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An Adolescent Unit Assessed: A Consumer Survey

By P. G. WELLS, A. MORRIS, R. M. JONES and D. J. ALLEN

The paper describes the therapeutic programme of the Young People's Unit, Macclesfield. Admission is based on a therapeutic contract agreed with the youngster and family. Data on the first 150 admission to the Unit are presented. The information was collected from all referring agencies and a sample of youngsters and parents after an average period of two years since discharge. Results were similar to those of other follow-up studies of discharges from adolescent units, i.e. 78 per cent of neurotic disorders, 53 per cent of mixed neurotic and conduct disorders and 47 per cent of conduct disorders showed improvement. There was a high incidence of recurrence of the most significant presenting symptom (72 per cent). Nevertheless, referrers and youngsters showed a positive attitude to the treatment experience. The possible relationship of this to the contract system is discussed. A longer period of stay was found to correlate positively with improvement in conduct disorders. There is a need for further research into what aspects of a treatment milieu produce significant and lasting changes in conduct disorders.

Introduction

Results from units admitting psychiatrically disturbed adolescents have been reported over the past twenty years. The studies differ significantly in many aspects of methodology such as evaluation of change, length of time to follow-up, and collection of data. Barker (1974) has recently drawn attention to the considerable difficulties in determining satisfactory measures of improvement following in-patient care. The various papers published support his comments. They indicate that psychiatric units for adolescents and children differ considerably in their admission and treatment policies. The goals of admission may also vary for different clients within a single unit. Some units tend towards the medical model of admission, e.g. the Maudsley Unit described in Warren's (1952) paper and the St Ebba's Unit described by Sands (1953). On the other hand Bruggen *et al* (1973) emphasize admission arranged with involved adults (rather than the youngsters) on a contractual basis aimed at the resolution of an immediate crisis with the family or other primary care group. Treatment on a given unit may vary with time.

There are also differences in the methods used in follow-up studies. Diagnostic classification varies: some studies use one derived from adult psychiatry, e.g. Annesley (1961), Masterson (1958); some use Rutter's (1965) classification of disorders in children, e.g. Warren (1965). Framrose (1975) uses the classification of childhood and adolescent disorders prepared by the Group for the Advancement of Psychiatry (1966). Most of the diagnoses made in these studies fall within the range of behavioural or neurotic disturbance. Psychoses or organic brain syndromes, when mentioned at all are much less common.

As noted above, there are considerable variations in length of time to follow-up, and in the way improvement was assessed. Some studies use an assessment made at discharge,

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e.g. Framrose. Others draw on information from a clinical interview several years after discharge, e.g. Warren (1965).

However, general trends are evident. Beskind (1962), reviewing follow-up studies up to 1961, indicates high rates of improvement in the psychoneuroses and affective disorders (80–90 per cent improvement), intermediate results (around 50 per cent improvement) in those diagnosed as psychopathic disorder, and poor outcome (30–40 per cent improvement) in those diagnosed as suffering from schizophrenia.

Warren (1965), using a minimum follow-up period of six years, indicates that two-thirds of those with neurotic disorders, just over one-half with mixed neurotic and conduct disorders and just over one-half with conduct disorders did well. Nurcombe *et al* (1973) confirm the good prognosis of those adolescents presenting with neurotic symptoms. Both Warren and Nurcombe draw attention to family involvement and attitudes as significant factors affecting prognosis.

In a review of prognostic factors identified in 13 follow-up studies, Gossett *et al* (1973) summarize the outcome in 8 of these. After a follow-up period of at least six months, a median of 83 per cent of those with neurotic disorder, 53 per cent of those with character disorder, and 45 per cent of those with psychotic disorder were rated improved.

Youngsters followed up from Approved Schools show poorer prognosis. Reconviction was the parameter used in a 1964 Home Office study. Sixty-seven per cent of the boys had been reconvicted three years after discharge. Annesley draws attention to the difference in prognosis between those adolescents in whom behaviour disorders appear to arise from severe constitutional and environmental disruption, and those from good backgrounds where the behaviour is better seen as a neurotic equivalent. It may be that factors such as these determine whether youngsters with behaviour disorders are selected for admission to adolescent units or Approved Schools, and they may also contribute to the differences in outcome.

This paper describes methods of treatment employed on a Young People's Unit and presents data from three sources about the outcome. A further paper will explore the attitudes of referrers, youngsters and parents to aspects of the treatment régime.

Treatment Environment

The Macclesfield Young People's Unit is a purpose-built building in the grounds of Parkside Psychiatric Hospital. It is also linked with the University Hospital of South Manchester. It is a modified therapeutic community with beds for 20 adolescents of both sexes between the ages of 13 and 17.

The aim of the Unit is to provide brief therapeutic intervention with selected families of adolescents in crisis.

Selection for therapy depends on the family's motivation to change and on their agreement that separation is needed for the changes to occur. This is the focus of the three pre-admission meetings, consisting of a home visit by a Unit social worker and nurse, a Clarification Meeting in out-patients and a Contract Meeting on the Unit. A referring agency representative is where possible expected to attend the latter two meetings. The culmination of a successful interaction between the Unit team and the family is a therapeutic contract, to which the youngster's assent is vital, which is given to the family and their referrer in writing. This expresses the dynamics of the problem and the changes in the family and in the youngster's behaviour which parents and youngsters agree to be desirable, and sets out what roles the Unit and the referring agency are to play during the youngster's stay. In this way the therapeutic partnership is provided with a clear focus of work. Progress on the agreement is then reviewed in a formal meeting every month with the youngster, his parents and the referring agency worker.

The Unit staff consider that no useful purpose can be served by admitting to this type of therapeutic setting a youngster who is neither capable of utilizing it to change, nor desires to. A youngster whose motivation is in doubt may be put on a points scheme, related to the earning of more time on the unit. It is thought that the very unintegrated personalities (Dockar Drysdale, 1968), most psychotics and those of subnormal intelligence require a more protective environment than this unit provides.

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Nursing staff on night and morning shifts, medical staff and youngesters meet daily in a morning community meeting. Each youngster is allocated a member of staff as individual counsellor and also takes part in daily group therapy. These alternatives provide for dependency, modelling, reality confrontation and peer group identification. There are weekly groups in art therapy and psychodrama. Education is provided at the Unit school, although some youngsters attend outside schools daily from the unit during the last phase of their stay.

The Unit attempts to modify destructive ways of behaving by restricting acting out and by providing maximum opportunity for talking out. This calls for a high staff/patient ratio and for emphasis on full and open communication among staff through frequent handovers, daily staff meetings and a weekly staff sensitivity meeting.

The Unit closes from Saturday morning to Sunday evening. Crises which erupt during weekend leave can be dealt with at weekly multi-family group meetings for parents and youngsters, purposely timed to take place on Monday evenings. Occasionally a whole family needing more intensive help is admitted for weekend conjoint family therapy.

The use of psychotropic drugs on the Unit is uncommon. Reality confrontation in community meetings and other group settings define acceptable boundaries of behaviour. Other controls include self- or staff-imposed room restriction, and staff and youngster arbitration meetings (to examine a youngster's behaviour and to agree upon some form of reparation or alternative way of behaving). Special Contract Review meetings can be called for the youngster, his parents, the referring agency and Unit staff whenever the contract is repeatedly jeopardized by any party. This may result in the youngster returning home temporarily or being discharged.

Method

A number of possible control groups were examined at the outset, but unfortunately none proved suitable. The local circumstances did not favour a random allocation to one or another unit. Nevertheless, a longitudinal study was considered to be of value.

All the youngsters discharged from the Unit from its opening on 28 November 1970 to 30 June 1974 were included in this study, which was planned retrospectively. Data collection started in January 1975. This gave a minimum follow-up period of six months and an average of 26 months. Case notes were used to provide demographic information only. Three major sources of information were used: referring agencies, youngsters and parents.

The referring agencies of all 150 youngsters were sent postal questionnaires. The referrer was asked to indicate on a checklist (based on one prepared by the Group for the Advancement of Psychiatry), the most significant symptom leading to referral and other minor symptoms. The referrer was asked what changes in symptom had been observed at the time of discharge and during the subsequent period. Further sections included information about referrers' attitudes to the pre-admission and treatment procedures, and asked for details of the youngster's overall performance after discharge in areas such as work, family and marital adjustment.

From the symptom checklist, the consultant psychiatrist, the clinical psychologist and the senior social worker each independently grouped the youngsters into diagnostic categories, using Rutter's classification. There was total agreement on 61 per cent of the cases, two-thirds agreement on 36 per cent and no agreement on 3 per cent. These last were excluded whenever diagnostic categories were used.

More detailed information was then sought from a random sample of 50 families whose youngsters had been in-patients for at least one month. The research graduate interviewed these youngsters where they were currently living. He was not known to any of the families and was not employed in treatment. A structured interview was tested and refined following a pilot study. A questionnaire was developed for joint completion by youngster and interviewer. The interviewer's responses to youngsters' questions about the interview were standardized to increase reliability. The questionnaire covered attitudes to the treatment experience, subsequent patterns of behaviour, and change achieved through the treatment

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experience. The youngsters were also invited to add any other comments.

The parents in this sample were sent a postal questionnaire which covered similar ground.

The computer facilities at Keele University were used for the statistical analysis.

Results

The total population consisted of 150 youngsters. Questionnaires sent to referring agencies produced follow-up data on 131 youngsters; a response of 87 per cent. Where information supplied was lacking, calculations of percentages and statistical significance involved the number of known values.

Interview information was available on 40 of the 50 youngsters in the 'detailed sample'; a response rate of 80 per cent. Of those not interviewed, four were 'missing from home', and six refused or avoided the interview. Replies were obtained from 26 of the 50 parents or guardians who were sent postal questionnaires; a response rate of 52 per cent. Referring agency information was available on 44 of the 50; a response rate of 88 per cent. Data were available from at least one source on all but one youngster in this sample. Overall, such response rates provided a favourable basis for analysis.

General characteristics ($N = 150$)

The population had been referred as follows:

Social Services Departments	28%
General practitioners	24%
Child Guidance Clinics	21%
Hospital child psychiatrists	12%
Adult psychiatrists	9%
Other sources	7%

They came predominantly from Greater Manchester (67 per cent) and Cheshire (21 per cent).

There were 65 (43 per cent) boys and 85 (57 per cent) girls. Their ages on admission were distributed between 12 and 17; those aged 14 and 15 constituted 70 per cent of the total. The mean age on admission was 14·2 years. Since this study was conducted the mean age on admission has risen sharply following the raising of the official school-leaving age.

The distribution of social class by guardian's occupation (using the Registrar General's Classification Manual) was as follows: Class I: 5; Class II: 12; Class III: 59; Class IV: 33; Class V: 33; not known: 8. (Although the figures were compiled by three successive social workers, it was not possible to test for inter-rater reliability.)

Youngsters stayed on the Unit for periods ranging from a few nights to just over nine months. Most youngsters (56 per cent) stayed between three and six months, but a large proportion (34 per cent) stayed for less than three months. The mean length of stay was 3·2 months. The time between discharge and follow-up varied between 7 and 48 months.

Of those youngsters about whom information was obtained 90 per cent had been away from the Unit for over one year and 56 per cent for over two years. The mean post-discharge period was 26 months.

The population characteristics of the 150 youngsters outlined above, and those of the detailed sample of 50 were essentially similar.

Symptoms and classifications

Referrers reported one main and an average of five minor pre-admission symptoms for each youngster (see Table). School refusal, depression, aggression towards people and sexual behaviour problems were the most frequently stated main problems. Among minor problems there was a high incidence of aggression towards people, lying, inability to relate to peers, inability to relate to adults, temper tantrums, running away and depression. Certain symptoms with a high overall incidence were rarely viewed as a main problem. This applied particularly to lying, inability to relate to peers, inability to relate to adults, temper tantrums and aggression to property.

Diagnostic ratings were accepted as viable on 122 youngsters. Of these 26 (21 per cent) were classified as neurotic disorders, 43 (36 per cent) as mixed (conduct and neurotic) disorders, and 43 (36 per cent) as conduct disorders. These groups did not differ greatly in their sex, age on admission, or rate of admission, but

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TABLE

The distribution of pre-admission symptoms and their post-discharge history (mean follow-up period 26 months)

Symptoms	Pre-admission (N = 125)*			Main symptoms (N = 102)*			Minor symptoms (N = 102)*		
	Main	%	Minor	Improvement	No change	Deterioration	Improvement	No change	Deterioration
Somatic disturbance	4	(3)	16	3	0	1	4	9	1
Over anxious	7	(6)	23	6	0	0	7	15	2
Depressed	14	(11)	33	8	2	0	10	19	2
Specific phobias	1	(1)	3	1	0	0	0	2	0
Aggression to people	15	(12)	45	5	4	2	22	21	0
Aggression to property	1	(1)	18	1	0	0	8	10	0
Aggression to self	5	(4)	18	2	1	1	9	8	2
Stealing—solitary	7	(5)	14	3	3	0	5	7	1
Stealing in groups	5	(4)	14	4	1	0	3	10	1
Lying	0	(0)	44	0	0	0	15	26	1
Running away	9	(7)	33	3	4	1	12	17	3
Truanting	5	(4)	28	1	3	0	7	13	3
School refusal	17	(14)	27	6	5	0	11	11	0
Impulsive	4	(3)	27	0	3	0	6	19	2
Temper tantrums	4	(3)	43	1	3	0	17	23	0
Sexual behaviour problems	10	(8)	21	7	2	0	5	13	2
Unable to relate to peers	1	(1)	45	1	0	0	16	26	3
Unable to relate to adults	6	(5)	45	1	2	2	20	21	3
Psychotic disturbances	5	(4)	7	2	1	2	3	3	1
Other	5	(4)	6	1	3	0	1	4	0
Total no. of symptoms	125		510	56	37	9	181	277	27
Percentages		100		55%	36%	9%	37%	57%	6%

* N = Youngsters involved.

neurotic youngsters stayed significantly longer on the Unit compared with the other groups ($P < 0.01$).

A further 10 youngsters (8 per cent) fell outside the main diagnostic groups: psychotic disorder 5, personality disorder 3, hyperkinetic disorder 1, and developmental disorder 1.

Changes in symptoms

Details of changes in the main and in a range of minor symptoms were available for 102 youngsters. Total improvement, or some, in the main symptoms was observed in 56 (55 per cent), no change in 37 (36 per cent), and some or considerable deterioration in 9 (9 per cent) of the youngsters. Improvement was recorded in 181 (37 per cent) of the minor symptoms, no change in 277 (57 per cent) and deterioration in 27 (6 per cent). From other observations it appeared that the number of 'no changes' was inflated by a few instances by referrers who were evidently equating this with 'not known'.

The changes in symptoms for each diagnostic category were compared. Improvement in the main symptom was reported in 78 per cent of neurotic disorders, 53 per cent of mixed disorders, 47 per cent of conduct disorders, and 44 per cent of other disorders. The trend in favour of neurotic youngsters is not significant. This pattern of differential improvement is not repeated among the minor symptoms, which show considerable uniformity regardless of diagnosis.

Recurrence of symptom

Whatever changes occurred in the intensity of the symptoms, the pattern was more rarely extinguished. Although the main symptom was

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reported as improved for 55 per cent of youngsters, its recurrence was reported for 72 per cent. The proportion of youngsters whose main problem recurred showed little variation between diagnostic groups (neurotics: 70 per cent; mixed: 68 per cent; and conduct disorders: 80 per cent.

School and work

Figures for the work attendance of those who had passed school-leaving age and left full-time education were available for 42 youngsters, of whom 24 had a poor work record. No significant relationship was found with the main presenting symptoms. When work attendance was compared with the minor symptom checklist, a marked but non-significant association was found between poor work attendance, truancy ($P < 0 \cdot 07$) and running away ($P < 0 \cdot 06$).

Agency attitudes to future referrals

The effect of Unit treatment could be reflected in attitudes to the referral of further families. Of the referrers 63 were very or mildly enthusiastic, 26 were neutral, 15 were doubtful and one would never refer again. The attitudes did not correlate highly with whether agencies did actually refer again, and 49 had done so. One condition which influenced the responses of some referrers was their low frequency of contact with families for whom Unit treatment would be considered appropriate. The unit catchment area too, is very large (population 4½ to 5 million) and agency use of the unit was inevitably determined by the distances involved.

The client's opinions

Youngsters ($N = 40$) and parents ($N = 26$) in the detailed sample responded to a balanced series of questions and statements about the treatment experience and outcome. Of the youngsters 65 per cent felt they had sorted their problems out whilst at the unit, although 85 per cent felt that these had continued in some form afterwards. Responses in general showed a high satisfaction rate, with very few disparities between youngsters and parents.

Length of stay and time since discharge

Longer stay was associated with improvement in the conduct disorders ($P < \cdot 005$), and this trend was found in the mixed disorders also, though not at a significant level. Although neurotic disorders had a significantly longer stay than other categories, their tendency towards a higher rate of improvement was not associated with length of stay.

In the period after discharge only mixed disorders were found to be deteriorating significantly with the passing of time, both in reported non-improvement and symptom recurrence. Conduct disorder showed the lowest association between poor outcome and length of time since discharge.

Discussion

Many follow-up studies from psychiatric adolescent units do not use adequate control groups. This study is no exception, since the random allocation of youngsters to the type of environment described earlier proved impracticable. Assessment of the value of a unit as an agent of therapeutic change and any quantification of the later experience of the youngsters have usually relied upon subjective criteria. Commonly reports derive from one source, e.g. parents as follow-up (Annesley, 1961) or discharge interviews conducted by unit staff (Barker, 1974), or clinical interviews supplemented by such reports as were available from other professionals (Beskind, 1962).

The present study attempted to overcome the inadequacy of single measures of outcome by employing an independent research worker to gather the evaluations of the three consumer groups—referrers, parents and youngsters after an average follow-up period of just over two years. The weakness of this approach is that inevitably some information provided second-hand from referring agency casenotes might be more detailed about youngsters who continued to make demands upon agencies. Referrers' responses may also be influenced by their cultural and agency frameworks.

Nevertheless, a tripartite consumer survey may be assumed to provide a more comprehensive picture of outcome than one derived

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from a single clinical interview. Similarly, the use in this study of one main presenting symptom and a range of minor ones, each rated by the referring agency at follow-up, yielded a richer harvest of information on which to evaluate improvement than from the rating of only one or few symptoms. Furthermore, the survey provided a thorough picture of changes over time, and the high response rate suggested a satisfactory commitment to the study.

It has been said that any treatment for neurosis must show better than 70 per cent improvement before it can claim to represent a significant therapeutic advance. Eysenck (1965) postulated a gross spontaneous remission rate of approximately two-thirds for neurotic disorders over a two-year period. Although the finding in this study of an improvement rate of 78 per cent in the neurotic group is favourable, it has to be contrasted with a recurrence of the main symptom in 70 per cent. No data were available about how temporary or otherwise the symptoms were when they recurred, but the overall improvement suggested that relapses were neither severe nor prolonged. This result compares with the two-thirds improvement in Warren's study (Warren, 1965) and 80 per cent improvement in Framrose's study of youngsters on discharge (Framrose, 1975). However, the use of three external reference groups to assess outcome in this study avoids both the bias arising from Unit staff appraising their own results and the limitations of single measures of outcome.

Figures for improvement in conduct disorders and mixed (neurotic and conduct) disorders are more modest, a trend reflected in many studies. Improvements of 47 per cent and 53 per cent respectively must be contrasted with recurrence of main symptoms in 80 per cent and 68 per cent. The improvement in conduct disorders compares with just over 50 per cent found by warren, and 53 per cent found by Gossett *et al.*

Considering that youngsters admitted to the Unit are selected on the grounds that they appear to show some motivation to change their behaviour, these results may imply that motivation in these groups does not survive for long after discharge; or that the therapeutic milieu is unsuitable; or that selection is faulty. It is well known that conduct disorders are resistant to treatment, and the results published from both therapeutic and more containing environments are uniformly disappointing.

Although Framrose and others indicate that impulsive youngsters have the poorest outcome, it does not follow that the milieu described at Edinburgh, or that described here, are therapeutically impotent. According to Framrose 18 of the 33 impulsive youngsters did achieve a good outcome. The present study showed that those with conduct disorders did not deteriorate with the progression of time but either immediately reverted to past behaviour or were substantially improved. Improvement in conduct disorders correlated significantly with the length of exposure to the treatment environment—to what extent this was cause and effect or the result of the earlier discharge of more intransigent youngsters is uncertain.

The results for conduct and mixed disorders, suggest that treatment for them may be insufficiently symptom-specific. The hopeful expectancy that exposure of youngsters to artificially fostered good relationships, the development of insight into the determinants of their behaviour and the salutory experience of the frequent costly consequences of anti-social behaviour should suffice to mediate change in many exhibiting conduct and mixed disorders has not been fulfilled. This does not imply, however, that these components of the therapeutic régime should be abandoned or that they are not of benefit to some.

Research should perhaps now be directed to determine which influences impart a more lasting effect. There has been controversy over the most appropriate type of treatment milieu for youngsters with conduct and mixed disorders. Scott (1964) maintained that although Approved Schools may need to be improved 'there is no firm evidence that they are on the wrong track'. This point, that 'the so-called modern schools' may make little difference to outcome was confirmed by the authors of a recent Home Office Study (Cornish and Clarke, 1975) in which delinquents were randomly allocated to a therapeutic community setting and a more paternalistic régime. Dunlop (1975) found that success rates at Approved Schools

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ranged from 54 per cent to 20 per cent (although only 16 per cent had not reoffended after two years), and found that success was highly related to the degree of agreement existing between boys and staff as to what was important in their experience at the school. The present study indicates substantial support for this finding, which we hope to amplify in a further paper. Dunlop also found success to be highly related to the school's emphasis upon trade training, not because of the training in itself, but because it provided a means by which 'the boys felt that the best opportunities were provided for them to develop responsibility and mature'. She implies that the relationship-orientated schools placed little emphasis upon responsible behaviour.

The Unit staff believe that negotiating a junior partnership with a youngster, and putting it in writing in the form of a therapeutic contract conveys to him that he is taken seriously and is expected to respond in a responsible way. When this cue is missing, he may assume that the contrary is expected and soon may find supportive evidence for this view. The failure to make this cue sufficiently explicit both in therapeutic communities and units employing a dependency model may serve to confuse both staff and patients, particularly over the aims and goals of treatment.

Whether the clarity of a contract plays a significant part in mediating changes in symptoms remains to be tested. Whether it is instrumental in reducing the period of separation (average stay 3·2 months) of a youngster from his family by facilitating changes early may also repay closer study (Bruggen *et al* (1973).

Nevertheless, the contract system and the periodic review meetings with each family provide a structure well suited to the furthering of insight and motivation to change. Response from youngsters and parents in this study—the subject also of a second paper—does indicate that a relationship-orientated milieu can foster strong and mutually acknowledged responsibilities with some beneficial effect. However, the results give no indication that the treatment environment was sufficiently developed to enable a high proportion of youngsters to modify their behaviour *totally* to any lasting extent.

This study demonstrates that the majority of youngsters improve, but that equally for the majority the main symptom recurs, although in a less intense and more tolerable form.

Treatment environments for disturbed adolescents may now benefit from attention to developing a more symptom-specific dimension of treatment, and to developing means of reinforcing residential treatment beyond discharge.

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