH QUESTIONNAIRE

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.  
Thank you very much for your cooperation.

### HAVE YOU RECENTLY:

- |   |                    |                     |                           |                                |
|---|--------------------|---------------------|---------------------------|--------------------------------|
| A1. Been feeling perfectly well and in good health?                           | Better than usual  | Same as usual       | Worse than usual          | Much worse than usual          |
| A2. Been feeling in need of a good tonic?                                     | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| A3. Been feeling run down and out of sorts?                                   | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| A4. Felt that you are ill?  | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| A5. Been getting any pains in your head?                                      | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| A6. Been getting a feeling of tightness or pressure in your head?             | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| A7. Been having hot or cold spells?   | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| B1. Lost much sleep over worry?   | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| B2. Had difficulty in staying asleep once you are off?                        | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| B3. Felt constantly under strain?   | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| B4. Been getting edgy and bad-tempered?                                       | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| B5. Been getting scared or panicky for no good reason?                        | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| B6. Found everything getting on top of you?                                   | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| B7. Been feeling nervous and strung-up all the time?                          | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| C1. Been managing to keep yourself busy and occupied?                         | More so than usual | Same as usual       | Rather less than usual    | Much less than usual           |
| C2. Been taking longer over the things you do?                                | Quicker than usual | Same as usual       | Longer than usual         | Much longer than usual         |
| C3. Felt on the whole you were doing things well?                             | Better than usual  | About the same      | Less well than usual      | Much less well than usual      |
| C4. Been satisfied with the way you've carried out your task?                 | More satisfied     | About same as usual | Less satisfied than usual | Much less satisfied than usual |
| C5. Felt that you are playing a useful part in things?                        | More so than usual | Same as usual       | Less useful than usual    | Much less useful than usual    |
| C6. Felt capable of making decisions about things?                            | More so than usual | Same as usual       | Less so than usual        | Much less capable than usual   |
| C7. Been able to enjoy your normal day-to-day activities?                     | More so than usual | Same as usual       | Less so than usual        | Much less than usual           |
| D1. Been thinking of yourself as a worthless person?                          | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| D2. Felt that life is entirely hopeless?                                      | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| D3. Felt that life isn't worth living?  | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| D4. Thought of the possibility that you might make away with yourself?        | Definitely not     | I don't think so    | Has crossed my mind       | Definitely have                |
| D5. Found at times you couldn't do anything because your nerves were too bad? | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| D6. Found yourself wishing you were dead and away from it all?                | Not at all         | No more than usual  | Rather more than usual    | Much more than usual           |
| D7. Found that the idea of taking your own life kept coming into your mind?   | Definitely not     | I don't think so    | Has crossed my mind       | Definitely has                 |

A ☐ B ☐ C ☐ D ☒ TOTAL

### Note

The version of the GHQ-28 used in the United States has 4 questions reworded:

- A1. Been feeling in need of some medicine to pick you up?  
B2. Had difficulty staying asleep?  
B7. Been feeling nervous and uptight all the time?  
D4. Thought of the possibility that you might do away with yourself.

McMaster



FAMILY  
ASSESSMENT  
DEVICE

Family Role: .....

Date: .....

Strongly Agree SA  
Agree A  
Disagree D  
Strongly Disagree SD

page 1

1. Planning family activities is difficult because we misunderstand each other.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

2. We resolve most everyday problems around the house.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

3. When someone is upset the others know why.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

4. When you ask someone to do something, you have to check that they did it.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

5. If someone is in trouble, the others become too involved.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

6. In times of crisis we can turn to each other for support.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

7. We don't know what to do when an emergency comes up.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

8. We sometimes run out of things that we need.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

9. We are reluctant to show our affection for each other.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

10. We make sure members meet their family responsibilities.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

11. We cannot talk to each other about the sadness we feel.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

12. We usually act on our decisions regarding problems.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD

You only get the interest of others when something is important to them.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

You can't tell how a person is feeling from what they are saying.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

Family tasks don't get spread around enough.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

Individuals are accepted for what they are.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

You can easily get away with breaking the rules.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

People come right out and say things instead of hinting at them.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

Some of us just don't respond emotionally.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

We know what to do in an emergency.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

We avoid discussing our fears and concerns.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

It is difficult to talk to each other about tender feelings.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

We have trouble meeting our bills.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

After our family tries to solve a problem, we usually discuss whether it worked or not.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

25. We are too self-centered.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

26. We can express feelings to each other.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

27. We have no clear expectations about toilet habits.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

28. We do not show our love for each other.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

29. We talk to people directly rather than through go-betweens.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

30. Each of us has particular duties and responsibilities.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

31. ~~There are lots of bad feelings in the family.~~

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

32. We have rules about hitting people.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

33. We get involved with each other only when something interests us.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

34. There's little time to explore personal interests.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

35. We often don't say what we mean.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

36. We feel accepted for what we are.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

37. We show interest in each other when we can get something out of it personally.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

38. We resolve most emotional upsets that come up.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

39. Tenderness takes second place to other things in our family.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

40. We discuss who is to do household jobs.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

41. Making decisions is a problem for our family.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

42. Our family shows interest in each other only when they can get something out of it.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

43. We are frank with each other.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

44. We don't hold to any rules or standards.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

45. If people are asked to do something, they need reminding.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

46. We are able to make decisions about how to solve problems.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

47. If the rules are broken, we don't know what to expect.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

48. Anything goes in our family.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_



41) We express tenderness.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

50) We confront problems involving feelings.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

51) We don't get along well together.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

52) We don't talk to each other when we are angry.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

53) We are generally dissatisfied with the family duties assigned to us.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

54) Even though we mean well, we intrude too much into each others lives.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

55) There are rules about dangerous situations.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

56) We confide in each other.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

57) We cry openly.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

58) We don't have reasonable transport.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

59) When we don't like what someone has done, we tell them.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_

60) We try to think of different ways to solve problems.

\_\_\_\_\_ SA \_\_\_\_\_ A \_\_\_\_\_ D \_\_\_\_\_ SD \_\_\_\_\_



**Austin Hospital Heidelberg Victoria 3084 Australia**

All correspondence  
to the General Manager.  
Please quote:

**TO:** Dr. Peter Jenkins  
Dept. of Child, Adolescent & Family Psychiatry

**FROM:** Lyn Robertson - Secretary, Committee of Human Ethics in Research.

**PROJECT:** An evaluation of inpatient psychiatric Treatment.


**PROJECT NO:** H95/054

**DATE:** 6 July, 1995

I wish to inform you that at the meeting of the Committee of Human Ethics in Research held on Friday 16th June 1995 the above project was approved subject to rewording the Patient Information Sheet in terms of inviting people to participate and including on the Patient Information Sheet an assurance that confidentiality extends to all members of the family, that is, information will not be shared between members. It is also requested that, on the Child's Information Sheet, a sentence be included to read "If any of the questions cause you worry or distress, please tell us immediately so we can stop this happening to you and to other people who may be given this questionnaire". The Child's Information Sheet should also clearly state the number of questionnaires involved, rather than "one or two". On the Parent Consent Form under 2(b), the wording should be "The researchers will be available to help you with any distress caused by the issues raised ....".

The Committee has requested me to make arrangements for progress reports to be submitted by the Investigator to the Committee at the end of twelve (12) months or sooner, if the project is completed within twelve months. You must also advise the date of termination of the project. Therefore, I would appreciate it if you would advise me of the actual date on which this project will commence and also let me have your progress report at the end of each twelve (12) months.

Could you please sign and return the attached copy of this letter, to indicate that you accept the conditions of approval .

SIGNED  .....Lyn Robertson

I acknowledge that I have read the above conditions, and agree to abide by them.

SIGNED.....Researcher



**Austin & Repatriation  
Medical Centre**

27th November 1997

**Dr Craig White**  
Secretary  
Human Research Ethics Committee  
Austin & Repatriation Medical Centre  
Burgundy Street  
HEIDELBERG 3084

**Austin Campus**

Studley Road Heidelberg  
Mail: Locked Bag 25 Heidelberg 3084  
Telephone (03) 9496 5000  
Facsimile (03) 9458 4779

**Repatriation Campus**

Banksia Street West Heidelberg  
Mail: Locked Bag 1 West Heidelberg 3084  
Telephone (03) 9496 2111  
Facsimile (03) 9496 2541

Dear Dr White,

re: 'An evaluation of inpatient family psychiatric treatment' (H95/054)  
Statewide Child Inpatient Mental Health Service  
Child & Adolescent Mental Health Service  
(formerly Child & Family Residential Unit, Department of Child, Adolescent & Family Psychiatry)

We are writing to provide an update to the above mentioned project which was approved by the Human Research Ethics Committee in July 1995 with Dr Peter Jenkins as the principal investigator.

As planned, data has been collected, since July 1995 until present date, at the three scheduled intervals - on admission, at discharge, and at six months post discharge from the programme. Following a pilot period, three of the instruments were not used further in the project. These were the Harter Self Perception Scale, the Achenbach Teacher Report Form, and the McMaster Family Assessment Device to be completed by clinicians. The parent-completed McMaster Family Assessment Device remained in the study. No other alterations have been made to the project.

As the Child & Family Residential Unit programme shifted to a primarily individual child admission focus in July 1997 as the Statewide Child Inpatient Mental Health Service, the current project is drawing to a natural conclusion. The final six month post discharge data is due to be collected in December 1997.

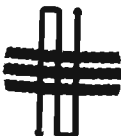
Ms Donna Volk (project co-investigator and former Unit Manager of the Child & Family Residential Unit), under the research supervision of Dr Suzanne Dean through Victoria University, will now complete the project in the form of her doctoral thesis, as partial fulfillment of the Doctor of Psychology (Clinical Psychology) degree. It is therefore requested that Dr Suzanne Dean be included as a co-investigator for the project.

If you have any queries or require further information, please do not hesitate to contact either Dr Peter Jenkins (9496 5108), Dr Suzanne Dean (9365 2336) or Ms Donna Volk (9243 1013)

Yours sincerely,

**Dr Peter Jenkins**  
Consultant Psychiatrist  
Child & Adolescent Mental Health Service  
Austin & Repatriation Medical Centre

**Ms Donna Volk**  
Doctorate of Clinical Psychology trainee  
Department of Psychology  
Victoria University





**Austin & Repatriation  
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Facsimile (03) 9496 2541

**TO:** Dr P Jenkins  
Dept of Child & Adolescent Mental Health Service  
Austin Campus

**FROM:** Dr Craig White, Secretary

**PROJECT:** An evaluation of inpatient psychiatric treatment

Correspondence from Dr P Jenkins & Ms D Volk (dated 27/11/97)  
updating study and amendment to add Dr Suzanne Dean as Co-  
Investigator.

**PROJECT NO:** H95/054

**DATE:** January 7 1998

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I wish to inform you that at the meeting of the Human Research Ethics Committee held on Friday December 12 1997 the protocol amendment (detailed above) for this project was approved.

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**Dr Craig White**

8.3

# **AUSTIN & REPATRIATION MEDICAL CENTRE**

## **ADULT PATIENT INFORMATION SHEET**

The study titled - 'An Evaluation of Inpatient Family Psychiatric Treatment' is designed to evaluate the outcome of family admissions to the Child & Family Residential Unit, within the Department of Child, Adolescent, & Family Psychiatry at the Austin & Repatriation Medical Centre.

Your family is invited to participate in this study. With your consent the study will be undertaken during your admission to the Child & Family Unit, at discharge and then again six months after discharge. It will involve several questionnaires that measure child, parent and family functioning. Family members and staff of the Child & Family Unit who have seen your family will be asked to complete questionnaires about your family. If your child(ren) is at school/kindergarten your child(ren)'s teacher will be asked to complete questionnaires about your child(ren). On average the questionnaires

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should take you a total of 90 minutes and your children 20 minutes to complete. This information will provide a comprehensive understanding of the difficulties which your family faces, changes occurring within your family and provide valuable information as how the team may best assist both your family as well as other families in the future.

Your participation in this study must be voluntary. If you express the wish not to be involved in this study, this will in no way compromise your management in this department.

You should ask for any information you want from the researchers who will see you. If you would like any more information about the study, or if there is any matter which concerns you either now or in the future, do not hesitate to ask one of the researchers or one of the clinical staff treating you. People you can ask include Peter Jenkins, Anne McLoughlin, Heather Evans, Donna Volk (all may be contacted on 496 5108) or Lyn Littlefield (479 2020).

Before deciding whether or not to take part you may wish to discuss the matter with a friend or relative or with the staff treating you. You should feel free to do this.

Information obtained about you and your family will be treated as confidential.

Confidentiality extends to all members, that is, information will not be shared between members of your family. We will not divulge information about you to other people except by your request and with your consent.

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**AUSTIN & REPATRIATION MEDICAL CENTRE**

**CHILD PATIENT INFORMATION SHEET**

**COVERING LETTER - CHILD CONSENT**

Dear .....

We are doing a research project to study whether (or not) and in what way admission to our Unit helps families.

To help us with our research we are asking you to answer a questionnaire and allow your parent(s) and classroom teacher to do so as well. These questionnaires ask you about yourself, ask your parent(s) about your family and your behaviour, and ask your teacher about your school work and behaviour.

If you do not want to answer the questionnaire, or if you do not want your parent(s) or classroom teacher to answer questionnaires about you that's OK. It won't make any difference to your treatment here.

If you feel OK about answering the questionnaire and allowing your parent(s) and teacher to answer the questionnaires about you, please sign the consent form attached.

If any of the questions cause you worry or distress, please tell us immediately so that we can stop this happening to you and to other people who may be given this questionnaire.

---

Thank you for helping us with our study.

Yours sincerely,

Peter Jenkins  
Anne McLoughlin  
Heather Evans  
Donna Volk  
Lyn Littlefield

(Research team for the Child & Family Residential Unit)

# **AUSTIN & REPATRIATION MEDICAL CENTRE**

## **ADULT (PARENT) RESEARCH CONSENT FORM**

I, .....agree to participate in a research project entitled: **"An Evaluation of Inpatient Family Psychiatric Treatment"** being conducted by Child & Family Residential Unit team members. My agreement is based on the understanding that:

**1. My involvement entails:**

**a) my completion of the following questionnaires:**

- i) Achenbach Child Behaviour Checklist for each child in my family**
- ii) General Health Questionnaire for myself**
- iii) The McMaster Family Assessment Device for my family**
- iv) Family Adaptability & Cohesion Evaluation Scale III for my family**

**b) agreeing to my child(ren) to complete the following questionnaires:**

- i) Achenbach Youth Self Report Form**
- ii) Harter Self-Perception Profile**

**c) agreeing to my child(ren)'s classroom teacher to complete the following questionnaires:**

- i) Achenbach Teacher Report Form**
  - ii) Harter Teacher's Rating Scale of Child's Actual Behaviour**
- 

**d) agreeing to staff of the Child & Family Residential Unit team to complete the following questionnaires:**

- i) Achenbach Child Behaviour Checklist for each child in my family**
- ii) McMaster's Family Assessment Device for my family**

**2. The following risks, inconvenience and discomfort have been explained to me:**

- a) The forms take me approximately 90 minutes, and each of my children 20 minutes to complete during admission, at discharge and then again six months after discharge**
- b) The researchers will be available to help you with any distress caused by the issues raised by the questionnaires during the admission period and also after discharge**



- 3. I have read the attached 'Patient Information Sheet' and understand the general purposes, methods and demands of the study.
- 4. I understand that the project may not be of direct benefit to me.
- 5. I can withdraw from the study at any time, without prejudicing my further management
- 6. I am satisfied with the explanation given in relation to the project so far as it affects me and my consent is freely given.

Signatures:

Read over and explained to the patient

Signed by the Investigator.....Date.....

Signed by the Patient.....Date.....

Signed by the Witness.....Date.....

Please feel free at any time to contact the researcher with regard to any queries or concerns you may have with regard to your participation in this project.

---

**AUSTIN & REPATRIATION MEDICAL CENTRE**

**CHILDREN'S RESEARCH CONSENT FORM**

I, ..... agree to take part in a research project called "An Evaluation of Inpatient Family Psychiatric Treatment" being undertaken by Dr Peter Jenkins, Ms Anne McLoughlin, Ms Heather Evans, Ms Donna Volk, and Mrs Lyn Littlefield.

My agreement is given on the understanding that:

1. I will be asked to answer a questionnaire, and to allow my parent(s) and classroom teacher to answer questionnaires about me.
2. I have been told that the questionnaire asks me about myself and that the other questionnaires ask my parents about my family and my behaviour, and ask my classroom teacher about my behaviour and school results.
3. I can ask any of the people involved in the study to help me if I have any worries or concerns.
4. I have been told, and understand, why the study is being done and how the study will be done.
5. I understand that the research project may not help me directly.
6. I can withdraw from the study at any time, without affecting any further help that I may need.
7. I am happy with the way the research project has been explained to me so that I know how it affects me, and my consent is freely given.

Signatures (Read over and explain to the child).

Signed by the Investigator.....Date.....

Signed by the Child.....Date.....

Signed by the Witness.....Date.....

## APPENDIX XII: Clinician Semi-Structured Interview

### SEMI-STRUCTURED INTERVIEW for CLINICIANS

#### **Introductory Statement:**

This interview will ask you to reflect upon your experience of therapeutic work with families admitted to the Austin & Repatriation Medical Centre's Child & Family Residential Unit (AC&FRU). The interview is divided into three parts covering your conceptualisation of the AC&FRU's

- a) underlying theory
- b) practice, as well as the
- c) overall outcomes for families admitted to the programme.

The interview should take about 60 minutes to complete. With your permission, the interview will be taped and once a written transcription has been completed, the tape will then be erased. Confidentiality regarding the specific content of individual clinician's interviews will be maintained at all times.

#### **A) Theory**

1. How did the AC&FRU programme conceptualise the presenting family difficulties?
2. How did the AC&FRU programme conceptualise the place of the identified patient's difficulties in the context of overall family functioning?

#### **B) Practice**

3. How did you see the AC&FRU programme addressing problems at a family level?
- ~~4. How did you see the AC&FRU programme address problems at an individual level?~~
5. How would you describe both your own and other team members designated roles on the C&FRU team?

#### **C) Outcome**

6. What benefits to the family were provided by their admission to the AC&FRU? What contributed to these benefits?
7. In what ways was a family admission to the AC&FRU not beneficial? What contributed to this not being a beneficial intervention for the family? What were the barriers, difficulties or challenges?
8. How did you perceive the outcomes for the identified patient compared with other family members?
9. Did you notice any changes in perception of family members at both an individual level and a family level over the course of treatment?
10. In conclusion, can you say what outcomes there have been for you, what, if anything have you taken from your experience with the programme to your subsequent work practice?

## APPENDIX XIII: Clinician Self-Report Questionnaire

### CLINICIAN QUESTIONNAIRE

Name:.....

Age:.....

The following questions are to provide background information regarding the training and experience of the clinicians who were involved in the Child & Family Residential Unit programme between July 1995 and June 1997.

- a) Over what time period were you a member of the AC&FRU team?
- b) What had been your professional experience prior to working on the AC&FRU?
  - i) number of years and prior experience working within the health field and mental health field?
  - ii) number of years and prior experience in child and adolescent psychiatry?
  - iii) please list any specialist training and/or experience in working with whole families within a child and adolescent mental health service (CAMHS) prior to your work on the AC&FRU
- c) What position did you hold on the AC&FRU team?
- d) What has been your professional experience since working on the AC&FRU?
- e) Please list any specialist training since working on the AC&FRU.



**Austin & Repatriation**  
Medical Centre

**Human Research Ethics Committee**  
Clinical Services, Austin Campus

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**Repatriation Campus**  
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**Royal Talbot Campus**  
Yarra Boulevard Kew  
Victoria Australia 3101  
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Telephone (03) 9496 4500  
Facsimile (03) 9496 4501

**TO:** Ms Donna Volk  
103 Ivanhoe Pde  
IVANHOE VIC 3079

**FROM:** Dr K (Humsha) Naidoo, Secretary

**PROJECT:** Stage 2 of an Evaluation of Inpatient Family Psychiatric Treatment.

**PROJECT NO:** H2000/01041

**Participant Information Sheet (Version 1 dated October 2000)**  
**Consent Form (Version 1 dated 5/10/00)**  
**Clinician Consent Form**

**DATE:** October 30, 2000

---

I wish to inform you that at the meeting of the Human Research Ethics Committee held on October 20 2000 this project was fully approved providing the following administrative points are addressed :

---

The Participant Information Sheet is to be adjusted as follows: 1) the wording *at the first two time intervals* is to be explained clearly to the participant. 2) the words *for thematic analysis* are to be deleted. 3) the word *attained* is to be changed to *obtained*. 4) the words *such as* (before ARMC) are to be deleted. 5) the sentence re *Confidentiality* is to be rewritten in a more realistic way, viz: *there is a possibility that it may be possible to identify specific comments even if they are deidentified*. 6) the words *unless prior consent has been given* are to be deleted. 7) the word *terminate* is to be replaced by the word *withdraw*. 8) the last sentence is to commence with *If you have any concerns during or following the project the researcher .....etc.* 9) the Consent Forms are to include *I agree to being audiotaped.*

**Please ensure that the document showing the administrative changes is returned to this office.**

It is now your responsibility to ensure that all people associated with this particular project are made aware of what has actually been approved. Any changes to the original application will require a submission of a protocol amendment to the Committee for consideration as this approval only relates to the original application as detailed above.

The Committee has requested me to make arrangements for progress reports to be submitted by the Investigator to the Committee at the end of twelve (12) months, or sooner if the project is completed within twelve (12) months. You must also advise the date of completion of the project. Therefore, I would appreciate it if you would advise me of the actual date on which this project will commence and also let me have your progress report at the end of each twelve (12) months.

The Committee wishes to be informed immediately of any untoward effects experienced by any participant in the trial where those effects in degree or nature were not anticipated by the researchers.

**DETAILS OF ETHICS COMMITTEE:**

It is the policy of the Committee not to release personal details of its members. However I can confirm that at the meeting, at which the above project was considered, the Committee fulfilled the requirements of the National Health and Medical Research Council in that it contained men and women encompassing different age groups and included people in the following categories:

Chairman	<b>Additional members</b>
Lay Man	<b>include :</b>
Lay Woman	Neuro-Psychologist
Minister of Religion	Nursing Administrator
Lawyer	Surgeon
Person with Research Experience	Pharmacologist
Person with Counselling Experience	Pharmacist

I confirm that the principal investigator or co-investigators were not involved in the approval of this project. I further confirm that all relevant documentation relating to this study is kept on the premises of the Austin & Repatriation Medical Centre for more than three years.

This Committee is organised and operates according to Australian guidelines of Good Clinical Research Practice (GCRP) and the applicable laws and regulations.

Could you please sign and return the attached copy of this letter, to indicate you accept the conditions of approval.

  
**Dr K (Humsha) Naidoo**

I acknowledge that I have read the above conditions and agreed to abide by them.

Signed: ..... Researcher

**7(B)**

Please be reminded that a condition of approval is that a 12 monthly Progress Report and/or a Final Report is to be submitted by all researchers.

Memorandum

REF:

ETH0247

TO:

Dr Suzie Dean  
Department of Psychology

FROM:

Dr Keis Ohtsuka  
Acting Chair, Faculty of Arts  
Human Research Ethics Committee

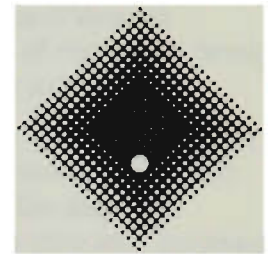
DATE:

20 November 2000

SUBJECT:

***HRETH.FOA.0038/00 involving human subjects***

**VICTORIA  
UNIVERSITY**



OF  
TECHNOLOGY

The Faculty of Arts Human Research Ethics Committee considered the following application which was granted provisional approval.

***Stage 2 of an Evaluation of Inpatient Family Psychiatric Treatment***

It was resolved to approve application HRETH.FOA.0038/00 from 1 November 2000 to 31 December 2001.

Dr Keis Ohtsuka

## PARTICIPANT INFORMATION SHEET

As a former team member of the Austin & Repatriation Medical Centre's (A&RMC's) Child & Adolescent Mental Health Service's (CAMHS's) Child & Family Residential Unit (C&FRU), you are invited to take part in the project:

### **"Stage 2 of an Evaluation of Inpatient Family Psychiatric Treatment".**

The aim of this project, jointly devised by the Austin & Repatriation Medical Centre and Victoria University, Department of Psychology, is to evaluate the effectiveness and process of short-term family inpatient treatment in a dedicated family admission programme in a child psychiatry setting.

As you may recall, Stage one of the project, conducted between July 1995 and July 1997 involved the parents of the families admitted to the C&FRU completing the Achenbach Child Behaviour Checklist (CBCL), the General Health Questionnaire and the McMaster Family Assessment Device – on admission, at discharge and then six months post discharge. As you will recall, the clinicians involved in working with these families also completed the Achenbach CBCL for each child at the first two time intervals – on admission to and at discharge from the programme. This data is currently being analysed.

Stage two of this project invites each of the clinicians who worked with the families during this designated time period to reflect more fully on the processes of, and perceived outcomes of the C&FRU programme. You will be requested to reflect on your conceptualisations of the underlying theory and practice of the C&FRU programme, as well as the perceived outcomes for the families admitted to the programme.

This will be undertaken through individual semi-structured interviews with the researcher Ms Donna Volk. It is planned that the interview, conducted at a location of your choosing, will take approximately 60 minutes to complete. An audiotape will be used and then once this material has been transcribed, the audiotape will be erased by the researcher.

Background information regarding your professional training and experience will also be required. This will be obtained through a self-report questionnaire that will take approximately 15 minutes to complete.

The interview transcripts and information regarding your professional training and experience will be kept under safe storage in a locked filing cabinet by the researcher for seven (7) years after completion of the study. Participant records may be inspected for purposes of data audit by authorised persons within the ~~respective institutions – A&RMC and Victoria University~~ Ethics Committees. Access to the data will otherwise be restricted to the researcher, Ms Donna Volk and her research supervisor, Associate Professor Suzanne Dean.

In all, the degree of risk, discomfort or inconvenience that may be encountered in relation to your involvement in this study is perceived by the researcher to be no more than that which would be encountered during the course of your daily working environment. It is possible however that you may experience some discomfort in reflecting upon the programme because it was discontinued, but is anticipated that this will be offset by the opportunity to have documented your views about the value of the programme.

Confidentiality regarding the specific content from individual clinician's interviews will be maintained at all times. As this project is to comprise the researcher's Doctor of Psychology (Clinical Psychology) thesis, the researcher will ensure that individual clinicians are not personally identifiable in the thesis or other reports of the study. However, it is important that you are aware that it is feasible that another individual may be able to identify the owner of specific comments even if they are deidentified.

Your participation in the project remains entirely voluntary and you may choose to withdraw at any time without prejudice.

If you wish to contact someone independent of the study, about ethical issues or your rights, you may contact Mr Max Griffiths, Chairman of the Austin & Repatriation Medical Centre Human Ethics Research Committee on (03) 93902241. Alternatively you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 MC, Melbourne, 8001 or telephone (03) 9688 4710.

If you have any concerns during or following the project, the researcher Ms Donna Volk may be contacted on \_\_\_\_\_ or her supervisor, Associate Professor Suzanne Dean of Victoria University may be contacted on 9365 2397.





**Austin & Repatriation  
Medical Centre**

<p><b>Version:2</b></p> <p><b>Date: 2/11/00</b></p>
---

## Consent Form to Participate in Research

<p><b>Project Title: Stage 2 of an evaluation of inpatient family psychiatric treatment</b></p>
---

I, ....., have been invited to participate in the above study, which is being conducted under the direction of Ms Donna Volk.

I understand that while the study will be under her supervision, other relevant and appropriate persons may assist or act on her behalf.

My agreement is based on the understanding that the study involves:

1. My completion of a self-report questionnaire regarding my professional training and experience.
2. Participation in a semi-structured interview which will require reflection on my conceptualisations of the underlying theory and practice of the Child & Family Residential Unit programme, as well the perceived outcome for the families admitted to the programme.
3. I agree to being audiotaped.

---

**Is this a drug trial? NO**

The study may involve the following risks, inconvenience and discomforts, which have been explained to me:

1. The self report questionnaire will take approximately 15 minutes to complete
  - ~~2. The interview will be of approximately 60 minutes duration.~~
  3. I may experience some discomfort in reflecting on the programme due to the circumstances of its discontinuation.
- I have received and read the attached 'Participant Information Sheet' and understand the general purposes, methods and demands of the study. All of my questions have been answered to my satisfaction. I understand that the project may not be of direct benefit to me.
  - I can withdraw or be withdrawn by the Principal Investigator from this study/project at any time, without prejudicing my further management.
  - I consent to the publishing of results from this study provided my identity is not revealed.
  - I hereby voluntarily consent and offer to take part in this study.

Signature (Participant)	.....	Date: .....	Time: .....
Witness to signature	.....	Date: .....	Time: .....
Signature (Investigator)	.....	Date: .....	Time: .....

## APPENDIX XVIII:

### Example of thematic analysis grouping process to third level of analysis

#### Q1: Responses by clinicians regarding the conceptualization of the presenting family difficulties

##### **1. Family system principles (9)** F2a, G1

###### a) seen as the main or one of main viewpoints (6)

- main viewpoint J1b
- one of two main theories
  - psychodynamic being the other A1a
  - developmental being the other B5a
  - humanitarian being the other D2a
  - broad umbrella/underlying theory H4, I2

###### b) difficulties seen in the context of the family and wider system (6)

- looked at family issues as played out by the child A1b
- provided a Q: 'a global view of everything from outside the family to the parental relationships to the child' A32a
- systems perspective allowed the team to get a handle on the issues for families A32b
- see the child's behaviour as a response to what was happening within the family and wider system eg. school and other relatives such as grandmothers B5b
- incorporated wider systemic issues such as involvement with care and protection & justice system D4

- 
- each person had a role to play in the family F2b
  - family development considered H2
  - tried to understand the child's difficulties in terms of the family context and wider social context that the family was embedded in J1a

###### c) drawn from various family therapy models (3)

- solutions focussed family therapy model C4
- systemic & structural family therapy models D3
- various family therapy models used by clinicians H11

##### **2. Psychodynamic principles (7)** D17, G46, I8a

###### a) psychodynamic perspective favoured by several people on the team who worked primarily with individuals within the family (5)

- visiting practitioners seen to function from one of the more narrow dynamic theories A13
- a few people on the team had more of psychoanalytic perspective, seen more of a determining theory than it was for other team members (two psychologists) B4b
- used mainly in individual work with a parent or a child H12
- used in couple and individual therapy I8b

- thought to be more important to clinicians who saw children individually J4b

b) various psychodynamic models identified (2)

- self-oriented Eriksonian perspective A2b  
- formulations had a Freudian/Kleinian feel A20c  
- Winnicott's idea of containment used in practice J13

c) seen as the main or one of main viewpoints (2)

- one of two main theories (the other systemic) A2a  
- considered to be very important J4a

d) details of framework (2)

- tried to integrate how it would be for the child themselves in their own development A2c  
- 'reflected on the child's and the parent's inner world and the family of origin's experiences and how those two coalesced' H5

e) psychodynamic theory not consciously integrated into the milieu work (1)

- team member's especially nurse's countertransference issues with the families not formally articulated or processed by the team I8c

- Q: 'I felt the nurses were at the centre of the activity and what was happening, but I felt as far as the, the conceptualising of what was happening, um, we were relegated to the cognitive behaviourist side of things and not really participating in the psychodynamic and talking about our own issues in relation to the, to the family' I8d

Q: 'the nurse would recount on what she saw, but never talked about her own experience of it ... that wasn't considered or asked to be considered'. I8e

- psychodynamic thinking did not seem to consciously integrate into the milieu work I18a

**3. Integration of several frameworks (7)**

a) range of theoretical perspectives applied (6)

- wide range of theories applied A5a  
- different practitioners would bring their own theoretical perspective to the family A5c  
- the team approach assisted in drawing together & integrating a number of viewpoints C26  
- eclectic conceptualisation C2  
- a multidisciplinary understanding was derived from team members contact with family members F3  
- the Unit operated theoretically with a variety models in mind H1  
- many working models operated at the same time with several dominant I15a  
- program integrated a variety of viewpoints J3

b) the manner in which various theories interacted (5)

- considered a good mixture of theories A5b
- systems theory perspective was the common ground with most people A5d
- little in terms of CBT approach A5e
- Q: 'So much of what was done could be seen from multiple (theoretical) perspectives' A10h
- ward-based programme seen to be trying to hit on the whole system (family) at multiple levels, theoretically 'tricky' – difficult to classify A11
- systemic and psychodynamic theories interacted fairly well B3
- developmental psychology theory seen as one of two main theories (other systemic) B4a
- psychodynamic theory was not the main theory for the team B6a
- team discussion for review of the family utilised a mixture of theories (generic development, life cycle, psychiatric...) H14
- the mode of practice was seen to be dependent on which process of the Unit being observed or listened to – milieu/day-to-day or somebody else's office H13
- each team member had their own theoretical perspective from which they worked I14
- behavioural strategies used were encompassed by a systems understanding J7a
- behavioural strategies were not an end within themselves but were used in collaboration with other strategies J7d

c) uncertainty regarding how several theoretical models worked together (1)

- systems theory and DSM approach viewed subsequently as conflictual and contradictory - issue regarding having a subjective view yet being able to diagnose an individual on one hand – looking at individual in context of relationships, what was happening in the family and influencing the behaviour of the child & on the other hand – providing a diagnosis I4
- theoretical perspectives weren't formally discussed that much which could make things difficult I10b
- viewpoints weren't objective I10a
- unsure how the different theories fitted together I16 & I19

d) team debates partially derived from differing theoretical perspectives (1)

- at times there would be combat over the relative importance of some of the dynamic theories as played out in team discussions re where to invest the team's resources for a given family eg. mother depressed - individual work with mother, parenting work with mother, biological treatment
- Q:- 'the relative importance of what was necessary was the usual debate' A6

- team debates regarding the diagnosis which reflected both differing theoretical perspectives but more so the evidence held by the practitioner regarding the individual's presentation A7a
- considered the perspectives were more determined by the roles clinicians were playing, than their theoretical perspectives, even though often couched in theoretical perspective terms by others A7b

#### 4. Cognitive-behavioural principles (5) B7, J6

##### a) predominately used within the milieu setting (4)

- there was a lot of practical behavioural parenting input A10a
  - this did reflect people's training or cognitive approach A10b
  - 'conditioning' or behaviourist type interventions not discussed or consciously applied A10c
  - a type of 'reconditioning' was applied A10d
  - eg. parent anxious about disciplining a child and have to deal with their fear about being abusive – be placed in a position that they would need to intervene and have to do it A10e
  - could be seen as psychodynamic as in the child needs these things, holding etc A10f
  - from parents point of view considered to be a 'conditioning' or 'anti-panic device' where they were effectively held so that they could deal with their anxiety and perform the necessary act as a parent –
  - Q: 'deconditioning of avoidant strategies' A10g

- predominately used within the ward milieu H10, I18b
- cognitive-behavioural informed management of children's behaviour on the Unit I7
- practice very influenced by behavioural management contracts J7b

##### b) use of the behavioural strategies allowed other issues to be explored and addressed (1) J7c

#### 5. Biopsychosocial principles (5)

##### a) described as a wholistic approach incorporating a range of factors and influences that impact on the individual and families (5)

- 'whole person level' A4,
- 'wholistic approach' C3
- parent's mental health issues, environmental factors, trauma/abuse, child developmental

problems, alcohol or drug problems, parent's personality type individual vulnerabilities, educational factors, culture within the family, history of the client	D26
- the couple relationship, child-parent relationship, parents experience of being parented themselves, wider systems issues – eg. school, parents own personal issues	G5
- wholistic approach incorporated biological, psychological, social and cultural factors in working with and conceptualising the families	I1a & I1b
b) <u>nurses predominately mentioned and worked within this theoretical orientation</u> (5)	(as above) & A12a
- approach considered favourable	A12b, I1c

## 6. Psychiatric diagnosis or biological status (5)

a) <u>consideration given to possible psychiatric diagnosis or biological status</u> (5)	
- most people willing to consider biological presentations	A20d
- straight psychiatric conditions minimised as people had been thru the filters pre admission and conditions addressed eg. BAD, PND, Sz	A20e
- recognition that at times the child had their own specific mental health issues	D35a
<del>- child's psychopathology and biological areas of life/diagnostic DSM</del>	<del>J2a, I3</del>
- eg. some children had severe ADHD	J2b
- children with ADD, PDD, autism	G3
- eg. Phobic, obsessional behaviour or thinking	D35b

## 7. Developmental psychology theory (3)

- children's maturity and how they responded to life circumstances	B4b
-	
- learning (education) theory	J5

## 8. Other relevant comments (2)

a) <u>team not seen to have a 'conscious way' of conceptualising family difficulties</u>	B1
b) <u>theory and practice seen as different</u>	H8

## APPENDIX XIX:

*Table displaying Percentage of IPs (n=24) Placed in the Clinical, Borderline and Normal Ranges by Mother- and Clinician-ratings on the Achenbach CBCL Summary Problem Scales at Time 1 and Time 2*

Summary Problem Scale	Time	Mother	Clinician
Total	1	N: 20.83% (n=5) B: 0% C: 79.17% (n=19)	N: 16.67% (n=4) B: 12.50% (n=3) C: 70.83% (n=17)
	2	N: 20.83% (n=5) B: 8.33% (n=2) C: 70.84% (n=17)	N: 33.33% (n=8) B: 16.67% (n=4) C: 50.00% (n=12)
Internalising	1	N: 16.67% (n=4) B: 16.67% (n=4) C: 66.66% (n=16)	N: 12.50% (n=3) B: 16.67% (n=4) C: 70.83% (n=17)
	2	N: 33.33% (n=8) B: 4.17% (n=1) C: 62.50% (n=15)	N: 41.67% (n=10) B: 16.66% (n=4) C: 41.67% (n=10)
Externalising	1	N: 25.00% (n=6) B: 8.33% (n=2) C: 66.67% (n=16)	N: 29.17% (n=7) B: 8.33% (n=2) C: 62.50% (n=15)
	2	N: 37.50% (n=9) B: 4.17% (n=1) C: 58.33% (n=14)	N: 37.5% (n=9) B: 12.50% (n=3) C: 50.00% (n=12)

Note: Summary Problem Scale T scores:

N: normal range <60; B: borderline range 60-63; C: clinical range >63

APPENDIX XX:

*Table displaying Mean Scores as Reported by Mothers and Clinicians on the Achenbach CBCL Summary and Syndrome Problem Scales for IPs at Time 1 and Time 2 (N=24)*

Summary Problem Scales				Syndrome Problem Scales								
	Tot	Int	Ext	I	II	III	IV	V	VI	VII	VIII	IX
M-T1	72.25	68.71	69.71	66.83	63.67	68.75	69.42	66.63	70.75	68.13	72.79	60.35
M-T2	66.75	63.50	64.42	66.25	58.38	66.00	66.54	60.83	66.92	63.75	66.79	59.00
C-T1	66.71	65.96	64.04	65.50	56.96	66.13	65.92	60.46	63.29	62.88	65.50	54.11
C-T2	61.46	60.71	60.54	62.13	53.42	61.79	63.21	54.67	61.46	59.96	61.58	52.58

Note:

Summary Problem Scale T scores: <60 normal range, 60-63 borderline range, >63 clinical range

Syndrome Problem Scale T scores: <67 normal range, 67-69 borderline range, >69 clinical range

Tot: Total, Int: Internalising, Ext: Externalising, I: Withdrawn, II: Somatic Complaints,

III: Anxious/Depressed, IV: Social Problems, V: Thought Problems, VI: Attention Problems,

VII: Delinquent Behaviour, VIII: Aggressive Behaviour, IX: Sex Problems

M: mother, C: clinician, T1: Time 1, T2: Time 2.



## APPENDIX XXI

*Table displaying Percentage of Siblings (N=17) Placed in the Clinical, Borderline and Normal ranges by Mother- and Clinician-ratings on the Achenbach CBCL Summary Problem Scales at Time 1 and Time 2*

Summary Problem Scale	Time	Mother	Clinician
Total	1	N: 29.41% (n=5) B: 11.76% (n=2) C: 58.82% (n=10)	N: 47.06% (n=8) B: 17.65% (n=3) C: 35.29% (n=6)
	2	N: 52.94% (n=9) B: 5.88% (n=1) C: 41.12% (n=7)	N: 52.94% (n=9) B: 23.53% (n=4) C: 23.53% (n=4)
Internalising	1	N: 41.18% (n=7) B: 11.76% (n=2) C: 47.06% (n=8)	N: 29.42% (n=5) B: 35.29% (n=6) C: 35.29% (n=6)
	2	N: 64.71% (n=11) B: 0% C: 35.29% (n=6)	N: 35.29% (n=6) B: 41.18% (n=7) C: 23.53% (n=4)
Externalising	1	N: 41.18% (n=7) B: 5.88% (n=1) C: 52.94% (n=9)	N: 58.82% (n=10) B: 0% C: 41.18% (n=7)
	2	N: 58.82% (n=10) B: 0% C: 41.18% (n=7)	N: 64.71% (n=11) B: 0% C: 35.29% (n=6)

Note: Summary Problem Scale T scores:

N: normal range <60; B: borderline range 60-63; C: clinical range >63

## APPENDIX XXII:

*Table displaying Mean Scores as Reported by Mothers and Clinicians on the Achenbach CBCL Summary and Syndrome Problem Scales for Siblings at Time 1 and Time 2 (N=17)*

	Summary Problem Scales				Syndrome Problem Scales							
	Tot	Int	Ext	I	II	III	IV	V	VI	VII	VIII	IX
M-T1	64.47	63.71	63.00	61.12	60.65	64.18	60.76	57.24	62.00	61.18	67.00	57.31
M-T2	58.35	58.00	57.53	58.18	59.06	59.76	56.88	52.88	58.71	60.41	60.18	56.06
C-T1	60.29	60.65	58.18	62.65	53.59	61.65	59.53	54.71	60.59	57.47	61.00	54.88
C-T2	57.71	59.47	55.41	60.41	53.00	61.88	58.29	54.35	58.41	55.00	57.71	54.00

Note:

1. Summary Problem Scale T scores: <60 normal range, 60-63 borderline range, >63 clinical range
2. Syndrome Problem Scale T scores: <67 normal range, 67-69 borderline range, >69 clinical range
3. Tot: Total, Int: Internalising, Ext: Externalising, I: Withdrawn, II: Somatic Complaints, III: Anxious/Depressed, IV: Social Problems, V: Thought Problems, VI: Attention Problems, VII: Delinquent Behaviour, VIII: Aggressive Behaviour, IX: Sex Problems
4. M: mother, C: clinician, T1: time 1, T2: time 2.
5. N=17, except for IX: N=16