ISSUES IN CLINICAL PRACTICE: INNOVATION

By

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This is to certify that except where acknowledgement is given, this thesis is my own work. It has not been submitted in part, or in total, for any other award.

Monica May Maud.

ABSTRACT

One of the requirements for the D. Psych. was to undertake three practical placements in clinical settings and to undertake a small research project in each. Reports were prepared for each placements and a fourth article was prepared to discuss the practice issues that relate to those placements. The theme explored in relation to the 3 projects was the issue of innovation in clinical practice. As shown in the various reports, innovation can occur at a micro level as in Study 1 when aspects of two therapies were combined in an attempt to speed therapy; in Study 2 the innovation was more routine and practical in amalgamating the various practices of different Departments at the Ballarat Health Services into a Treatment Protocol for the treatment of young patients affected by critical eating disorders, or innovation in a wider sense; in Study 3 the effectiveness of a new treatment centre was researched. Some of the ethical and practice issues around innovation in clinical practice were examined in the final paper.

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INNOVATION IN CLINICAL PRACTICE

OVERVIEW

The following three studies were undertaken as part of programme of the Doctorate of Psychology (Clinical). A fifty-day practicum was undertaken at each of the following: the Ballarat and District Aboriginal Co-operative, the Ballarat Health Services, and at Pomegranate House. Whilst the student was a registered psychologist with more than a decade of experience, each practicum extended the student's experience, strengthened her skills, raised new issues about practice, offered new rewards, and deepened the student's knowledge of psychology in general.

An additional requirement for these placement studies was that there should be some uniting theme for the research undertaken during these placements. Inevitably, because the settings were so diverse, the tasks undertaken in each setting reflected the needs of the different organizations, not the student's needs. As a result, the three studies described here do not reflect a carefully pre-orchestrated overall plan. Nonetheless, a common theme was identified post hoc, namely, the issue of innovation. So the final chapter reviews the individual studies in the light of current thinking on innovation. It applies an innovation model, originally developed by Anderson, De Dreu, and Nijstad (2004), to demonstrate innovation in organizations and in clinical practice.

The first study, presented in Chapter 1, looks at innovation in individual therapy. The innovative element in this study was, in the hope of speeding up therapy, to combine elements of two unrelated therapies. The second study involved innovation at a group level. Here the task was simply to develop a new practice protocol for the treatment of children and adolescents admitted to hospital with eating disorders. The newly amalgamated Ballarat Health Services (BHS) sought a unified approach which reflected the requirements of the various departments involved in the treatment of such young patients. The third study (Chapter 3) was undertaken at the newly established therapy centre, Pomegranate House. This study examined how successfully the new centre was at meeting the goals that had been set for it before it opened. The innovative element in this study was simply the establishment of the new centre itself. The fourth section (Chapter 4) reflects on the issue of innovation in clinical practice. It looks at the tension between the push for careful, empirically supported practice, and innovation.

CHAPTER 1

INNOVATION IN PSYCHOLOGY

Overview

As indicated earlier, the circumstances under which students undertake their placements make it difficult for them to identify what the uniting theme for their placements will be in advance. In this case, it became apparent, post-hoc, that all three studies were concerned with innovation in clinical practice. The concept of innovation is introduced in this chapter.

Because innovation is a topic generally more of interest to organizational psychology than to clinical psychology, the literature of organizational psychology was consulted to identify a suitable theoretical framework from which to examine clinical innovation. The model selected was the one proposed by Anderson, De Dreu, and Nijstad (2004) and is outlined in the next section.

What is innovation?

Before discussing the Anderson et al. (2004) model, it is important to clarify what is meant by innovation. The definition favoured here is one proposed by West and Farr (1990). They write that innovation is "the intentional introduction and application … of ideas, processes, products or procedures… designed to significantly benefit the individual, the group, the organization or wider society" (West & Farr, 1990, p. 9). In the light of this definition, it is clear that innovation also occurs in clinical psychology.

Anderson et al. (2004) distinguish between innovation and creativity. They suggest that whereas creativity can refer to idea generation alone, innovation refers to the implementation of the idea (Anderson et al., 2004).

Some of the necessary pre-conditions for innovation are: an ability to generate hypotheses that "jolt one's conceptualizing out its usual ruts" (McGuire, 1997, p. 11); an ability to "recognize and account for the oddity of occurrences" (McGuire, 1997, p. 3); and the ability to conjecture 'interaction variables that qualify a relation" (McGuire, 1997, p. 4). Innovation also requires deductive reasoning and the ability to integrate past information.

Distress-Related Innovation Model

While innovation can arise as the result of individual creativity, come about through teamwork, or, at an organizational level, be the result of an organizational culture that supports creativity and innovation (Anderson et al., 2004), it generally arises in response to some problem. Anderson et al. (2004) put forward what they call their 'distress-related' innovation model. This model suggests that innovation arises out of distress at an individual, group or organizational level. That is, the innovation process only starts when some distress or stress is recognized; it continues when creative ideas are generated to respond to stress; and the process is only complete once the creative idea has been implemented.

There are three stages of innovation. These are the recognition of distress to act as a spur, the introduction of the innovation, and the consequences of innovation.

Figure 1. Stages of Innovation.

In this model, innovation is a dynamic process, and it occurs in a cyclical or dialectical manner. One need or distress precipitates an innovation, then the implementation of the innovation reveals another need, and this spurs the next round of innovation, and so on. These stages and processes will be referred to in the other chapters as the various studies are discussed.

Levels of Innovation

Because distress can occur at three levels, individual, group or organization, innovation also arises at these different levels.

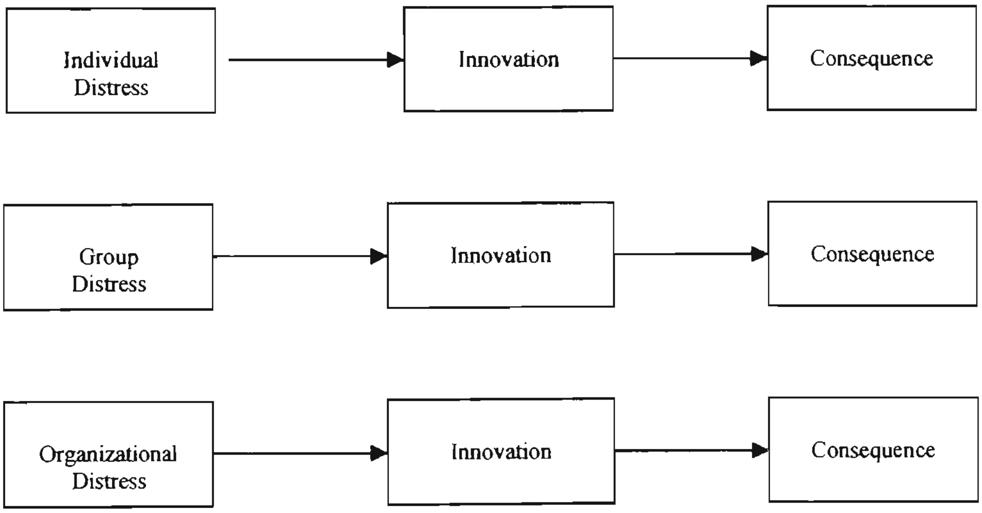

Figure 2. Levels of distress and innovation.

Individual distress can arise out of negative mood states, dissatisfaction, conflict or ambiguity. In Study 1, the distress that pushed innovation was distress at an individual level. Here the individual clinician felt conflict. She wanted to follow a treatment plan, but could not know in advance whether there would be adequate time for this treatment to take place. This dilemma spurred the clinician to be creative and to hypothesize a novel solution and implement it. In this way, innovation occurred.

Distress at the group level can be the result of intergroup distress, competition, task conflict, or minority dissent. In Study 2, the group stress arose, not from group conflict, but from a lack. Because the Ballarat Health Services had recently amalgamated a number of previously autonomous services, the hospital had no protocol for the treatment of young eating-disorder patients. Innovation occurred when the different groups combined to address this and a protocol was developed.

Innovation can also occur at the organizational level. At this level, distress arises out of a turbulent environment, or from the recognition of deficiencies. Study 3 illustrates distress of the latter kind, namely, the recognition of a deficiency. In this case, a number of discrete, unrelated organizations all recognised that there was no psychological service to which they could refer their less wealthy clients. This recognition of deficiency brought them together in an attempt to remedy it. Together they worked to visualize a remedy and to develop a new treatment centre. Innovation can be said to have occurred when their idea was implemented and the new treatment centre was opened for business.

Impact of Innovation

Innovation can arise at one level, but impact at another level. For example, innovation at an individual can impact at an organizational level. The opposite can also be true, such as when organizational innovation impacts at a group or individual level. This multi-level cyclical innovative process is illustrated by Andrews et al. (2004) and reproduced in Figure 3.

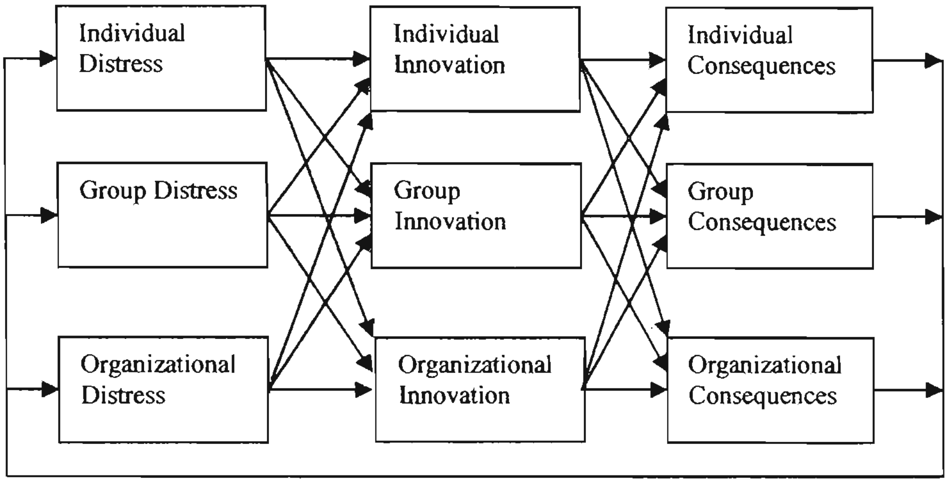

Figure 3. Levels, stages, and consequences of innovation cycle (Andrews et al., 2004, p.15).

This cyclical process of innovation can be clearly seen when the history of clinical psychology is examined. A clinician notices a gap; then, alone or in concert with others, the clinician develops and tests a new therapy. This therapy is then implemented at the level of the individual, as when it is applied in the treatment of the individual patient. It is also responded to at an organizational level, as when it is endorsed by professional bodies.

These levels and stages of innovation are returned to in the final chapter.

Conclusion

Innovation involves the perception of distress, the conception of a novel solution, and the implementation of the solution. Innovation can arise at the level of the individual, group or organization.

The next three chapters are devoted to describing the three studies undertaken on the placements. The studies exemplify clinical innovation at the individual, group and organizational level.

CHAPTER 2

STUDY 1: INNOVATION IN INDIVIDUAL THERAPY: A CASE STUDY

Overview of Study 1

The innovation discussed in the first study refers to innovation at the level of the individual. Study 1 is a case study of the progress of a young woman through treatment and beyond.

Background

In 2001 the therapist undertook a clinical placement at a local community agency, the Ballarat and Region Aboriginal Co-operative. During the placement, the therapist provided a number of services to members of the community: individual counselling, staff development, and anger management.

The following case-study was undertaken to examine whether 'desensitizing' a particular Early Maladaptive Schema (EMS) held by the patient would bring any noticeable relief to the patient. The student, a registered psychologist since 1993 and member of the APS Counselling College, as part of ongoing professional development, had undertaken Level 1 and 2 training in Eye Movement Desensitization and Reprocessing with Shapiro in 1992 and 1994, and training in Schema Focused Therapy in 1994.

As a background to Study 1, a brief overview is given of cognitive therapies in general, and some brief details of two recently developed ones, namely, Young's

Schema-Focused Therapy (Young, 1990), and Shapiro's Eye Movement Desensitization and Reprocessing (Shapiro, 1989a, 1989b, 1995).

Cognitive Theories of Psychological Disorder

Cognitive approaches to therapy, such as Cognitive Therapy (CT) (Beck, 1976), Rational Emotive Therapy (RET) (Ellis, 1962), and similar (Kendall & Watson, 1986; Salkovskis, 1996; Young, 1990), all point to the importance of thought in emotional and mood disorders. Since their advent about fifty years ago, these therapies have become increasingly popular. In part, this is because these therapies are brief and amenable to empirical research. In fact, Simos (2002) claimed,

> CBT fulfils the criteria for a true system of psychotherapy by virtue of the fact that it provides a comprehensive theory of psychotherapy and a body of knowledge and empirical evidence to demonstrate its effectiveness (p. xiii).

These cognitive therapies are based on the idea that emotional disorders, as well as being associated with behaviour and biochemistry, are associated with cognitions. In fact, they suggest that it is precisely the way in which a depressed individual processes information that contributes to their depressive symptomatology (Young, Weisenberger, & Beck, 2001). For example, depression has been shown to be commonly associated with negatively biased cognitions, such as viewing oneself as 'worthless, inadequate, unlovable, and deficient' (Young, et al., 2001, p. 269), and viewing the environment as overwhelming, believing that there is no way to overcome this, and that should one try, one will fail. Depressed persons see the future as hopeless and, for this reason, often entertain thoughts of suicide (Clark, Beck, & Beck, 1994).

Beck (1976), Young (1990), and Stein and Young (1992) claimed that a predisposing factor in many depressed patients, is the presence of what they term maladaptive schemas. Schemas are thought to be “cognitive structures” for “screening, coding and evaluating the stimuli that impinge upon the organism” (Beck, 1976, p. 283). When such maladaptive cognitive schemas are activated, they bias an individual’s perceptions, and trigger negative emotions such as depression, anxiety or anger. In addition, when they are active, maladaptive schemas make positive schemas less accessible. This makes it is difficult for an individual to challenge these negative cognitions.

From his work with patients with a range of personality disorders, Young (1990) identified a number of maladaptive schemas. Because he thought these schemas originated in early life, he called them Early Maladaptive Schemas (EMSs). He developed the Young Schema Questionnaire (YSQ) to explore these EMSs, and used them as the basis for his Schema Focused Therapy (SFT).

Schema Focused Therapy.

Schema Focused Therapy was specifically developed for working with persons who had developed personality disorders, which traditionally are regarded as disorders that are extremely treatment-resistant. SFT is also used with patients who show similarly highly charged beliefs, for example, with depressed patients (Young, Weinberger, & Beck, 2001). Because the maladaptive beliefs associated with these disorders have such high emotional valency, mere ‘logic’ is not sufficient to challenge and shift them. Once an individual has acquired an EMS, he or she believes that the cognitions associated with it, are true. The individual either tries to avoid situations that trigger EMSs, or overcompensates for the schema by acting in ways which, perversely, serve to strengthen it. Schema-focused Therapy is a fairly lengthy process. It combines cognitive behavioural therapy and goal setting. Patients are trained to recognize their automatic thoughts, and therapy includes experiential and didactic exercises. SFT also includes a type of exposure therapy through a regime of homework. This can take the form of deliberately triggering EMSs, then reading flash cards which display statements that challenge the triggered EMS. Because SFT requires both in-session work and out-of-session homework, it is best suited to clients who are able to make a commitment to ongoing therapy, to manage their time, and have the motivation to do follow-up homework. For this reason, SFT is less suitable for clients with more chaotic life circumstances, or who are unable to do 'homework' consistently. In such cases, a more rapid method of addressing the distressing schemas is required.

Eye Movement Desensitization and Reprocessing

Another novel treatment which targets negative cognitions is Eye Movement Desensitization and Reprocessing (EMDR). EMDR was developed serendipitously by Shapiro (1989b). It is based on the assumption that the discomfort of anxiety, depression or fear can be triggered by negative beliefs or physical sensations or mental pictures. Even though the effects of the negative schemas are not as distressing or as dramatic as the flashbacks experienced in PTSD, they reduce a person's sense of well-being. The EMDR procedure is as follows. The therapist takes a history and explains the EMDR treatment to the client. Should the client wish to proceed, the client then decides a problem to work on. The client is then asked to hold an image of the traumatic event, and to name the negative self-cognition or self-statement that comes up when the client thinks about the event. An example of a negative self-cognition could something like the thought "I don't deserve to be happy." Next, the client designates how he or she would rather think about him or herself – the Positive Cognition. Then the client describes any negative emotions experienced when thinking about the traumatic event, and rates how upset he or she feels when thinking about it. This rating is known as the Subjective Units of Distress (SUDS). In addition, the client identifies any physical sensation or discomfort experienced anywhere in the body when thinking about the negative event or mental picture (Shapiro, 1995).

From here, the client is required to concentrate on any of the following: the distressing picture, the thought or self-cognition, the body sensation, or the emotion, whilst at the same time watching the therapist's pen or finger as it is moved from side to side, or up and down. After a 'set' of eye movements, that is, about a dozen eye movements, clients are asked to report any changes in thought, emotion, sensation or image. This continues until the troubling material is 'desensitized,' indicated by the SUDS rating being substantially reduced. When the emotional valency of the cognition has been reduced and the client believes the positive cognition, then the positive cognition is held in mind whilst further eye movements are undertaken. This is known as 'cognitive interweave,' which aims to strengthen the positive cognition. Case studies and more extensive formal studies have shown that positive and dramatic results have been obtained by some PTSD clients who have found that EMDR can bring rapid, long-lasting and marked relief (Shapiro, 1989a, 1989b, 1995; Wilson, Becker, & Tinker, 1995; Wolpe

& Abrams, 1991). Such therapies are described as being a 'very' brief therapy, where even a single session can bring relief (Nathan & Gorman, 1998; Shapiro, 1989).

Because it is 'a-theoretical,' EMDR has been viewed as a controversial treatment (Pitman, Orr, Altman, Longpre, Poire, & Macklin, 1996; Resick & Calhoun, 2001), yet it has also been found to be an 'effective treatment' (Chemtob, Nakashima, & Carlson, 2002). For instance, it has been found to resolve long-standing traumatic memories within relatively few sessions (Chemtob et al., 2002). It has also been extensively researched, so that it is now described as an empirically validated therapy that is 'probably efficacious' (Chambless et al., 1998). So whilst this status is not yet as firm as being 'empirically validated,' it is expected, that, on the basis of these results, it will achieve that status when further similar research results are returned.

The present case study sought to discover whether, by applying elements of Eye Movement Desensitization and Reprocessing (EMDR) and Young's Schema Therapy (Appendix A), so that EMDR was used with high scoring items on the Young Schema Questionnaire (YSQ), that this would result in the reduction of the strength of the patient's Early Maladaptive Schemas (EMSs), and provide the client with recognisable relief. The innovative element of this treatment was that, instead of taking time to formulate the negative cognitions to be targeted in EMDR, the high scoring YSQ Schema items were substituted for the usual negative cognitions. This constituted a pilot study with a single case.

Aims

The aim of the study was to find a means of enhancing the rapid progress of therapy by discovering whether the emotional valency of Early Maladaptive Schemas (EMS) can be reduced by EMDR.

Hypothesis

The hypothesis tested in Study 1 was that scores for Early Maladaptive Schemas (EMSs), as measured on Young's Schema Questionnaire (YSQ), would decrease after the application of EMDR.

Method

Participant's History

The participant was a young Aboriginal woman in her mid twenties. At birth she had been surrendered by her natural mother for adoption. Her adoptive family was a non-indigenous, white family. Because her adoptive father had died when she was a young child, she and her adopted brother were mainly brought up by their adoptive mother. Her adoptive mother was a strict Catholic, and so the participant was also raised as a Catholic.

The adoptive mother often told the participant the story of how she had "saved" the participant when she was a "poor little aboriginal baby." The participant had come to feel she should be grateful for being saved, but also felt she was not seen as a person first, but as a brown baby who had to be "saved."

The participant reported that even as a young child she had felt she was different and "second rate." In part, this was because the adoptive mother's extended family - her parents and siblings and the participant's adoptive "grandparents, aunts and uncle" - had shown favouritism towards the "real" grand-children. For example, the adopted grandchildren were given less expensive Christmas presents and fewer privileges than were the biological grandchildren.

The patient reported she had been sexually abused as a primary school child, and when she tried to report this to her mother, she was accused of lying. She attributed this to fact that the man who abused her had, in her terms, been a 'prominent person'. She reported she could not talk to anyone about what had been done to her. The outcome of this was that, even as an adult, she still felt very angry, depressed, hopeless, cheated, and defective.

Her anger had been compounded when, at the age of 19, she had tried to establish contact with her natural mother. She did not manage to speak to her, but spoke to her maternal grandmother, who told her that her mother would not want to meet her. It was not clear whether the natural mother actually knew that her daughter - the baby she had relinquished for adoption nineteen years earlier - had tried to contact her. As a result of this rejection, the participant felt doubly abandoned by her aboriginal mother. She did not know who her natural father was, so she could not contact him either. This episode left the participant feeling perpetually furious and rejected.

She left school before Year 11, worked in child care, had a series of relationships, became pregnant twice, and married the father of the second child. The marriage failed, which, in retrospect, was something of a relief to her, because her husband was a heavy drug-user, and she had been concerned that the children would be adversely affected by this if they were to grow up with him.

She reported that after her husband moved out, she and her children had lived in a small country town, and had almost no support. She reported that there she had been introduced to "chroming," that is, sniffing thinners or paint, and she had chromes when she felt desperate, because she felt it gave her some sort of an escape. When the Department of Human Services (DHS) discovered her affected by chroming while caring for her children, she was charged, and her children were taken into care. The older girl was placed with the participant's adoptive mother, and her baby son, with her ex-husband.

In her attempt to get her children back, she agreed to attend Odyssey House, a drug rehabilitation centre, where she was successfully rehabilitated. During the time she was at Odyssey House, her own Housing Commission house was burgled and all her furniture and possessions, including the baby's cot and toys, and even the electrical and other fixtures, had been stolen from the house. Because of the damage to the house the Housing Commission evicted her from her house while she was in Odyssey House, and sued her for damages of $3,000, even though she had had no part in the damage. This meant that when she left Odyssey House, she was homeless and in debt. On leaving Odyssey House, she had moved into a hostel in a supported environment.

Because of the temporary nature of her housing, she was not allowed to have her children with her. Because the children were in care, she was allowed to see them only at times arranged through the DHS. They informed her that, only when she could find suitable housing would her children be returned to her. Whilst she found people at the hostel were kind, she felt that some were drifters, and others were still heavily involved in a drug culture. Whilst there, she had no sense of stability and no control over her life.

She also felt victimized because she had been blamed for the damage to her Housing Commission house. In all, she felt trapped and angry. As well as her practical difficulties, she faced several dilemmas. She did not want to associate with her ex-husband and his friends because they were still using drugs. She did not want her child to live with her mother because of how she, herself, had been treated as a child. She was unemployed and in the early stages of a third pregnancy and, without a house to move into, she had no hope of getting her children back.

When, in November 2001, she heard about the anger management group being run at the Aboriginal Co-op, she decided to join it. Her anger stemmed from the unfairness of her present circumstances, and a seething anger and hatred towards her natural mother. Whilst she felt this strong anger, she did not manifest it in violence, but more as a self-loathing. After attending the anger group for a few weeks, she requested some individual counselling. At the commencement of her individual counselling she was asked if she would consider allowing me to write up a case study on her. Once she had considered this request, she agreed to be involved.

Materials

Two scales were used: Young's Schema Questionnaire- Long (YSQ-L) (Appendix B) and the Therapy Feedback Form (Appendix C).

Young's Schema Questionnaire – Long. Young's Schema Questionnaire-Long is a 205 item questionnaire. Young developed it out of his clinical practice, when he discerned patterns of maladaptive cognitions in his patients. He discovered 16 different schema types: Emotional Deprivation (nine items), Abandonment (15 items), Mistrust/Abuse (17 items), Social Isolation (15 items), Defectiveness/Shame (15 items), Failure (nine items), Dependency/Incompetence (15 items), Vulnerability (twelve items), Enmeshment (eleven items), Subjugation (ten items), Self-sacrifice (17 items), Emotional Inhibition (eight items), Unrelenting Standards (16 items), Entitlement (eleven items), Insufficient Self-control (19 items). Items included statements such as, "For much of my life, I haven't felt that I am special to someone," "I feel that I am not lovable," "I'm a failure," "I worry about being attacked," or "I strive to keep everything in perfect order."

The client scores each item from 1 to 6 (1 = *Completely untrue of me*, to 6 = *Describes me perfectly*). Scoring was achieved by tallying up the number of items with scores of 4, 5 or 6. This total was then transferred to a score sheet, then, depending on the number of items in each schema, a percentage score was found for each cognitive-schema type. Scores 1, 2, or 3 are not considered to be troublesome. Because there are variable numbers of items for different schemas, Young devised a format which allowed percentage scores for each schema to be found by reading the score off the prepared score sheet.

Factor analyses of the YSQ –L revealed 16 factors (Lee, Taylor, & Dunn, 1999; Schmidt, Joiner, Young, & Telch, 1995). The psychometric qualities of the YSQ have been examined (Schmidt, Joiner, Young, & Telch, 1995), and the YSQ-L was found to have adequate test-retest reliability and internal consistency. There was evidence of convergent and discriminant validity when compared with the Weissman and Beck (1978) Dysfunctional Scale (DAS) on measures of psychological distress, self-esteem, cognitive vulnerability for depression, and personality disorder symptoms. The YSQ appears to be a useful means by which to tap cognitive schemas.

Therapy Feedback Form. The Therapy Feedback Form was derived from an article by Seligman (1995), who wrote an assessment of the clinical effectiveness of therapy in the *Consumer Report on Mental Health.* He outlined a number of informal questions which he felt would give a picture of how patients had fared during therapy. These have been used as the basis of the Therapy Feedback Form. It is an 8 item questionnaire about the effectiveness of therapy. It simply asks what the patient's emotional state was before they started therapy, after therapy, and how much they were helped (Appendix C). Clients are asked to place a tick under the comment that best reflects their experience.

Procedure

In Week 1, the participant completed the YSQ-L. In week 2, the results of the YSQ-L were discussed with her. She was shown which of her schema were elevated. These were discussed with her, and one "negative cognition" was identified for the EMDR schedule. The negative cognition which resonated most strongly with her was encapsulated in the statement, "I am no good." Her "positive cognition," that is, what she would prefer to believe about herself, was, "I am good enough."

In week 3, a 60 minute session of EMDR was undertaken. After each set of 12 eye movements, all changes in cognition, image, sensations, or emotions were noted. Towards the end of the session, the participant started to agree with the positive cognition. After some *cognitive interweave*, where the positive cognition is held in mind as a set of eye movements was undertaken, the participant reported, "I have a secret excitement inside me." She reported that, for the first time, she was starting to believe that she might be "good enough."

In week 4, the participant was not able to attend but, when contacted by telephone to enquire how she was, she replied enthusiastically, "I'm good enough!" She also reported that she had handled some criticism from her ex-husband. She remarked that previously, when her husband criticized her, she became very upset, but that this time she noticed that she "didn't worry about what he said because I knew that I was good enough!" She reported that she still could not stop smiling.

Each week when the participant attended the Anger Management programme or for counselling, she reiterated that she was good enough. She reported that even when her adoptive mother had made a critical comment about her, which, before, would have distressed her and caused her to feel hopeless, on this occasion she noticed that she had not felt upset. This was because 'inside herself, she now **knew** that she was good enough.' This knowledge seemed to neutralize the power of her mother's criticism.

Whilst originally it had been intended to take one different high-scoring YSQ schema item each week and to use it as the negative cognition for the next EMDR session, for a number of reasons, this did not eventuate. For example, therapy sessions were missed, once because the participant was sick and, on another occasion, because she had to undertake child care when her husband was injured. At the third meeting, the participant requested help in setting some goals for her next meeting with her supported-accommodation worker. Because the participant's welfare revolved around her need for secure housing where she could be reunited with her children, this was the issue of paramount concern for her, so the collection of further data for this study became a secondary goal, and the additional schemas were not investigated or treated.

Somewhat unexpectedly, the treatment ended after six weeks, effectively after two formal treatment sessions, because the participant was offered accommodation in Melbourne by a Catholic housing agency. Before leaving Ballarat, the participant again completed the YSQ-L as a post-treatment measure. In this final session the participant also completed the Therapy Feedback Form. These results are discussed next.

Results

Young Schema Questionnaire

The patient's pre-treatment and post-treatment YSQ scores are shown in Table 1, as recorded on Young's result sheet. In Young's terms, scores are considered to be elevated when they reach a 20% elevation. Her scores were elevated on ten of the 16 primary schemas. The highest of all these was the schema for Self-Sacrifice (90%), then, in descending order, Emotional Deprivation (60%), Emotional Inhibition (50%), Subjugation, Social Isolation, Social Undesirability (all 40%), Failure (35%), and Insufficient Self-Control/Self-Discipline (30%).

This profile, with its elevations on schemas relating to Emotional Deprivation and Abandonment, Failure, Self-Sacrifice and Subjugation, gives a picture of a person with a low sense of self worth, who feels they have to fit in with others because they are not worthy. On six of the 16 schemas the participant gave very low scores (0 % - 10%), Mistrust, Defectiveness, Dependence, Vulnerability, Unrelenting Standards and

Entitlement, indicating that these were not issues that troubled her. These results are presented in Table 1.

Post-Treatment results

After treatment there was little elevation on most schemas, with only low levels of elevation on Subjugation and Self-Sacrifice (20%), Mistrust and Abuse, and Emotional Inhibition (10%). These are shown in Table 1.

Table 1

Pre- and Post-treatment scores on YSQ-L (in descending order)

YSQ Schema Types	Pre- %	Post- %
Self-Sacrifice	90	20
Emotional Deprivation	60	0
Emotional Inhibition	50	10
Subjugation	40	20
Abandonment	40	0
Dependency/Incompetence	40	0
Social Isolation	40	0
Social Undesirability	40	0
Failure	40	0
Insufficient Self-control	30	0
Defectiveness/Shame	20	0
Mistrust & Abuse	10	10
Vulnerability	10	0
Enmeshment	10	0
Unrelenting Standards	10	0
Entitlement	0	0

Therapy Feedback Results

Feedback from the participant at the end of treatment shows that the problem for which the participant had originally sought help was anger, and that the participant saw her emotional state before treatment as poor. After one treatment session she said that she had found the therapy had improved her mood, increased her sense of wellbeing, and, in her words, "made things better." She no longer felt depressed, angry or afraid, as often as she did before treatment. She found that she felt happy and content some days and was very satisfied with the treatment of her problem. She reported that her present emotional state was good.

Discussion

First the results obtained are discussed, and then the innovative elements in the treatment programme are considered.

After 6 weeks, the participant completed the YSQ-L as a post-treatment measure. The obvious feature of the post-treatment scores is how few elevations there were on any of the schemas, and how big were the reduction of scores. The most substantial drop in scores was in Self Sacrifice. After treatment, the pre-treatment elevations disappeared, suggesting a greatly reduced level of distress.

In psychology it is possible to determine statistical significance and levels of confidence in treatment, but these measures do not any give information about the clinical significance of the changes. Clinical significance refers to the effectiveness of the treatment.

> Clinical significance is usually viewed as a more stringent criterion than statistical significance because many statistically reliable effects can be obtained without clear or detectable impact on everyday participant functioning. It is generally true that, with clinically significant effects, behaviour change is especially marked and hence typically statistically significant (Kazdin, 1984, p. 320).

Sometimes, there can be clinically significant effects where statistical tests are not applicable. For example, this can happen in cases when "complete amelioration of the problem is achieved in one trial" (Kazdin, 1984, p. 320). The effectiveness of treatment can be gauged only from the subjective experience of the participant.

In case studies, changes in pre- and post-treatment scores can be reported on, yet the psychological significance of these changes is much harder to assess because they are based on a single case. Consequently, it is rash to make bold inferences about the success of the procedure. However, because the YSQ-L is a reliable and valid instrument, the changes reported by the client are relevant, particularly because they were accompanied by behavioural changes and an increase in reported wellbeing. For example, the participant reported that she had experienced some important changes in how she felt about herself. This flowed through into her behaviour, for example, it affected how she handled criticism from her adoptive mother.

The real problem in assessing progress in a single case is how to assess whether such changes came from the treatment, from external factors, in this case joining the anger management group, or whether the changes came from other improvements in her circumstances. Nonetheless, when using a single case, it is possible to inspect the nature of any changes that have occurred. These may indicate important psychological alterations, even though the precise reasons for change may be difficult to ascertain, especially when, as in this case, measures were taken on only two occasions.

In this case-study, from the time that the EMDR session was completed, the participant reported noticeable, subjective improvements. Thus, the changes recorded in the YSQ-L for pre- and post- treatment responses, which gave an objective measure of her progress through therapy, were supported by and mirrored in the client's subjective experiences. These changes served to corroborate the objective results recorded on the YSQ-L. These changes were cognitive, emotional, and behavioral changes. As reported earlier, she described differences in how she felt, such as her secret excitement, and in her belief that she was good enough. The participant also reported that she was more self-accepting, and less self-condemning than she had been before. She had started to think that she was important. She reported changes in her self-beliefs, such as she now believed that she **was** good enough, and no longer believed she was a failure.

There were differences in her behaviour in response to other people. Not only did there appear to have been substantial changes in how the participant saw herself, but also in how she responded to her circumstances. The participant talked about her changed mood (her secret smile inside her). She handled situations which she had previously found overwhelming. She had started to plan for the future. She reported her changed reactions to situations which had previously upset her. She had managed to handle taunts from her ex-husband that she was not good enough, by responding, "I am good enough;" or, when faced with criticism from her mother, she had been able to stay calm in a situation which previously would have upset her. Instead of believing that she was unworthy, bad, stupid and unlovable, she reassured herself, that, even if her mother made judgemental comments about her, she was good enough. These changes were clinically significant, if not statistically significant.

Duration of Change

On Christmas morning 2003, after a year and a half of being out of contact, the participant telephoned the therapist, to wish her a merry Christmas, and to say how happy she was, and how well her life was going. She added that once or twice a week, usually when taking a shower, she found herself smiling and telling herself "I'm good enough!" She reported that whatever it was that happened in the EMDR session, she was very grateful, that she had had the chance to accept herself, and to let go of her anger and pain. She saw that her experience in therapy had been a very important and positive turning point for her. Again, in November 2004, three years later, the participant phoned the therapist, this time to seek help for a friend. Again, she reported that she still felt she was good enough and was still smiling, that she was settled in a relationship and was living with her children.

Innovation

In this study, innovation occurred at two levels, that is, at the client level, and at the therapist level. For the client, innovation sprang from individual emotional distress, which was reflected in her seeking therapy. For the therapist, innovation sprang from ambivalence arising from wanting to set up a treatment plan, but having no way of ensuring that treatment would run for the set number of treatment sessions. So the therapist had to formulate a short-term therapy that would allow each treatment session to be discrete, with a different topic being addressed each session. In this way, if the client was to be granted housing, she would not have to leave without completing her treatment. By extrapolating from previous experience of two discrete therapies, the therapist intentionally introduced a new procedure, which, as it happened, resulted in significant benefit to the client.

In any innovative situation, implementing an untested procedure brings the risk that the process would not be effective. In this case, because innovation was based on prior successes, it seemed that there was a good chance of success. The idea of putting the two therapies together was a creative act, translating the idea into practice, was innovative.

Conclusions

In any studies assessing the effectiveness of treatment, the use of self-report is sometimes seen as problematic. The problem lies in the fear that the patient will try to please the therapist, or possible could learn what way to rate therapy. One could argue in this particular case study that with only a single treatment session this would not be enough for the participant to learn the right things to rate.

The participant's responses on the Therapy Feedback Form showed that she saw herself as having made progress over the weeks. It is not clear whether this was due to any of the interventions or treatments or was simply an example of the *Hawthorne Effect,* that is, she reported that she felt stronger and more able to continue her life simply because someone had taken an interest in her. For her, therapy was effective. She agreed that she also experienced an improvement in her general functioning and gained some relief from her negative belief that she was not good enough.

When one examines the outcomes of this case, one of the surprising aspects is that after a single EMDR session, which focused on a one schema, there were so many changes in the participant's other schemas. There was a reduction in every category of schema where previously there had been some elevation. Whilst originally it was hypothesized that the participant would experience relief from the particular single schema targeted in the EMDR session, it appears that, fortuitously, the schema chosen to work on in this session might have been linked to many of the other schemas. Because the reduction in pre-and post-treatment schema scores was found across-the-board for maladaptive cognitions and not just in the area targeted, it could even be argued that this particular schema must have underpinned all the other schemas. Certainly, her responses on the YSQ-L identified Self-Sacrifice as the most troublesome one for her.

It would appear that lasting cognitive, emotional and behavioural changes happened during the weeks in which the participant was in therapy. However, whether these good effects are attributable to the effect EMDR is less clear. As Seligman (1996) points out, there are so many 'nonspecifics' at play in most people's lives, that to isolate a single specific as the cause is to have great trust. In this case, for example, one of the nonspecifics for this client could have been joining the anger management group.

What is clear is that in the four weeks that treatment took place EMDR was applied once, to a single negative cognition, namely, "I am not good enough." It is also clear that, after this experience, the participant reported feeling more self-accepting and behaving differently. It would seem that if there was some turning point, perhaps it was due to EMDR. However other factors such as attending anger management, learning new skills, being part of a social group, or having time to reflect on her life while living away from her family, could have been involved. Equally, it could have been related to the fact that she had made progress in sorting out her life and had taken steps to make changes, such as starting to set goals, and preparing for taking back the care of her children. Any of these may have contributed to her feeling of solid self-acceptance and believing that she was good enough. Whatever it was, the EMDR, her emotional maturing, or the combination of all of the above, the participant reported that she felt different. In fact, she was different. Now; she looked forward to her life, rather than simply seeking to numb her pain with drugs as she had done formerly. She was also proud of herself and the changes she had made.

In this particular case, it could be argued that the hypothesis that combining therapies would bring relief was supported, yet, it would be unwise to claim that these changes arose solely from the application of EMDR to a negative schema, for the reasons already discussed. The fact that the changes occurring during this period of treatment endured over more than 36 months after treatment was gratifying.

In this case study, innovation occurred for both the participant and the therapist. For the participant, there was the idea that she did not have to feel so bad. For the therapist, innovation occurred when she combined elements from two treatments. Whilst modest, innovation at an individual level can be seen to have been successfully achieved.

Limitations

As with any case study, the results of only one case cannot be used as the basis to draw strong conclusions.

Future Research

The positive results experienced by the client, while gratifying, need further explanation. More research is needed to confirm whether the conclusion that applying EMDR to maladaptive schemas can reduce the distress felt as the result of negative self schemas is warranted.

CHAPTER 3

STUDY 2: GROUP INNOVATION

Overview of Study 2

The Ballarat Health Service provides clinical, psychiatric and allied health services to inpatients and outpatients. It is the principal referral centre for Central and West Victoria Grampians Region and extends from Bacchus Marsh to the South Australian border, an area of 48,000 square kilometers.

Study 2 was undertaken at the Ballarat Health Services (BHS). The Ballarat Health Services had recently been formed by amalgamating a number of previously discrete health services. As a result, there were still numbers of protocols to be developed following this amalgamation. Before amalgamation each service had its own approaches to treatment, so the task in this study was to unite the previous treatment protocols, where they existed. In this way, a uniform approach for the treatment of patients would be available, regardless of what sector of the hospital the patient had contact with.

As part of her placement, the Clinical Psychology Department of the Ballarat Health Service asked the student to develop a protocol for the treatment of in-patient children and adolescents with eating disorders. This study describes how the protocol was developed. In this study, innovation occurred at a group level and the distress that pushed innovation was the need for a common approach for the amalgamated services. The innovative processes included bringing the members of a number of heterogeneous services together so they could participate in the development of a new protocol that reflected all these services.

In this chapter, some background is given on eating disorders. Then there is a description of how the protocol was developed.

Background

Eating disorders are not only a medical problem, but also involve psychological factors, including attitudes towards food and body shape, and behaviour, such as efforts to control body weight. It appears that the unhealthy efforts to control body weight strongly relate to cultural attitudes. For example, Abraham and Llewelyn-Jones (2001) describe the changes in cultural beliefs about what is deemed to be the culturally desirable shape for women. For most of Western history, it has been considered desirable that a woman should have a curvaceous body. Abraham and Llewelyn-Jones suggest that this was because such a shape indicated that the woman would be more likely to survive during periods of food shortage. As a bearer of children this enhanced her attractiveness to males keen to ensure the survival of their own genes.

In the West, over the past 75 years, there has been an abundant and constant supply of food. This may explain why, for the first time in history, slimness has become more desirable than being curvaceous. This change in value has been reflected by fashion magazines which record the 'vital statistics' of women winning beauty contests (Abraham & Llewelyn-Jones, 2001). These statistics show that women, in general, and fashion models, in particular, have become taller and thinner, with body weights at least 20% lower than women of similar age and height in the past. A current modelling agency describes what they consider desirable features for models: "they should be tall, thin, fit but not muscular, brown or tan, strong shouldered, big 'well shaped' boobs (breasts), small waist, no stomach, small hips, small, high bottom, thin thighs, long legs, and definitely no cellulite or body hair" (Abraham & Llewellyn-Jones, 2001, p.1). At the same time as promoting this view, the same magazines have proclaimed an endless array of 'new and exciting' diets, which were often nutritionally inadequate or even dangerous. Not only do adult women seek slimness, but so do adolescents, and even young children. For example, a study by Schur, Sanders, and Stein (2000) showed that 55% of primary-school aged girls and 35% of boys want to be thinner, and that 16% of them had already tried dieting. These trends are particularly problematic as, during adolescence, both boys and girls gain weight. Whilst boys often gain self-esteem as they become bigger and stronger, girls gaining weight around menarche often display a loss of confidence and decrease in self-esteem. In either sex, being what is perceived as overweight in teenage years is related to lower self-esteem (Abrahams & Llewelyn-Jones, 2001).

Eating Disorders and contributing factors

Eating disorders in children can arise at any stage or age, and include eating problems in infants and young children (O'Dea, & Abraham, 1996; Schur, Sanders, & Stein, 2000). Whilst eating disorders in children can range from refusing solid food to food faddism, generally, the term eating disorder refers to severe disturbances in eating, 'maladaptive and unhealthy efforts to control body weight', and 'abnormal attitudes about body weight and shape' (Wilson, Heffernan, & Black, 1996). The Diagnostic Statistical Manual (DSM-IV-TR, 2003) outlines the main eating disorders in children. In addition to *pica*, which is the persistent eating of non-nutritive substances, *rumination disorder,* which is the repeated regurgitation and re-chewing of food, and *feeding disorders of infancy or early childhood,* which refer to the persistent failure to eat adequately, the two main eating disorders that affect children and adolescents are *Bulimia Nervosa* (BN) and *Anorexia Nervosa* (AN). They are found mainly in adolescent girls and young women but some young men are also affected.

Anorexia Nervosa. The Diagnostic and Statistical Manual of Metal Disorders (DSM IV-R) (2002) outlines the essential features of Anorexia Nervosa as the failure to maintain body weight at or above the minimal level for age and height, fear of weight gain or being overweight, a disturbance of body image, and, in girls, amenorrhea - the absence of at least three consecutive expected menstrual cycles. There are two major subgroups of anorexia, the Restricting type, in which patients simply reduce intake, and the Binge-eating and Purging type, in which sufferers eat excessively and then purge.

The onset of AN tends to be in early adolescence. In girls, the highest prevalence is in the 14 - 19 age-group. It is rare before the age of 8, though it does occur in children under 8 years of age, and when it does, it is similar to the disorder in the older group. Whilst anorexia is found much less often in boys, it is more prevalent in pre-teen boys than in older boys (Kronenberger & Meyer, 2001).

Bulimia Nervosa. Bulimia Nervosa is a disorder that consists of the patient consuming large amounts of calorie-rich food, often consumed in secret. Again, among patients, there is a preoccupation with weight. The DSM-IV-R diagnostic criteria for

Bulimia Nervosa are, firstly, recurrent episodes of binge-eating characterized by a sense of lack of control and overeating a large amount of food in a discrete period of time; secondly, showing recurrent, inappropriate compensatory behaviour in order to prevent weight gain, such as vomiting, abuse of laxatives, diuretics, or the misuse of medication; fasting; and excessive exercise. Bulimia Nervosa includes a minimum average of two binge eating episodes and inappropriate compensatory behaviours per week over the previous three months. Further, self-evaluation is unduly influenced by body shape and weight. Finally, the disturbance does not occur exclusively during episodes of anorexia nervosa. Bulimia nervosa patients are further subdivided into purging and non-purging types. The Purging type is characterized by the regular use of self-induced vomiting, laxatives, diuretics or other medications, fasting, or excessive exercise, and the non-purging type is characterized by fasting and exercise (American Psychiatric Association, 2003). The onset of BN is found to be a little later than the onset of AN, usually in the early 20s.

Common elements in AN and BN. There are some elements that the two disorders share. For example, sufferers of both have an excessive preoccupation with food, body size, body shape and weight control. Both use extreme measures to reduce weight and maintain low weight. For example, there is rigid dieting, purging, vomiting, diuretic abuse, and use of excessive exercising regimes. Both AN, and BN can develop independently as separate syndromes, or can co-occur. Robinson (1986) found that bulimic episodes may be experienced concurrently with anorexia nervosa, and also that some hospitals have found that 50% of anorexic patients eventually become bulimic.

Psychological Aspects of Eating Disorders. In both groups, there is a real fear of fatness. In AN this fear is coupled with a distorted body image, and the thinner the patient becomes, the more she overestimates her body size. In both AN and BN patients there is a strong issue of control where the anorexic fears fatness from the *anticipated* loss of eating control, the bulimic fears fatness from the *actual* loss of eating control (Anorexia and Bulimia Nervosa Foundation of Victoria, n.d., p. 2.).

Neurological Effects. Serotonin is the neurotransmitter that is involved in both the regulation of food intake and mood. Short-term dieting can lower serotonin levels and mood it can also alter the serotonin function of the brain (Bergh, Eriksson, Lindberg, & Sodersten, 1996). In particular, the effects of dieting affects brain serotonin function in women which may in explain why more women and girls are affected by eating disorders than are men and boys.

Aetiology. A number of different aetiologies have been suggested for eating disorders. One of the main factors is dieting to lose weight. It has been suggested that in many Western countries, where there has been an emphasis on slimness in women, this value has encouraged more dieting. More dieting has been associated with the increase of both Bulimia and Anorexia Nervosa.

Both Anorexia and Bulimia have been thought to have a predominantly psychological basis. Some of the psychological elements that may be involved are personality factors, such as perfectionism and social phobia, and environmental factors, such as the promotion of slimness for fashion reasons. For example, Szmukler and

Tantum (1984) found addictive personality elements in anorexia and bulimia; while Srinivasagam, Kaye, Plotnicov, Greeno, Weltzin, and Rao (1995) found that perfectionism is a significant factor in eating disorders. In addition, links have also been found between eating disorders and early attachment problems (Armstrong & Roth, 1989; Dozier, Stovell, & Albus 1999) Specifically, eating disordered individuals appear to be insecurely or anxiously attached, which, according to Bowlby's attachment theory, causes an individual to try to get close to an attachment figure in an attempt to feel secure, and one of the means of trying to get close is to diet in the hope that the parent will then accept her (Armstrong & Roth, 1989).

Anorexia Nervosa and Bulimia Nervosa appears to run in families, and there appear to be some special risk factors related to family environment. Some of these are parents with obesity problems, parental alcohol abuse, or parents making critical comments about a girl's body, weight, or eating (Brownell, Fairburn, 1995; Fairburn, Marcus, & Wilson, 1993). Bowlby (1973) suggested that if a child is given messages that suggest he or she will have difficulty functioning independently, or is unlovable, this can result in the child feeling inadequate and out of control. Cole-Detke and Kobak (1996) found that eating disorders in girls are an attempt to gain control by directing their attention away from their feelings of distress which arise when they receive critical messages.

There seem to be a number of elements that occur in association with eating disorders, for example, issues of control, body dysmorphia, that is, disliking parts or all of one's body, having been abused, or other family distress. However, no single adequate explanation has been found to account for these disorders, so research continues.

Incidence. Although, Wilson, Heffernan, and Black (1996) reported that definitive epidemiological data are not yet available, they suggested that the prevalence of eating disorders in girls under 16 years has doubled in a generation, rising from 0.5% in 1976, to 1% in the late 1990s. They claim that concentrations of AN sufferers occur in groups where there is a high premium on weight control, for example, in adolescent students of dance or modelling, in young gymnasts, and among athletes. Among these groups, eating disorder rates are as high as 5% to 7%. Kronenberger and Meyer (2001) report a 1% incidence of AN levels in girls, and a much lower incidence, of 0.02%, in boys, the incidence of BN is more difficult to identify. This is because bulimic behaviours are usually private, weight is within the normal range, and sufferers very often deny that there is a problem. As a result, BN is often unreported, and so untreated. Kronenberger and Meyer (2001) suggested that the incidence of BN is much higher than for AN. They estimate that about 1-3% of girls and 5% of boys are affected. Whilst BN is not often life threatening, it can have serious health outcomes, such as dental erosion, electrolyte imbalance, scarring of the oesophagus, and dehydration.

Ballarat Health Service Project

In recent years, most Ballarat children and adolescents suffering from Anorexia Nervosa or Bulimia Nervosa were sent to Melbourne if they needed specialist nursing and hospitalization. Prior to that, some children were treated in Ballarat, using a predominantly medical approach, and any child who needed non-nursing treatment, such as dietetics or psychological support, was referred to other health services. Since the amalgamation, all non-nursing support, such as dietetics, psychiatry, psychology, and occupational therapy, has become available within the one organization. This means that any treatment protocol developed, as well as reflecting nursing services, had to reflect these non-nursing services as well.

Aims of Study 2

The aim of the current project was to update previous protocols, so that children and adolescents with an eating disorder could be treated with a unified service.

Method

Procedure

The first step was to meet with the various services to discuss their needs and demands when treating young eating-disorder patients. Contact was made with nurses, psychologists, psychiatrists, physiotherapists, psychologists, and dieticians to determine the various treatment approaches.

The project involved a number of components: collecting literature on treatments of eating disorders; examining previously used protocols; liaising with departments to discuss treatment issues; and developing the treatment protocol for Ballarat Health Services.

Collecting literature. The first step was to collect literature on current treatment approaches for AN, and BN. Numerous articles were collected from journals, internet, and addition, books, and placed into a resource folder. (Appendix D) shows some examples of recent treatment approaches).

A number of programmes and protocols for treatment of patients with eating disorders had previously been obtained from other treatment centres, such as Melbourne's Monash Medical Centre. These protocols addressed the nursing component of the treatment of such young patients. Most were similar to the nursing protocol used previously at Ballarat Base Hospital.

Examining previously used protocols. The second step involved reviewing treatment guidelines from other Victorian hospitals, such as the Monash Medical Centre's "Treatment Guidelines for Patients with an Eating Disorder admitted to 42 North." These outlined nursing requirements for severely compromised patients with eating disorders. The Anorexia and Bulimia Nervosa Foundation of Victoria (Inc.) provided their Information for Health Practitioners. This outlined the treatment needs of patients, and described a variety of treatment approaches.

In addition, the protocols previously used by the Ballarat Base Hospital were examined. They included a form for children, a form for parents, and two nursing protocols. All were formal: they used a medical format and were written in a technical medical language. There was also much duplication of information, so that similar information was asked for, or presented, in a number of forms in the same document.

Treatment Issues

After gathering the background information and the previous protocols, meetings were held with different departments to discuss the earlier protocols and recommend changes. The issues raised by the different services are discussed next.

Nursing issues. The paediatric nursing department raised several issues. The changes that had come about from the redevelopment of the hospital meant that the paediatric ward in the new hospital catered for children of all ages and disorders. Because the ward was now a general ward, there were no special facilities for specific kinds of patient, such as the eating-disorder patients. In addition, there would be no specialized nurses for nursing children with eating disorders.

In these changed circumstances, it was crucial that a consistent nursing approach was developed to ensure the welfare of these patients, because, as always, there are several nursing shifts each day.

After reviewing the previous nursing protocols, there was discussion about some of the issues it raised. For example, questions which had to be settled included whether patients would be allowed telephone calls, or restricted, as they had on the original protocol. If calls were allowed, would they be limited to particular times? The main concern about telephone calls was whether they would interfere with the child's meals and rest periods after eating, or whether a child would use telephone calls as a strategy to avoid eating. It was decided that the telephone would be delivered to the child by the nurse, rather than allowing the child to have ready access to a phone at their bedside. Such a procedure would ensure that the child would not be permitted to take calls during meal-times.

There were questions over whether children would be expected to eat everything on their plates, as had been required in the original protocol. This issue led to a discussion of what was meant by "eat everything on the plate" – did this include garnishes like parsley, a strawberry or cream? In the end, as an acknowledgement that the child would not be forced to eat, it was decided that the nurse should record all food eaten and what food was left, after 30 minutes for meals, or after 15 minutes for snacks.

Some of the issues that were raised about the previous protocols were whether or not a child or adolescent should lose privileges if he or she did not eat the food provided. Other issues concerned whether children should be forced to eat all meals. The issue of whether they should be nursed in locked wards was superseded by the arrangement of the new ward.

Other issues were not addressed by these protocols, such as how to prevent young patients disposing of their food instead of eating it, for example, by wrapping it in tissues and then flushing it down the toilet. To prevent this, it was decided that a nurse would be present during mealtimes for these patients.

Dietetic issues. The meeting with the dietetics department raised several issues. The first was that the dieticians wanted to be involved at the onset of any treatment. They also wished to have an ongoing relationship with any child, both during any hospital stay, and after release from hospital. They demanded that they alone would decide what would be fed to individual patients.

It was decided that the Dietetics Department would monitor the child's nutritional needs and plan a diet suitable for the child's stage of treatment. To achieve this, no other authority, such as parent, patient, or nurse, would be allowed to deviate from the planned food schedule. It was decided that once the diet schedule had been set for the week by the treating-dietician, no changes were to be made until after the next group meeting.

Another discussion concerned how and when the patient would be weighed, and whether or not the child would be informed about their weight, or how staff would ensure that a child did not drink water before the weighing. It was decided that, in order to prevent drinking before weighing, all water bottles would be removed by night nursing staff at midnight on the nights before a child was to be weighed. This meant that children would not be able to ingest water to increase their weight. It was noted that there were taps on the ward. This meant that duty nurses would need to watch to see that young patients did not surreptitiously take drinks before weighing.

Psychiatric issues. The psychiatric department (CAMHS) wanted any child diagnosed with an eating disorder to be treated in family therapy. However, they acknowledged that, because their waiting lists were often six month long, realistically they would probably only be able to be involved in emergencies, such as when a child was suicidal.

Psychological issues. The psychology department wished to be involved in the initial assessment of patients; to be involved in decisions about any psychological treatment received by the patient whilst on the ward; and to determine the conditions under which the young patient would be treated whilst in the hospital. For example, would any non-hospital counsellor, already working with the child, be allowed to treat the child while he or she was in hospital?

Legal issues regarding external professionals. As well as reflecting the concerns of these departments, the protocol had to be acceptable to the treating paediatrician and to leave options for the involvement of the child's own visiting GP. There were concerns, because the child was legally in the care of the hospital, that if additional persons were involved in treating the chid, then the treating team would not necessarily know what role such a person was playing, what treatment they were providing, or whether this treatment would undermine the treatment provided by BHS. This issue was resolved by making it a requirement that any other non-hospital professional wishing to treat the child in hospital had to seek registration from the hospital, prior to working with the child.

Child and parent issues. Because there were no patients in treatment at the time, the concerns of families and patients were not canvassed directly. However, given that most often, by the time a child is admitted as an inpatient for an eating disorder, his or her health is severely compromised, the key issue is survival. For this reason, it was thought that the child's welfare lay in having a clear treatment plan, with clear procedures so as to reduce any unrealistic expectations in these patients.

Whereas in the original protocol, there were many restrictions put on patients' visitors, telephone access and television watching, after discussion, it was decided that, apart from meal times, rest periods after meals, and school times when the child would continue with their school programme, the patient's programme could be more relaxed than formerly. It was also decided that privileges would not be lost if a child failed to make progress.

In order to safeguard the child, protect the nursing staff from the demands of the patient or family, and avoid decisions being made on the run, it was decided that no changes to any aspect of the treatment plan would be allowed between group meetings. It was also decided that parents and young patients would be able to bring their concerns to the weekly group meeting of the patient's treatment team, when all members of the team would be gathered to discuss the child's progress and to develop a treatment plan for the following week. In this way, parents and patients were given a formal means by which to raise their concerns and so to have an input into treatment. They were to be encouraged to register their concerns prior to these meetings, even though they were not to be invited to the team meetings.

Any change to the programme would occur only after the whole treatment team was consulted. This was to ensure that all the important treatment elements were safeguarded by means of this relatively inflexible programme. It also meant that treatment elements decided on by non-nursing departments could not be overridden by a patient prevailing on a nurse for special treatment.

Protocols

All the issues and requirements raised by the various departments were formally written down in the Child's Booklet (Appendix E). This booklet was to be presented to the child on admission. In this way, the patient and her or his family would have a clear understanding of how treatment would proceed, and under what conditions.

When these documents were drafted, they reflected the changes agreed upon at the various departmental meetings. Next, the documents were presented to the various participating departments (nursing, psychiatric, psychology and dietetics) and further comments and suggestions were sought. These comments were noted and any changes were incorporated into the next draft. This process continued until a final format was agreed upon.

In its final form the children's and adolescents' information was presented in a little booklet in A5 format. The children's booklet was presented with the new matching Nursing Guidelines (Appendix F) and the patients' Eating and Toilet Record (Appendix G).

After the student's placement ended, the protocols were presented to the Ballarat Health Services protocol committee for approval. They were duly adopted, and are now a part of BHS policy.

Discussion

The process of formulating the protocol was somewhat drawn out because the departments were geographically and managerially discrete. This meant that joint meetings were not always possible and, when they occurred, they were cumbersome. However, because this was seen as an important protocol, staff attended and contributed to protocol development when they were able. Despite the length of time it took to develop, the protocol was completed successfully.

When the original project was outlined, there were to be three parts to the programme: a review of the current literature on treatment of childhood eating disorders; a review of treatments conducted previously at the hospital and at other hospitals; and the production of an updated protocol. The literature review involved bringing together the existing resources in the hospital, scouring the internet, and searching recent journals at the university. These, however, were not discussed or referred to at any stage. So it is not known if, or how, they have been used in any treatment of young patients at the hospital.

Second, when the previous nursing programmes and protocols were examined, the Monash protocol and the previous Ballarat protocols were substantially similar. This meant that most time in developing the protocol was devoted to examining the previous Ballarat Base Hospital protocol and adapting it to meet the current needs of the amalgamated institution. Because it was decided that the main role required of the Ballarat Health Services would be in the critical stages of inpatient nursing, an approved nursing approach was the key focus of treatment.

As far as the hospital was concerned, the project was successfully expedited, yet, because no child was admitted before this report was completed, the effectiveness of the nursing protocol remained untested. Nonetheless, feedback from the nurses and other staff suggested that they were pleased with the programme and expected that it would meet the treatment needs of children and adolescents with eating disorders. The protocol was also welcomed by the various departments and they all agreed that the prepared booklet was a great improvement on previous documents.

Despite this, the writer still has some concerns about the protocol. As the list of people working with the child grew in length, it was a concern that the number of people working with a child in critical care would be confusing to such an ill child. Second, because the Child and Adolescent Mental Health Service (CAMHS) within the BHS uses a family therapy approach and likes to work intensively with patients, this reduces the number of patients CAMHS can work with. As a result, it was not clear who would work with a young patient not able to access CAMHS for six months, and it was not clear what ongoing psychological support would be provided to the child, or what treatment approach would be followed.

A third concern was that given the push in hospitals for case-mix funding, which focuses on patients being discharged as soon as possible, it was not clear how such an economic focus would impact on treatment of Anorexia Nervosa or Bulimia Nervosa, because neither of these disorders can be seen as short-term.

In addition, it was not clear whether any of the newly developed treatments identified in the literature would be reflected in any BHS programme. For example, would any use be made of findings about the effects of starvation on temperature regulation, would any consideration be given to empirically supported treatments for BN, or would any attempt made to keep abreast of new developments, so that if an empirically supported treatment for AN is established, this could be followed?

In all, it appears that if the protocol had addressed these issues at the time, the protocol could have reflected this. That these matters were not addressed might in part reflect the fact that there is no unified approach between the psychology and psychiatry department (CAMHS), and that the focus of the protocol was really on the young patient *in extremis*. The CAMHS/Psychology gap might reflect the fact that there are different cultures in these departments, an amalgamation issue that is yet to be faced. This issue obviously involves philosophical, political, and practical considerations.

Limitations

The increasing level of mobile telephone ownership was not reflected in the protocol. It would probably have been wise to disallow young patients bringing personal mobile telephones into hospital. Had this been done, telephone calls could only be taken when they did not interfere with treatment or schooling.

There was no discussion of what psychological treatment approaches would be adopted by the Psychology Department. This was in part due to the fact that one of the psychologists became ill and another went on leave. It also seemed that because individual practitioners subscribed to different psychological schools, it would be difficult to select a single approach. As a result no detailed psychotherapeutic approach for post- hospitalization treatment was established. This would seem to be an obvious gap. It should be noted that not all the different eating disorder treatment programmes have received empirical support. For example, whilst the Fairburn (1995) programme for treating BN is acknowledged as an empirically supported programme, he also indicated that there is no equivalent empirically supported treatment for AN. This means that any treatment approach selected for adoption by the psychology department should have been shown to be effective before being undertaken with young patients.

Innovation in Study 2

The type of innovation demonstrated in this study could not be said to reflect absolute novelty, but rather to be an example of relative novelty. The stress that precipitated innovation was the need to achieve a common protocol for all departments involved in the treatment of children and adolescents with eating disorders. Whilst the distress was perceived at a management level, innovation happened at the team level. The innovative processes involved teamwork by the heterogeneous service groups, reflexivity, decision making and integration. Innovation in this study occurred at a group level, with members of the nursing, dietetics, psychiatry, and psychology departments providing feedback on the old protocol, and making suggestions about what was needed in the new protocol.

Innovation can be seen to have occurred through the development of a new protocol because there was an intentional introduction and application of new and improved ways of doing things. These changes had the potential to bring significant benefits at a number of levels. There were potential benefits at an individual level for any young eating disorder patient. There were benefits at the group level for those who provided the service, because it was now clear how they were to manage these patients. There were benefits at an organization level, because a unified service could be offered. There were benefits at the wider community level, because any family with an affected child could now have their child treated locally, instead of having to travel to Melbourne. Whilst this was a modest project, innovation can be said to have occurred, because ideas were generated, then they were implemented.

Conclusions

The incidence of eating disorders among young persons appears to be rising (DSM-IV-TR, 2003). It often happens that if an eating disorder is not identified early, the child or adolescent falls seriously ill and requires careful nursing. The new protocol addresses these issues, and attempts to ensure consistent and safe nursing practices for affected children and adolescents.

Whilst there is ongoing research into the treatment of eating disorders, and many questions in this area remain unanswered, children and adolescents will still need to be treated. This protocol was a small step in the direction of improving the treatment of young patients when they are *in extremis.* It will be of benefit to patients until more is known about the prevention of eating disorders, or more is known about effective treatments.

CHAPTER 4

STUDY 3: INNOVATION AT AN ORGANIZATIONAL LEVEL

Overview of Study 3

Study 3 was undertaken at a new treatment centre, Pomegranate House, in a major regional city in Ballarat, Australia. This chapter outlines how the new centre was set up in response to a perceived need in the community. It examines how well the new centre met the goals that were set for it. It looks at who was using the centre, and who was referring patients to it, and at how patients assessed the treatment they received at the centre. Then an assessment is made about the type of innovation that occurred in this project.

Background

The city of Ballarat has had a long history of treating mental illness (Appendix H), yet, by 2001 it had became obvious to community service organizations like the Catholic welfare organization, Centacare, that there were very few organizations to which they could refer their non-psychotic clients with restricted finances. The C.E.O. of Centacare contacted a local psychologist to discuss the issue with her. They discussed possible ways of providing these services and decided to investigate the idea of setting up a treatment centre. Members of the Catholic Order of St John of God were invited to join the discussion. These nuns have always had a focus on providing mental health services and for years had run a large psychiatric hospital at Brighton, Melbourne. However, in response to the push for psychiatric patients to be deinstitutionalized, they closed the psychiatric hospital and sold the building. Over the years, the hospital had become very desirable real estate, and the nuns decided that the sale proceeds should be directed to the provision of other mental health services in the community, and were looking for suitable projects.

A meeting occurred in March 2002 to discuss a paper prepared by Centacare, *Proposal to establish an innovative treatment facility for people who have a psychiatric illness*. By chance, at the same time, Centacare was contacted by the Victorian Division of General Practice. The Division, already actively engaged in shared-care mental health projects such as *More Allied Health Service* (MAHS), the *Clinical Psychology in Rural General Practice Project*, and the *Primary Mental Health and Early Intervention Initiative,* also wanted to find funding for a psychologist.

The Division of General Practice was very supportive of Centacare's proposal to set up a treatment centre. This was particularly so because, due to current regulations, the Division itself could not employ a psychologist because it was not an 'auspicing body,' which meant it was not eligible to disperse public funds. This meant that it had to find another auspicing organization, such as Centacare, who were eligible to disperse funds. From this contact emerged the idea of a mental health centre which could cater for less affluent members of the community in Ballarat, and meet the needs of Centacare and those of the Division of General Practice.

During the development phase, the partners involved in the group (Appendix I) formed a steering committee. Over the next two years the goals of the proposed centre were refined. The Division of General Practice sought funding for one psychologist's salary, the St John of God Hospital offered a building to house such an organization, and the St John of God nuns suggested they might be able to manage to fund another psychologist's salary.

However, given the expected demand for services, more psychologists would be needed. At that point, a member of committee approached the Professor of Psychology at University of Ballarat to see whether some of the doctoral clinical psychology students could be involved in treating patients. The Professor was very supportive. The University offered a professional doctorate in clinical psychology, within which students were required to be involved in professional internships. Finding these internships was often difficult in Ballarat because the number of clinical placements, at which clinical supervision was possible, was very restricted. An arrangement such as that proposed would help the University provide its students with internships. In this way, the University of Ballarat became the fourth party to become involved in the planning the new facility. In 2002, the committee decided that it was necessary to employ a project consultant. St John of God Hospital agreed to fund this position. A consultant was employed in October 2002 to develop the project.

During the period of late 2001 - 2003 a number of possible of service models was investigated. For example, in mid 2002, one proposed model suggested that probationary psychiatrists at the Grampians' Psychiatric Service -a wing of BHS - could be involved. By August 2002, another model had emerged. This involved four or five Mental Health trained GPs working on a rotational basis, along with a psychologist, and perhaps some doctoral psychology students, a psychiatrist, a social worker, a mental health nurse, and a counsellor. Another model looked at providing a joint professorial position, funded by St John of God and University of Ballarat. The professor would be expected to teach and supervise students, provide leadership at the new facility, and provide staff development. This model was not adopted, partly because of the long lead time that making such an appointment would take. The model that was finally adopted was none of these. Instead, it was decided that one psychologist would be employed by the Division of GPs, one would be employed by St John of God Hospital, and Ballarat University doctoral students would make up the balance of the psychologists at the centre. To ensure that the needs of the maximum number of patients could be met, it was decided that any patients referred through GPs, Psychiatric Disability Support Services (PDSS), Centacare, St John of God, or through self-referral, would be offered a time-limited treatment of up to six sessions, with the proviso that GPs could recommend a second set of six sessions where needed.

Once the model was decided, funding was found for a two year pilot programme, and the client group was identified. A Management Committee was formed to undertake the longer term governance of the service, and the salary and job description of the employed psychologist was determined. It was also decided that the target clients would be those with a mental disorder who were on low-incomes. Where patients were able to pay something, they would be asked to pay some 'gap' payment at the same rate as was asked for by Centacare services: $1 per $1,000 of their annual income. It was also decided that the service would not duplicate already existing services. For that reason, the centre would not offer therapy for substance abusing patients, because a detoxification service already existed in Ballarat. Only once such patients had undertaken detoxification would they be seen at the new centre.

By December 2002 it had been decided that the centre would focus on treatment, rather than on assessment or diagnosis. This was so psychologists would be able to devote their time to treating patients rather than writing reports or attending court.

The issue of what type of therapy would be offered at Pomegranate House was also determined. The GPs and the University both subscribed to empirically-based approaches, such as Cognitive Behavioural Therapy (CBT), because they were time-limited. However, when the appointments were made, the two psychologists were not CBT trained, and both subscribed to a psychodynamic approach, which favoured long-term therapy rather than time-limited CBT.

By February 2003, it was decided that the facility would be sited at the St John of God property at 103 Webster Street, and named ‘Pomegranate House’. Plans were drawn up and adopted and the building was prepared for the opening. It contained treatment rooms, a reception desk, kitchen, bathrooms, and ramps. The rooms were redecorated and re-carpeted and, in one, a one-way mirror window was installed for training purposes.

By June 2003, the senior psychologist had been appointed and the University had been contacted to recruit later-stage doctoral students to work in the centre. An office manager was appointed, and the centre was linked to the St John of God IT centre. During this stage, the steering Committee developed protocols for client records storage, security and transmission of confidential records, and the handling of confidential client material within or outside Pomegranate House. They also established a grievance resolution procedure for service users based on the one used by St John of God Hospital. Outcome measures were selected. It was decided to conform to measures used by the rest of the hospital. These were Health of a Nation Survey (HONOS) for adults (Appendix J), and Health of a Nation Survey for Children (HONOSCA). The International Classification of Disorders-10 (ICD-10) was adopted for making diagnosis. To aid with data gathering, it was decided that patients would be given a short *Intake Questionnaire* to answer before treatment commenced. This sought details of the person's age, marital status, ethic origin, first language, income and health insurance, and present mental status. This information was recorded on the IT system to be used for evaluation purposes. Finally, a Memorandum of Understanding was drawn up and signed by the four partners, St John of God Hospital, Centacare, Division of General Practice, and University of Ballarat. The new treatment centre, Pomegranate House, opened in June 2003, when patients started to be referred to or to seek the service provided

After Pomegranate House service had been running for six months it was considered a suitable time to evaluate the service, and this became the purpose of this study.

Aims of Part 1 for Study 3

The aims of this study were to discover, first, whether the persons using the service were those whom the service had been set up to serve, namely, patients who had restricted finances and needed short term treatment. A second aim was to establish whether the organizations which had set up the service were referring patients and who else was referring patients. In addition, the study aimed to discover what patients thought of the service, whether they had found any relief from their problems, and in what ways they saw the service could be improved.

Method

Participants

Before examining who the participants were, a glimpse of the demographic features of Ballarat population is given. These are based on the Census figures for 2001 gathered by the Australian Bureau of Statistics and these are shown in Table 2.

Table 2

Census Details about Ballarat Population 2001

	Persons	% of Total Persons
Population	72,766	
Male	34,727	47.7%
Female	38,039	52.3%
Age group		
0 – 4	4.946	6.8%
5 – 14	10,485	14.4%
15 – 24	11,796	16.2%
25 – 54	29.323	40.3%
55 – 64	5,975	8.2%
65 and above	10,241	14.1%
Marital status		
Married	26.6555	46.5%
Never Married	19,847	34.6%
Separated or Divorced	6,378	11.1%
Widowed	4, 457	7.8%

When the marital status of Ballarat adults is examined, it can be seen that the majority are married or never married. However, it is not clear whether those who live in *defacto* relationships are included in the 'married' or 'never married' group.

These Ballarat census figures give some backdrop for the following results.

Results

PART 1: WHO IS POMEGRANATE HOUSE SERVING?

Using the routinely collected data, a number of questions were able to be investigated about who used the service, and what services they sought. Results are discussed in two parts. Part 1 discusses the questions about those who attended Pomegranate House in the first six months of its operation. Part 2 discussed how patients assessed the services provided by Pomegranate House. The results for each question are described below.

Service Users

In the six months of operating, two hundred and twenty four patients attended Pomegranate House. Not all patients gave their details when they completed the demographic questionnaires, so, when discussing some questions, totals do not always reflect the responses of the whole group, but only of those who completed each question.

Gender and Age-groups of Service Users

Of those using the service, a third were males (87, 34%), and two thirds were females (167, 66%). The age of those who attended ranged from under 10 to over 80. The majority of patients (66%) fell in the 21 – 50 years age group. In general, male patients were slightly younger than female patients. Seventy eight percent of males were between the 11 – 50 years, whereas eighty two percent of females were in the 21 to 60 year age group. Details are shown in Table 3.

Table 3

Age and Gender of Patients Treated in First 6 Months (n = 224)

Age	Total		Males		Females	
	N	%	N	%	N	%
0-10	14	6%	4	5%	10	7%
11-20	24	10%	13	16%	11	8%
21-30	40	18%	13	16%	27	19%
31-40	66	30%	26	33%	40	28%
41-50	40	18%	10	13%	30	21%
51-60	28	13%	7	9%	21	14%
61-70	10	4%	5	6%	5	4%
71-80	2	1%	1	1%	1	1%
Total	224		79		145	

Financial Status of Service Users

The financial status of patients is shown in Table 4. Most of those who attended (74%) indicated their income level was less that $20,000 a year, and 89% earned less than $35,000 a year. This was precisely the group that the centre had been set up to cater for.

Table 4

Income Groups of Patients Treated in First 6 Months (N = 212)

Income	Total	%
Up to $15,000	112	53%
$15,000 – $19,999	44	21%
$20,000 - $35,000	31	15%
$35,000 - $50,000	15	7%
$50,000-$65,000	7	3%
$65,000 +	3	1%

Marital Status of Patients

The marital status of those using the service is shown in Table 5. Of those who sought help, 25% of men and 37% of women were in relationships ('Married' and 'Defacto'). Over half the males (53%) and 34% of females were single, the remainder separated, divorced or widowed.

Table 5

Marital Status of Service Users (N = 209)

Marital Status	All	%	Males	%	Females	%
Single	85	41%	36	53%	49	34%
Married	54	26%	11	16%	43	30%
Separated	29	14%	10	15%	19	13%
Divorced	21	10%	4	6%	17	12%
Defacto	16	8%	6	9%	10	7%
Widowed	4	2%	0	0%	4	3%

Health Insurance Cover

Another question that patients were asked in the Intake Questionnaire was what sort of health cover they had (private or public). If patients indicated that they had a Health Card, this indicated that they received a pension or benefit. These results are shown in Table 6.

Table 6

Health Cover of Patients Treated in First 6 Months (n = 197)

	Total	%
Health Card	125	63%
Other entitlement	40	21%
Private Health Cover`	32	16%

Over half were entitled to a health card. Only 16% had private health cover, despite a strong push by the Australian government to encourage people to take out private insurance.

Type of Service Sought

The type of service patients sought was examined. This is shown in Table 7. The main type of service sought was individual counselling (95%). Couple or relationship counselling was sought by 3.5% of patients.

Table 7

Nature of Service Sought (n= 242)

	Total	%
Individual Counselling	231	95 %
Relationship counselling	7	3 %
Group	2	1 %
Educational	1	0.5%
Couple	1	0.5%
Family	0	0 %
Other	0	0 %

Treatments Sought

At the initial interview, the psychologist was required to assess the patient's issues in terms of an ICD-10 classification (International Classification of Disorders – 10th Edition). This system groups patients on the basis of their current symptoms into diagnostic categories such as Depression, Anxiety, Obsessive-Compulsive Disorder, Post-traumatic Stress Disorder, Sexual Abuse, and so on.

The disorders for which patients sought treatment at Pomegranate House are presented in Table 8 for adults and Table 9 for children. The majority of adult patients (69%) were treated for anxiety, depression, anxiety and depression, depression with suicidal ideation, sexual abuse, or relationship breakdown. Other diagnostic categories were treated less often. Some patients had multiple diagnoses.

Table 8

ICD-10 Diagnosis of Adult Patients Treated in First 6 Months (n = 248)

Problem Type	Total	%
Adults		
Depression	57	23%
Anxiety and depression	29	12%
Anxiety	25	10%
Sexual Abuse	21	9%
Depression with suicidal ideation	18	8%
Relationship breakdown	15	7%
PTSD	10	5%
Anger issues	9	3.6%
Loss and grief	9	3.6
Social Isolation	8	3.2%
Schizo-affective	8	3.2%
Psychosis / Schizophrenia	6	2.4%
Bipolar	6	2.4%
Personality Disorders	4	1.6%
Mental retardation	4	1.6%
Domestic violence	4	1.6%
OCD	3	1.2%
Phobias	3	1.2%
Drug and Alcohol Dependency	3	1.2%

The figures for child patients are not clear because the diagnosis was not always recorded for children, however, it appears that more children were attending for reactive disorders, mentally ill parents, sexual abuse or violence, than for conduct disorders. The attendance rates of child patients are show in Table 9.

Table 9

ICD-10 Diagnosis of Children Treated in First 6 Months

Type of disorder	Number of cases
Conduct Disorders	2
Coping with mentally ill parents	2
Reactive disorders	few*
Sexual abuse/ violence	few*

(* The category 'few' is the designation given in Pomegranate House Caseload Information Report of 30/01/04)

Number of Sessions Attended

The number of sessions of those who had concluded their therapy was also examined. The categories for the numbers of sessions had been decided on prior to the commencement of data collection. These are presented in Table 10.

Table 10

Number of Sessions Attended (n = 78)

Number of sessions attended	Total	%
2 – 6 Sessions	17	22%
7 – 11 Sessions	6	8%
12 – 20 Sessions	34	44%
More than 20 Sessions	21	26%

Seventy percent of patients were in moderately long to long term treatment, which meant that they had 12 or more sessions. Thirty percent received between two and 11 sessions. Given that GPs referred patients in blocks of six sessions, the choice of categories was unfortunate.

Type of Therapy Offered

When the manager ran a survey of what therapy type was used by psychologists and doctoral students, therapists were required to categorize the treatment into three categories: ‘Psychodynamic,’ ‘CBT’ and ‘Supportive or Other’. Their responses are shown in Table 11.

Table 11

Type of Therapy Given by Therapists

Therapy Type	%
Psychodynamic Therapy	53%
Cognitive Behavioural Therapy	30%
Supportive Therapy or Other	17%

From Table 11 it can be seen that over half of patients treated were treated with a psychodynamic approach, and a third with CBT. When therapists were asked what they had meant by the category 'Supportive,' it was discovered that therapists selected this category when they were involved in assessment, or had used approaches other than psychodynamic or CBT.

Hours Provided by Students

The number of hours provided by employed psychologists and students was examined. Employed psychologists provided 52% of the treatment – 665 hours, and students provided 48% - 616 hours. This shows that the level of service offered at Pomegranate House was greatly increased by having students on placement. Almost half of all the treatment hours were provided by students.

Sources of Patient Referrals

Because Pomegranate House was set up in response to the perceived needs of particular agencies, it was important to discover whether they were the organizations that had referred patients. Again this information was obtained from patients' Intake Questionnaires. Details are shown in Table 12.

Table 12

Patients' Referral Sources in First 6 Months. (N = 196)

Referrer	Total	(Subtotal)	%
GPs	82		42%
Community organizations	43		22%
Centacare		(21)	
Children and Families Services		(10)	
Centrelink		(4)	
Carer's Choice		(2)	
Internal		(2)	
Salvation Army		(2)	
Uniting Care		(1)	
Self referrals	34		17%
Family/Friends	12		7%
Public psychiatrists	8		4%
Ballarat Health Service	8		4%
Education/Professional	6		3%
Private Health Service	3		1%

The majority of referrals came from GPs (42%) and community organizations (22%), including Centacare, and a small number from other agencies. These were the organizations which had originally seen the need for the service and which had initiated the service. Of the remainder, the next greatest numbers were the self-referrals (17%).

Discussion of Part 1

From this study, it can be seen that the original aims set for Pomegranate House were being met. The service was largely reaching those who were financially less well off and were generally being referred by the organizations responsible for its inception. Furthermore, the range of problems dealt with and the modes of treatment used were in line with expectations. Whether the original aim of providing short-term therapy was being met was not clear because of the categories selected by the committee for reporting levels of treatment. With GPs having the option of referring patients for one or two blocks of treatment, each of six weeks, the category of seven to 11 sessions, rather than 12 sessions, was unfortunate. Those referred by GPs for two sets of treatment fell into the long-term group, and so would have inflated this category, even though they would have completed their treatment after 12 sessions.

Part 2

PART 2: EVALUATION OF SERVICE

Aims

The aim of the second part of the study was to discover whether those patients who had completed their treatment were happy with the service.

Method

Participants

When patients originally presented for therapy, they were asked to complete an Intake Questionnaire. This included a question about whether the person would be willing to be contacted in the future for feedback. If patients had indicated that they were willing to be contacted, they were sent a covering letter, the survey, and a stamped, return addressed envelope. They were asked to return the questionnaire within a week.

Those who had 'terminated' included both males and females, from each age group (child to older adult), and included self-referred, GP and Centacare referrals and those referred from other sources. Their income ranged across all income groups. In all, 85 persons were sent a questionnaire, and 28 (33%) responded.

Materials

The Feedback Survey was a questionnaire designed by a previous doctoral student to help review the centre. A further three questions were added, based on those suggested by Seligman (1995) to assess the efficacy of therapy. These questions asked what progress the patient felt they had made, and how they rated the psychologist they had worked with. The reliability and validity of the Feedback Survey was not tested. Because some of the patients could easily have been identified by their age group and gender, this information was not sought.

Research questions. Questions were of two types. The first type concerned practical matters related to the service in general, and were based on questions suggested by a previous student. They asked how easy it had been for patients to find Pomegranate House; whether they thought it had been worth their while coming to Pomegranate House; whether they would consider coming back if they had another issue they needed to discuss; and whether they would recommend the service to others.

The second type of question was based on Seligman's questions about therapy. These were open ended questions about why patients had used the service; what their emotional state had been when they started treatment; what their present emotional state was: whether they thought they were more able to handle issues after coming to Pomegranate House; how happy were they with the service, and how satisfied they had been with the therapist's treatment of their problem.

Scoring Responses about the Service

Participants were asked to respond to questions which involved ranking the service offered at Pomegranate House on a number of measures on a scale of 1 to 5, with scores of 1 and 2 indicating dissatisfaction with the service, and scores of 4 and 5 indicating satisfaction.

Procedure

Records of all patients who had completed their treatment were consulted to see whether they had agreed to participate in any reviews. All patients who had agreed were contacted by letter and asked to complete a short questionnaire. The results from those questionnaires returned are reported below.

Results

Each question is discussed individually. Not all respondents gave answers to all items, so the total is not always 28.

Reasons for Attending

The reasons patients gave for attending Pomegranate house are shown in Table 13. The question was an open question so patients used their own terms.

Table 13

Reasons for Attending (n = 20)

Reason	Total number attending for this reason
Depression	6
Anxiety	3
Sleeplessness	1
Bereavement	1
Unemployment	1
Relationship issues	3
Suicidal feelings	3
Self-esteem/ Poor emotional state	2

How Patients Felt Before and After Treatment

Participants were asked to rate their 'before' and 'after' treatment state, from 1 (very poor) to 5 (very good). The means of before and after are shown in Table 14.

Table 14

Emotional State Before and After Treatment

Emotional State	N	Mean	SD
Before treatment	17	1.65	.79
After treatment	17	3.94	1.09

A *t*-test was undertaken to assess any changes in emotional state following treatment. It revealed a significant increase in post-treatment scores, $t\ (16) = 7.8, p < .001$. This showed that, in general, the direction of change is upward, that is, emotional state was significantly improved.

Patients Opinions of the Service

Participants were asked to respond to questions by ranking 1 to 5. As before, low scores (1 and 2) indicated dissatisfaction. Satisfaction was indicated with higher scores (4 and 5). Patient responses are shown in Table 15.

Table 15

Participants' Opinions of the Service

Service	Mean Score	Ranking Key
How easy was it to find Pomegranate House?'	4.4	Very easy
Was it was worthwhile coming to Pomegranate House?	4.81	Very
Would they consider coming back if they had another issue they needed to discuss?'	4.81	Very likely
Would they recommend the service to others?'	4.85	Very likely
Did they think that after coming to Pomegranate House, they were now more able to handle issues?'	4.07	Very much
How happy were they with the service?'	4.85	Very happy
How satisfied were they with the therapist's treatment of their problem?'	4.75	Completely satisfied

A further question was asked, about why patients had stopped coming for treatment. In many 'manualized treatments' a set number of sessions are recommended for the treatment of various disorders, yet some patients stop coming before that number is achieved. So this question attempted to answer the question which is often left unanswered for therapists: why do patients stop attending. Patients were asked to select a response, or to give their own reason. These are shown in Table 16.

Table 16

Reasons for Stopping Treatment

Reason for stopping treatment	n.
I felt better	3
My psychologist and I agreed I didn't need to come any more.	7
I found help elsewhere	2
Other (supplied by patients)	6
Didn't want help	(1)
I make my mind up what to do	(1)
Thought I'd give it a try by myself	(1)
I am coming to terms with my disability	(1)
Xmas break for counsellor	(2)

Discussion of Part 2

Those patients who responded to the questionnaire indicated that they were pleased with the service and that they felt they had been helped. They also said they would recommend the service to others. In all it seemed that, apart from those had not wanted to attend in the first place, patients valued the new service.

General Discussion

From this information, it can be seen that the original aims of the organizations which set up the service appear, to a large extent, to have been met. They have developed a therapy service which appears to meet the needs of their clients. At this stage, over half the clients referred, were referred by the organizations which had set up the centre – namely, the Division of GPs and Centacare. However this proportion may change as community awareness of the service increases.

The clients who attended were largely those on restricted incomes, as was originally intended by the committee. However, it is also an expectation of the St John of God nuns, that the centre should become self funded in time. Even if some therapy is provided gratis by students, this goal might be difficult, particularly when some patients pay as little as $5 a session.

Whilst patients attended for a variety of treatments, principally they attended for treatment of depression, anxiety, or a mix of depression and anxiety. Whilst there was a hope that the centre would provide services for children, in the main, the patients were adults.

Conclusion

After studying who was using the service, some conclusions about how the service is running can be made. From the growing number of people attending the service it appears that there was a need for this new service. It also appears that the mix of two senior psychologists, plus doctoral students, was working well. Patients using the service were satisfied with the service, and felt that they were 'better' after receiving treatment.

Given that the centre was set up in response to a perceived need, it appears, from the numbers of patients attending, that the need perceived by Centacare and the Division of GPs was a real one. Given that most patients were very pleased with the service and found it effective, they had indicated they would refer their friends or family to the service, it appears that the service is meeting this need.

Innovation

In this project, there was a need to assess how successfully an idea had been translated into reality. A need was perceived by a number of discrete and unrelated service organizations. They had noticed that there was a need of psychological services for financially disadvantaged clients. This became the distress that drove innovation.

Innovation occurred when these disparate organizations imagined a service for these clients, and worked to bring this imagined centre into being. Much of the creativity involved in setting up the centre occurred in the months before the centre opened. The steering committee developed its vision for the centre, found funding for clinicians, arranged a partnership between four organizations, formulated the expectations for the centre, set procedures, found a suitable location, arranged for the building to be prepared for the opening, and employed staff. This was a more global type of innovation, one which established a new centre and offered a service which was not previously available. A creative idea was developed and implemented and, in the terms of Andrews et al. (2004), innovation occurred.

Once their ideas were implemented, the process of innovation happened. The doors of the new centre opened. There was an intentional introduction and application of new ways of doing things. Innovation had occurred.

CHAPTER 5

INNOVATION ISSUES IN CLINICAL PRACTICE

Overview

In this chapter there is a return to the issue of innovation in clinical practice. The cycle of innovation is illustrated in a clinical context, and there is some discussion of the contradictions and more contentious issues surrounding clinical innovation. There is an examination of some of the tensions between the push for using empirically based treatments versus the need to be responsive to client needs. Finally, there is some discussion about innovation at an individual, a group, and an organization level, as occurred in the three current studies.

Innovation in Clinical Practice

As discussed in Chapter 1, innovation is defined as "the intentional introduction and application ... of ideas, processes, products or procedures... designed to significantly benefit the individual, the group, the organization or wider society" (West & Farr, 1990, p.9). Often innovation is the implementation of a creative idea arising in response to distress at an individual, group or organizational level (Anderson, De Dreu, & Nijstad, 2004).

Whilst organizational behaviour is the branch of psychology most interested in innovation (Anderson et al., 2004; Nijstad & De Dreu, 2002), inevitably, innovation also occurs in clinical psychology. Innovation is often cyclical in nature: as one innovation addresses a particular distress, new distress springs from that innovation, and then new solutions are sought to remedy this new distress, and so on. Some examples of the innovation cycle in a clinical setting are given next: first, innovation at the level of the individual, then, innovation at the level of the organization.

Clinical Innovation Cycle at the Individual Level

An early example of the clinical innovation cycle at work can be seen in relation to Freud. Freud's individual distress was that he lived in an anti-Semitic society which denied him the opportunity of academic advancement. He sought to overcome this by developing a new way of understanding the human psyche and treating neurosis. Freud was an innovator at the individual level. The innovation cycle continued when his innovation was responded to at a number of levels, and when other individuals built on, or reacted to his ideas. For example, when psychoanalytic practitioners like Beck (1976) felt distress that psychoanalysis was not helping his patients to recover, this set off the next cycle of innovation. Seligman, writing of Beck's experience when using Freudian psychotherapy, notes that Beck found:

> that there was no problem getting depressed people to re-air past wrongs, and then to dwell on them at length. The problem was that they often unravelled as they ventilated, and he (Beck) could not find ways to ravel them up again.
>
> Occasionally this lead to suicide attempts, some fatal (Seligman, 2002, p. 966).

Beck's distress pushed him to develop his Cognitive Therapy (CT), which sought to provide, not insight, but a reduction in upsetting thinking. In turn, because of the cyclical nature of innovation, CT, in its turn, has been reacted against. CT is seen as superficial and mechanical by its critics, and this has given rise to other approaches such as Narrative Therapy (White & Epston, 1990).

Innovative Reactions to Therapeutic Excesses at an Organizational Level

Freudian psychoanalysis also inspired a great number of other therapeutic approaches. In the last 5 decades in Western societies, particularly in America, there has been a growing trend for people to seek help, meaning, or 'cure' through all manner of 'psychological' practices. This has both fuelled and been reflected in the profusion of novel therapies that have arisen in what is wryly been called 'the therapy of the week' phenomenon. Many of these novel 'therapies' such as EST, Sensitivity Training, Scientology, Orgone therapy, Gestalt therapy, and T Groups, emerged from the west coast of America. They often reflected a preoccupation with self, self-discovery, and therapy. Because many of these practices raised hopes and promised outcomes that were not fulfilled, the value of some of these practices was questioned. Some, like Scientology, are now classed as cults; others have become lucrative entrepreneurial enterprises, for example, EST and Hoffman Quadrinity, where the concern seems to be more with profit than client wellbeing. Some practices were actively damaging to clients. For example, certain 'therapeutic' approaches, such as 'recovered memory therapy,' have left some patients more traumatized than they were before therapy, which has led to litigation (e.g., Bongar, Cabot, & Packman, 1994). The deleterious effects of some of these so-called 'treatments,' have prompted individual psychologists, like Thomson (cited in Guilliatt, 1995), to warn about the dangers of pop psychologists 'wading in' to diagnose childhood abuse. Professional organizations have also stepped in to ensure that patients are protected from psychological damage or exploitation.

Along with this burgeoning of novel therapies has come a counter push to ensure that therapies actually benefit patients. Professional bodies have attempted to distance themselves from over-enthusiastic and entrepreneurial 'therapeutic' ventures by demarcating their professional bounds, and explicitly enunciating the ethical issues inherent in the practice of psychotherapy. Professional bodies like the Australian Psychological Society (APS) have also sought to safeguard patients by ensuring that members of the profession are adequately trained, trustworthy, ethical, and professional. Through regulating psychologists, professional bodies hope to guard against malpractices.

Search for Effective Practice

As well as seeking to protect clients, professional organizations have sought to understand just what the effective elements of practice are, how therapy 'works,' what the minimum time needed for effective treatment is, and how to assess the effectiveness of a particular treatment when compared to other treatment programmes. This is to ensure that when psychological treatment is meted out to patients, it is effective, efficient, good 'value-for-money', and takes no longer than is absolutely necessary. For example, in 1995, the American Psychological Association (APA) Division 12 (Clinical Psychology) Task Force (1995) formally sought to clarify what were the desirable standards of clinical practice. They called these the 'gold-standards' of treatment. Whilst acknowledging that, from a research perspective, no treatment is ever fully validated, they proposed three categories of treatment efficacy. These were: (1) 'well-established' treatments, which were those that had been empirically supported; (2) 'probably efficacious' treatments, which were those that appeared to be efficacious, but were still being tested; and (3) 'experimental' treatments, which were those that had not yet been tested or established as 'at least efficacious' (Nathan & Gorman, 1998, p.15).

Before a therapy is considered to be a well established therapy, it is rigorously compared to other therapies. If it is found to be effective, the studies are replicated. If, on replication, similar efficacious results are achieved, the therapy is then considered to be 'well established.'

The APS, as part of the *Better Outcomes in Mental Health*, has outlined 143 evidence-based interventions. All have been researched, and all are either associated with 'well established evidence of efficacy,' that is, the treatment has been shown to be 'responsible for a positive outcome', or are considered 'probably efficacious,' (APS, Evidence Based Psychology, 2000, p.2). These interventions apply to at least 25 different disorders, including, insomnia, social phobia, panic, generalized anxiety, anxiety, obsessive-compulsive disorder, depression, and so forth. This abundance of efficacious treatments should mean that the general level of therapy is enhanced and that patients benefit.

Once a therapy is considered to be well established, the procedures used in the therapy are often 'manualized.' This means that all the procedures undertaken during the treatment are recorded so they can be followed by other clinicians. Such manuals specify the number of treatment sessions needed for treatment, set the content for each session, and, where this applies, set homework for each session. Barlow (2002) and Kendall, Butcher, and Holmbeck, (1999) have collected examples of such empirically supported treatments. Among them are recent additions such as Interpersonal Psychotherapy for depression (Gillies, 2002), Dialectical Behaviour Therapy for borderline personality disorder (Linehan, 1993), Schema Focused Therapy for personality disorders and depression (Young, 1990), Acceptance and Commitment Therapy for depression (Hayes, Strosahl, & Wilson, 1999), Eye Movement Desensitization and Reprocessing for post-traumatic stress disorder (Shapiro, 1996), and Integrative Behavioural Couple Therapy (Wheeler, Christensen, & Jacobson, 2002).

As this emphasis on best practice continues, more treatments are being empirically tested. It is hoped that in this way treatment standards will become still higher, and that patients will be delivered still more effective treatments. As yet, though, there is no compulsion for clinicians to apply these interventions. Moreover, a number of therapeutic traditions, such as psychoanalysis and narrative and family therapies, have rejected the move towards manualized treatments. They claim that manualization is the therapeutic equivalent to painting-by-numbers.

Cycle of Innovation

As Anderson et al. (2004) point out innovation is cyclical, with one level of innovation triggering the next. A recent example is the push to find and use empirically supported therapies

Clinicians face a number of dilemmas, dilemmas such as how to balance staying in the bounds of standard practice, whilst also being open to new approaches, how to balance empirically supported practice and be open to following clinical hunches, and how to balance responsible and ethical practice and yet be ready to move into new areas of treatment or even extend the bounds established in empirically supported studies. Professional bodies would suggest that the answer and the only ethical course is to keep patient welfare in focus at all times.

The next section explores some issues that flow from a push to manualize treatments.

Individual Concerns about Manuals

In any meeting between an experienced clinician and a patient, there is more than a manual being applied. The clinician has a number of decisions to make. The clinician must gain some understanding of the patient's concerns, make some assessment of the patient's issues, and, on the basis of this, formulate a treatment plan. While professional organizations may have encouraged the development of manualized, empirically supported, clinical treatments, this sort of approach to treatment may not appeal to all clinicians, particularly those who already have a depth of experience, a range of skills.

There is a tension however, between what might be termed, 'using therapeutic imagination,' and the 'security' of following an empirically supported therapy manual. And, if the decision is to follow a manual, there is a tension if the client raises other issues or needs, which could derail a pre-set programme. This happened in Study 1, when the client, in response to pressure from her housing worker, asked to spend time discussing her goals, instead of then taking the next step of the planned treatment. External 'unknowns' like these can undermine even the most carefully constituted 'treatment plan' and subvert even the best manualized programme. There is always a tension, because the ultimate aim of therapy is to serve the client, not just to follow the programme.

Seligman (1995) grappled with these issues. Whilst he strongly agreed that high treatment standards are desirable, he pointed to the fact there are often problems in fulfilling the stringent requirements of 'gold-standard' treatments in the field. This is because the ideal treatment conditions usually present in efficacy studies are not found in the field. Treatments used in efficacy studies are always delivered under tightly-controlled conditions. When treatments are being compared, patients are carefully screened and matched before inclusion in the study. They are only included if they have a single diagnosis. Unfortunately, these ideal conditions are rarely found outside these studies. Seligman wrote:

> My belief has changed about what counts as a 'gold standard'... I came to see that deciding whether one treatment, under highly controlled conditions, works better than another treatment or a control group is a different question from deciding what works in the field ... I no longer believe that efficacy studies are the only, or even the best, way of finding out what treatments actually work in the field. I have come to believe that the 'effectiveness' study of how patients fare under the actual conditions of treatment in the field, can yield useful and credible 'empirical validation' of psychotherapy and medication (p. 966).

Seligman warned against the glorification of manualized treatments, and pointed out that there are many 'nonspecifics' involved in the therapeutic experience, nonspecifics such as rapport, attention, or expectation of gain. He suggested that for manualized therapies to be fully credible, they would have to include all possible contingencies, including the 'nonspecific' elements. This is obviously an impossible objective. For example, 'non-specifics' could be the ambience of a consulting room or a clinician's personality, and these could be important in determining whether or not a patient proceeds with treatment. There is no way that ambience or a clinician's personality can be manualized.

In the field, rather than having a single diagnosis, most patients present with multiple problems. Further, when working in-the-field, as well as having the goal of relieving a particular symptom, there is often another goal as well. This is to improve the general functioning of patients and help them enjoy more aspects of their lives. This is in marked contrast to the restricted goals set in efficacy studies, when the criterion is simply 'symptom reduction' in a particular disorder.

In efficacy studies a fixed number of sessions are nominated, and treatment stops when this number is reached. In the field, therapy is not so tidy. Therapy is not of a fixed duration, it simply keeps going until the patient has markedly improved, drops out, or can no longer afford to continue (Seligman, 1996).

Seligman also holds the view that therapy 'in-the-field' is self-correcting. This means that if one technique does not work with a particular patient, then another is tried. This makes therapy 'responsive' to each individual patient. Where a manual is followed, regardless of how it is received by the patient, an effective gold standard treatment might be derailed because the patient dislikes this approach or is expecting something different, so drops out.

Seligman contrasts the situation in efficacy studies when patients are passively assigned to groups, to the situation of 'in-the-field' therapy, when the patients can, and do, actively seek to find the clinician they wish to work with. At times, they 'shop around' until they find the 'right' person, that is, a person they feel comfortable with, whom they trust, and whom they think will be helpful to them. Unlike the conditions in efficacy studies, during in-the-field treatment, the "patient" is very active, not simply compliant.

Clinical Innovation and Ethics

Because manualized treatments represent the distillation of good practice, an argument can be made that once there are empirically validated therapies available for the treatment of a particular disorder, that clinicians should use them. Or even, that any clinician choosing not to use such treatments, is unprofessional, or unethical. It could be asked why a person would use a less efficacious treatment when a more efficacious one is available.

There are good and poor reasons for this. With so many new treatments endorsed as 'empirically supported', the question arises as to how a busy clinician keeps abreast of them and becomes skilled in them? Or, when there are three different empirically supported treatments for a disorder like depression, how does a clinician select between them? What if a clinician is not aware of a new and more effective treatment? Would it be ethical to choose a less well supported treatment option and, if not, how will innovative treatments be developed?

What would be the ethical status of a decision taken by the clinician to apply techniques in situations beyond those for which they were originally designed? Would it be ethical, for example, for the clinician to use elements of Dialectical Behaviour Therapy (DBT), originally introduced to treat Borderline Personality Disorder, when treating depressed clients? Yet, because such a treatment choice has not previously been researched, the effectiveness of such a novel approach cannot be guaranteed in the new situation.

In such cases, there is a risk that the client will be disadvantaged by this and that the treatment will not be helpful. This poses a moral dilemma for the clinician. Is it justifiable for a clinician to 'experiment' in this way, especially when an effective treatment programmes may already exist? Perhaps, applying novel approaches could be justified if both failures and successes were to be documented. This could advance therapeutic practice but, unfortunately, most clinicians would probably not be as keen to claim their failures as they do their successes.

Future Clinical Innovation

It could be argued that there are already sufficient effective treatments, so that there is no need for any new ones to be developed. Yet, as psychological and neurological research continues, there is a greater understanding of the mechanisms of the brain, and its part in behaviour. This knowledge may well be applied in future therapy. For example, more is known about the techniques of behaviour change, of the origins of emotions, and of the importance of cognition than was known in Freud's time. These advances have brought greater clarity to our understanding and provided deeper insights into treatment options. If these were not to be reflected in innovative treatments, then therapy would become fixed and stultified, in the same way as psychoanalysis did for many years. There is a real tension between accepting the orthodoxy of gold-standard manualized treatments, and the constant push for clinical innovation. Seeing empirically supported treatments as the only ethical ones could stultify future innovation and prevent even more effective treatments from emerging.

Innovative Aspects of the Three Studies

Innovation seems to be a constant process. It may arise at one level, but impact at another level. This is illustrated in the three studies undertaken during the practical placements. In the first study, there was innovation at the level of the individual. First, the client was prompted by emotional distress to seek new directions. The clinician's 'distress' was her perception that there were likely to be external factors that would interfere with the treatment of this patient. The options the clinician had were to work with a client, to refer her on to another psychologist, to follow a manualized treatment for an adjustment disorder, or to use EMDR, which is deemed a 'possibly effective' approach, in combination with elements of Young's Schema Therapy, which, at the time, was not even rated as 'possibly effective'. The reasons for deciding to continue with therapy and seek a rapid but untried approach, rather than refer the client on, were that the client was moving in order to get her young children returned to her care and that she would again be a full-time mother. This would make it hard for her to attend therapy and would probably also involve child-care costs. This made referring her on a poor choice, particularly when, after some reflection, the clinician estimated that the chances of this client following up such a referral were slight. The clinician acknowledged that one advantage in pursuing the treatment at that time was that the client had initiated the contact with her after meeting the clinician in an anger management class. This contact reflected the fact that the client had already formed a bond of trust. So, in order to meet this client's needs, it seemed expeditious to seize the opportunity whilst the client had the time to attend, and attempt to tailor any treatment to meet her special needs. So, the clinician selected a speedy approach, even if some of the details had not previously been empirically tested.

The fact that the clinician chose to combine elements of Schema Focused Therapy and EMDR is not as radical as it might first appear. After eight years of using the EMDR and six years of using SFT, the clinician had noticed that EMDR often offers a rapid change, requires less homework than some other cognitive approaches, is less directed to fostering self-awareness, and has little reliance on literacy or verbal fluency. Yet, one of the most crucial, yet difficult elements of EMDR, is getting the patient to define their 'negative cognitions' precisely. These negative cognitions are vital as they become the target for EMDR treatment. Applying EMDR to a poorly formulated negative cognition is a waste of time because it brings little or no relief. The YSQ Questionnaire, from SFT, quickly gives a clear picture of any characteristic, negative cognitions held by the patient. So using the YSQ to establish the negative cognition for EMDR seems less like an 'intuitive,' creative, treatment move, than a perfectly logical move. But still, it had to be tested. In this case, innovation instigated at an individual level was implemented at an individual level.

In Study 2, innovation happened in a group setting. The pressure or distress that encouraged innovation was the need for a new protocol for the treatment of child and adolescent patients with eating disorders. Study 2 showed another element in innovation, it required novel team of staff from different services to be formed and to participate in developing a protocol that reflected the needs of each department.

Whilst this project did not introduce any novel treatments, it provided an improved document. The new protocol moved the Ballarat Health Service closer to being able to provide a unified service for children, including those affected by eating disorders. So despite the fact that this was a modest project, it met the requirement that the innovation should benefit an individual, group, organization, or community. Once the protocol was approved, it would benefit any Ballarat children in need of critical treatment for eating disorders, because they could now be treated in Ballarat. Their parents and families would benefit because they would not have to be separated from each other, nor would they have to bear the expense of finding accommodation in Melbourne. The Ballarat Health Service benefited because it could offer a service that previously it could not. Even such a modest innovation can make an important contribution to the welfare of the community. In this study, innovation was instigated at a group level, and was to be implemented at an individual level.

The final innovation was the new therapy centre, Pomegranate House. In this case, innovation occurred at an organizational level. The distress that led to the innovation was the perception that clients from a number of agencies had no access to psychological support. Out of this need came a creative idea. The formerly discrete services united into a team, and came up with a creative idea about how to meet this perceived need. The team developed a vision. They imagined how this centre could be funded, where it could be situated, what its goals would be, and outlined its policies. They developed a plan to implement this idea. During the implementation phase, they found funding, premises were prepared, staff hired, and patients referred to the service. The innovation was complete, the idea was implemented.

Conclusions

It seems likely that in clinical psychology, as in other disciplines, there will be a continual drive towards for innovation. New theories will be developed and applied in response to some approaches being found to be less effective than others, or as new learning is derived from neurobiological and other research.

Where innovation is informed by theory and careful practice and where it proceeds with caution, by means of research, or by the agglomeration of single-case studies, it can enhance the body of knowledge, and lead to more effective practices. In their turn, these practices too will lead to new questions, and to further innovation. As long as clinicians are interested in understanding, as long as they observe carefully, questions will occur to them. They will puzzle over these, and perhaps this will lead them to look for answers. Innovation is inevitable, and, provided it increases patient wellbeing, or increases the efficiency of a treatment, it is not only acceptable, it is vital.

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Appendix A

General Background to Study 1

As a background to Study 1, a brief overview is given of cognitive therapies in general, and some brief details of two recently developed ones, namely, Young's Schema-Focused Therapy (Young, 1990), and Shapiro's Eye Movement Desensitization and Reprocessing (Shapiro, 1989a, 1989b, 1995).

Cognitive Theories of Psychological Disorder

Cognitive therapies have become increasingly popular since their advent about 50 years ago. In part this because they can be brief, and are amenable to empirical research. In fact, Simos (2002) claimed,

> CBT fulfils the criteria for a true system of psychotherapy by virtue of the fact that it provides a comprehensive theory of psychotherapy and a body of knowledge and empirical evidence to demonstrate its effectiveness (p. xiii).

CBT is based on the idea that emotional disorder, as well as being associated with behaviour and biochemistry, is associated with cognitions. In fact, CBT suggests that it is precisely the way in which a depressed individual processes information that contributes to their depressive symptomatology (Young, Weisenberger, & Beck, 2001). For instance, depression is commonly associated with negatively biased cognitions such as viewing oneself as 'worthless, inadequate, unlovable, and deficient' (Young, Weisenberger, & Beck, 2001, p.269), and viewing the environment as overwhelming, believing that there is no way to overcome this, and that should one try, this would fail.

Depressed persons see the future as hopeless, and for this reason, often entertain thoughts of suicide.

Beck (1976), Young (1990), and Stein and Young (1992) suggested that a predisposing factor in many patients with depression, is the presence of what they term “maladaptive schemas.” Schemas are thought to be “cognitive structures” for “screening, coding and evaluating the stimuli that impinge upon the organism” (Beck, 1976, p. 283). When such maladaptive cognitive schemas are activated, they are thought to trigger emotions such as depression, anxiety or anger because they lead an individual to interpret everything with a negative bias. This also makes positive schemas less accessible, and the individual becomes depressed. The characteristic schemas in anxiety involve themes of threat; anger involves themes of hurt or devaluation. From his work with patients with a range of personality disorders, Young (1990) identified a number of schemas which are associated with emotional distress, and because, he thought such schemas originated in early life, he called them Early Maladaptive Schemas (EMSs). He explored them in his Young Schema Questionnaire (YSQ) and uses these schemas as the basis for his Schema Focused Therapy.

Schema Focused Therapy

Schema Focused Therapy was specifically developed for working with persons who had developed personality disorders, which traditionally have been seen as treatment resistant. Schema Focused Therapy (SFT) is also used with other patients who also show similarly highly charged beliefs, for example, with depressed patients (Young, Weinberger, & Beck, 2001). Mere ‘logic’ is not sufficient to challenge such maladaptive beliefs because they have such high emotional valency. Once having acquired EMSs, an individual either: surrenders to the schema, believing it to be true; tries to avoid situations that trigger EMSs; or overcompensates for the schema by acting in ways which perversely serve to strengthen it. Schema-focused Therapy is a fairly lengthy process. It combines cognitive behavioural therapy, goal setting, recognizing automatic thoughts, and also includes experiential and didactic exercises, and a type of exposure therapy through a regime of homework which can take the form of deliberately triggering EMSs, then reading flash cards which display statements that challenge the triggered EMS. Because SFT requires both in-session and out-of-session homework it is best suited to a client who is able to make a commitment to ongoing therapy, is able to manage her time, and has the motivation to do follow-up homework. It is less suitable for any client with more chaotic life circumstances, or who is unable to do 'homework' consistently. In such cases, a more rapid method of addressing the distressing schemas is required.

Eye Movement Desensitization and Reprocessing

Another novel treatment which involves negative cognitions is Eye Movement Desensitization and Reprocessing (EMDR). This is often described as being a 'very' brief therapy, where even a single session can bring relief (Shapiro, 1989; Nathan, & Gorman, 1998). EMDR was developed by Shapiro (1989) by chance. Because it is 'a-theoretical,' EMDR has been viewed as a controversial treatment (Pitman, Orr, Altman, et al., 1996; Resick, & Calhoun, 2001). Yet it has also been found to be an 'effective treatment' (Chemtob, Nakashima, & Carlson, 2002). For instance, it has been found to resolve long-standing traumatic memories within relatively few sessions (Chemtob et al., 2001). It has also been extensively researched and is now described as an empirically validated therapy which is ‘probably efficacious’ (Chambless, Baker, Baucom, Beutler, Calhoun, Crits-Christoph et al., 1998). So whilst this status is not as firm as being empirically validated, should further similar research results be returned, it will achieve that status.

EMDR therapy is based on the assumption that sometimes, the discomfort of anxiety, depression or fear can be triggered by negative beliefs, physical sensations, or mental pictures. Even though the effects of the negative schemas are not as distressing or as dramatic as the flashbacks experienced in PTSD, they reduce a person’s sense of well-being. The EMDR procedure is as follows. The therapist takes a history and explains the EMDR treatment to the client. Should the client wish to proceed, the client then decides what problem he or she wishes to work on; s/he is then asked to hold an image of the traumatic event, then to name the negative self-cognition or self-statement that occurs to him/her when /she thinks about the event or the Negative Cognition. For example, the self-cognition could be “I don’t deserve go be happy”. From there, s/he designates how s/he would rather think about him or herself – the Positive Cognition. S/he then describes any negative emotions s/he experiences when s/he thinks about the traumatic event, and rates how upset s/he feels when s/he thinks about it. This rating is known as the Subjective Units of Distress (SUDS). In addition, s/he identifies any related physical sensation or discomfort s/he experiences anywhere in his/her body when /she thinks about the negative event or mental picture (Shapiro, 1995).

From here, the client is required to concentrate on any of the following: the distressing picture, the thought or self-cognition, the body sensation, or the emotion, whilst at the same time watching the therapist's pen or finger as it is moved from side to side, or up and down. After a 'set' of eye movements, that is, about a dozen eye movements, clients are asked to report any changes in thought, emotion, sensation or image. This continues until the troubling material is 'desensitized,' and the SUDS rating has been substantially reduced. This indicated that the emotional valency of the cognition is reduced, and the negative cognition has been replaced with the positive one, and the patient no longer believes the negative cognition. Then the positive cognition is held in mind whilst further eye movements are undertaken, this is known as 'cognitive interweave,' which aims to strengthen the positive cognition. Case studies and more extensive formal studies have shown that positive and dramatic results have been obtained by some PTSD clients who have found that EMDR can bring long- lasting and marked relief (Wilson, Becker, & Tinker, 1995; Wolpe & Abrams, 1991; Shapiro, 1989a, 1989b, 1995).

Appendix B

YSQ -L

Jeffrey Young, Ph.D. & Gary Brown, Ph.D.

Name --- Date ----------------------------

INSTRUCTIONS:

Listed below are statements that someone might use to describe him or herself. Please read each statement and decide how well it describes you. When you are not sure, base your answer on what you emotional **feel**, not on what you **think** to be true.
If you desire, reword the statement so that it would be *even more accurate* in describing you (but do not change the basic meaning of the question).
Then choose the **highest rating from 1 to 6** that describes you (including you revisions), and write the number on the line before each statement.

1. _____ People have not been there to meet my emotional needs.
2. _____ I haven't gotten enough love and attention.
3. _____ For the most part, I haven't had someone to depend on for advice and emotional support.
4. _____ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.
5. _____ For much of my life, I haven't had someone who wanted to get close to me and spend a lot of time with me.
6. _____ In general, people have not been there to give me warmth, holding, and affection.
7. _____ For much of my life, I haven't felt that I am special to someone.
8. _____ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.
9. _____ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.

**ed*

10. _____ I worry that the people I love will die soon, even though there is little medical reason to support my concern.

11. _____ I find myself clinging to people I'm close to, because I'm afraid they'll leave me.

12. _____ I worry that people I feel close to will leave me or abandon me.

13. _____ I feel that I lack a stable base of emotional support.

14. _____ I don't feel that important relationships will last; I expect them to end.

15. _____ I feel addicted to partners who can't be there for me in a committed way.

16. _____ In the end, I will be alone.

17. _____ When I feel someone I care for pulling away from me, I get desperate.

18. _____ Sometimes I am so worried about people leaving me that I drive them away.

19. _____I become upset when someone leaves me alone, even for a short period of time.

20. _____ I can't count on people who support me to be there on a regular basis.

21. _____ I can't let myself get really close to other people, because I can't be sure they'll always be there.

22. _____ It seems that the important people in my life are always coming and going.

23. _____ I worry a lot that the people I love will find someone else they prefer and leave me.

24. _____ The people close to me have been very unpredictable: one moment they're available and nice to me; then next, they're angry, upset, self-absorbed, fighting, etc.

25. _____ I need other people so much that I worry about losing them.

26. _____ I can't be myself or express what I really feel, or people will leave me.

**ab*

27. _____ I feel that people will take advantage of me.

28. _____ I often feel that I have to protect myself from other people.

29. _____ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.

30. _____ If someone acts nicely towards me, I assume that he/she must be after something.

31. _____ It is only a matter of time before someone betrays me.

32. _____ Most people only think about themselves.

33. _____ I have a great deal of difficulty trusting people.

34. _____ I am quite suspicious of other people's motives.

35. _____ Other people are rarely honest; they are usually not what they appear.

36. _____ I'm usually on the lookout for people's ulterior motives.

37. _____ If I think someone is out to hurt me, I try to hurt him or her first.

38. _____ People usually have to prove themselves to me before I can trust them.

39. _____ I set up "tests" for other people, to see if they are telling me the truth and are well-intentioned.

40. _____ I subscribe to the belief: "Control or be controlled."

41. _____ I get angry when I think about the ways I have been mistreated by other people during my life.

42. _____ During my life, those close to me have taken advantage of me or used me for their own purposes.

43. _____ I have been physically, emotionally, or sexually abused by important people in my life.

**ma*

44. _____ I don't fit in.

45. _____ I'm fundamentally different from other people.

46. _____ I don't belong; I'm a loner.

47. _____ I feel alienated from other people.

48. _____ I feel isolated and alone.

49. _____ I always feel on the outside of groups.

50. _____ No one really understands me.

51. _____ My family was always different from the families around us.

52. _____ I sometimes feel as if I'm an alien.

53. _____ If I disappeared tomorrow, no one would notice.

**si*

54. _____ No man/woman I desire could love me once he/she saw my defects.

55. _____ No one I desire would want to stay close to me if he/she knew the real me.

56. _____ I am inherently flawed and defective.

57._____ No matter how hard I try, I feel that I won't be able to get a significant man/woman to respect me or feel that I am worthwhile.

58. _____ I'm unworthy of the love, attention, and respect of others.

59. _____ I feel that I'm not lovable.

60. _____ I am too unacceptable in very basic ways to reveal myself to other people.

61. _____ If others found out about my basic defects, I could not face them.

62. _____ When people like me, I feel I am fooling them.

63. _____ I often find myself drawn to people who are very critical of me or reject me.

64. _____ I have inner secrets that I don't want people close to me to find out.

65. _____ It is my fault that my parent(s) could not love me enough.

66. _____ I don't let people know the real me.

67. _____ One of my greatest fears is that my defects will be exposed.

68. _____ I cannot understand how anyone could love me.

**ds*

69. _____ Almost nothing I do at work (or school) is as good as other people can do.

70. _____ I'm incompetent when it comes to achievement.

71. _____ Most other people are more capable than I am in areas of work (or school) and achievement.

72. _____ I'm a failure.

73. _____ I'm not as talented as most people are at their work (or at school).

74. _____ I'm not as intelligent as most people when it comes to work (or school).

75. _____ I am humiliated by my failures and inadequacies in the work (or school) sphere.

76. _____ I often feel embarrassed around other people, because I don't measure up to them in terms of my accomplishments.

77. _____ I often compare my accomplishments with others and feel that they are much more successful.

**fa*

78. _____ I do not feel capable of getting by on my own in everyday life.

79. _____ I need other people to help me get by.

80. _____ I do not feel I can cope well by myself.

81. _____ I believe that other people can take of me better than I can take care of myself.

82. _____ I have trouble tackling new tasks outside of work, unless I have someone to guide me.

83. _____ I think of myself as a dependent person when it comes to everyday functioning.

84. _____ I screw up everything I try, even outside of work (or school).

85. _____ I'm inept in most areas of life.

86. _____ If I trust my own judgment in everyday situations, I'll make the wrong decision.

87. _____ I lack common sense.

88. _____ My judgment cannot be relied on in everyday situations.

89. _____ I don't feel confident about my ability to solve everyday problems that come up.

90. _____ I feel that I need someone I can rely on to give me advice about practical issues.

91. _____ I feel more like a child than an adult when it comes to handling everyday responsibilities.

92. _____ I find the responsibilities of everyday life overwhelming.

**di*

93. _____ I can't seem to escape the feeling that something bad is about to happen.

94. _____ I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.

95. _____ I worry about becoming a street person or vagrant.

96. _____ I worry about being attacked.

97. _____ I take great precautions to avoid getting sick or hurt.

98. _____ I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.

99. ____ I am a fearful person.

100. ____ I worry a lot about the bad things happening in the world: crime, pollution, etc.

101. _____ I often feel that I might go crazy.

102. _____ I often feel that I'm going to have an anxiety attack.

103. _____ I often worry that I might have a heart attack or cancer, even though there is little medical reason to be concerned.

104. _____ I feel that the world is a dangerous place.

**vu*

105._____ I have not been able to separate myself from my parent(s), the way other people my age seem to.

106. _____ My parent(s) and I tend to be overinvolved in each other's lives and problems.

107. _____ It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.

108. _____ My parent(s) and I have to speak to each other almost every day, or else one of us feels guilty, hurt, disappointed, or alone.

109. _____ I often feel that I do not have a separate identity from my parents or partner.

110. _____ I often feel as if my parent(s) are living through me -- I don't have a life of my own.

111. _____ It is very difficult for me to maintain any distance from the people I am intimate with; I have trouble keeping any separate sense of myself.

112. _____ I am so involved with my partner or parent(s) that I do not really know who I am or what I want.

113. _____ I have trouble separating my point of view or opinion from that of my parent(s) or partner.

114. _____ I often feel that I have no privacy when it comes to my parent(s) or partner.

115. _____ I feel that my parent(s) are, or would be, very hurt about my living on my own, away from them.

**eu*

116. _____ I let other people have their way, because I fear the consequences.

117. _____ I believe that if I do what I want, I'm only asking for trouble.

118. _____ I feel that I have no choice but to give in to other people's wishes, or else they will retaliate or reject me in some way.

119. _____ In relationships, I let the other person have the upper hand.

120. _____ I've always let others make choices for me, so I really don't know what I want for myself.

121. _____ I feel the major decisions in my life were not really my own.

122. _____ I worry a lot about pleasing other people, so they won't reject me.

123. _____ I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.

124. _____ I get back at people in little ways instead of showing my anger directly.

125. _____ I will go to much greater lengths than most people to avoid confrontations.

**sb*

126. _____ I put others' needs before my own, or else I feel guilty.

127. _____ I feel guilty when I let other people down or disappoint them.

128. _____ I give more to other people than I get back in return.

129. _____ I'm the one who usually ends up taking care of the people I'm close to.

130. _____ There is almost nothing I couldn't put up with if I loved someone.

131. _____ I am a good person because I think of others more than of myself.

132. _____ At work, I'm usually the one to volunteer to do extra tasks or to put in extra time.

133. _____ No matter how busy I am, I can always find time for others.

134. _____ I can get by on very little, because my needs are minimal.

135. _____ I'm only happy when those around me are happy.

136. _____ I'm so busy doing for the people that I care about that I have little time for myself.

137. _____ I've always been the one who listens to everyone else's problems.

138. _____ I'm more comfortable giving a present than receiving one.

139. _____ Other people see me as doing too much for others and not enough for myself.

140. _____ No matter how much I give, I feel it is never enough.

141. _____ If I do what *I* want, I feel very uncomfortable.

142. _____ It's very difficult for me to ask others to take care of my needs.

**ss*

143. _____ I worry about losing control of my actions.

144. _____ I worry that I might seriously harm someone physically or emotionally, if my anger gets out of control.

145. _____ I feel that I must control my emotions and impulses, or something bad is likely to happen.

146. _____ A lot of anger and resentment build up inside of me that I don't express.

147. _____ I am too self-conscious to show positive feelings to others (e.g., affection, showing I care).

148. _____ I find it embarrassing to express my feelings to others.

149. _____ I find it hard to be warm and spontaneous.

150. _____ I control myself so much that people think I am unemotional.

151. _____ People see me as uptight emotionally.

**ei*

152. _____ I must be the best at most of what I do; I can't accept second best.

153. _____ I strive to keep almost everything in perfect order.

154. _____ I must look my best most of the time.

155. _____ I try to do my best; I can't settle for "good enough."

156. _____ I have so much to accomplish that there is almost no time to really relax.

157. _____ Almost nothing I do is quite good enough; I can always do better.

158. _____ I must meet all my responsibilities.

159. _____ I feel there is constant pressure for me to achieve and get things done.

160. _____ My relationships suffer because I push myself so hard.

161. _____ My health is suffering because I put myself under so much pressure to do well.

162. _____ I often sacrifice pleasure and happiness to meet my own standards.

163. _____ When I make a mistake, I deserve strong criticism.

164. _____ I can't let myself off the hook easily or make excuses for my mistakes.

165. _____ I'm a very competitive person.

166. _____ I put a good deal of emphasis on money or status.

167. _____ I always have to be Number One, in terms of my performance.

**us*

168. _____ I have a lot of trouble accepting "no" for an answer when I want something from other people.

169. _____ I often get angry or irritable if I can't get what I want.

170. _____ I'm special and shouldn't have to accept many of the restrictions placed on other people.

171. _____ I hate to be constrained or kept from doing what I want.

172. _____ I feel that I shouldn't have to follow the normal rules and conventions other people do.

173. _____ I feel that what I have to offer is of greater value than the contributions of others.

174. _____ I usually put my needs ahead of the needs of others.

175. _____ I often find that I am so involved in my own priorities that I don't have time to give to friends or family.

176. _____ People often tell me I am very controlling about the ways things are done.

177. _____ I get very irritated when people won't do what I ask of them.

178. _____ I can't tolerate other people telling me what to do.

**et*

179. _____ I have great difficulty getting myself to stop drinking, smoking, overeating, or other problem behaviors.

180. _____ I can't seem to discipline myself to complete routine or boring tasks.

181. _____ Often I allow myself to carry through on impulses and express emotions that get me into trouble or hurt other people.

182. _____ If I can't reach a goal, I become easily frustrated and give up.

183. _____ I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.

180. _____ I can't seem to discipline myself to complete routine or boring tasks.

181. _____ Often I allow myself to carry through on impulses and express emotions that get me into trouble or hurt other people.

182. _____ If I can't reach a goal, I become easily frustrated and give up.

183. _____ I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.

184. _____ It often happens that, once I start to feel angry, I just can't control it.

185. _____ I tend to overdo things, even though I know they are bad for me.

186. _____ I get bored very easily.

187. _____ When tasks become difficult, I usually cannot persevere and complete them.

188. _____ I can't concentrate on anything for too long.

189. _____ I can't force myself to do things I don't enjoy, even when I know it's for my own good.

190. _____ I lose my temper at the slightest offence.

191. _____ I have rarely been able to stick to my resolutions.

192. _____ I can almost never hold back from showing people how I really feel, no matter what the cost may be.

193. _____ I often do things impulsively that I later regret.

**is*

194. _____ It is important to me to be liked by almost everyone I know.

195. _____ I change myself depending on the people I'm with, so they'll like me more.

196. _____ I try hard to fit in.

197. _____ My self-esteem is based mostly on how other people view me.

198. _____ Having money and knowing important people make me feel worthwhile.

199. _____ I spend a lot of time on my physical appearance so people will value me.

200. _____ Accomplishments are most valuable to me if other people notice them.

201. _____ I am so focused on fitting in that sometimes I don't know who I am.

202. _____ I find it hard to set my own goals, without taking into account how others will respond to my choices.

203. _____ When I look at my life decisions, I see that I made most of them with other people's approval in mind.

204. _____ Even if I don't like someone, I still want him or her to like me.

205. _____ Unless I get a lot of attention from others, I feel less important.

Appendix C

Participant's responses on Therapy Feedback Form

Therapy Feedback Form

Date.....................

1. What would you say is the main reason that you are seeking/sought treatment?

.... *Anger* ....

....

2. What was your emotional state when you started treatment?

Very poor Barely managed to deal with things	Poor Life usually pretty tough for me	Fairly poor Life usually fairly tough for me	So-so I had my ups and downs	Quite good I had no serious complaintS	Good Life usually pretty good for me	Very good Life much the way I like it to be
	X					

3. What is your present emotional state?

Very poor	Poor	Fairly poor	So-so	Fairly good	Good	Very good
				X		

4. How long were you in treatment? ....*6*......... sessions.

5. How much has therapy helped you?

Made things a lot better	Made things better	Made things a bit better	Not much	Made things a bit worse	Made things worse	Made things a lot worse
X						

6. How often, in the last few weeks, have you felt:

	Not at all	Once in a while	Some days	Most days	Some time on all days	Most of the time on all days	All the time on all days
Depressed		X					
Anxious			X				
Worried			X				
Angry		X					
Afraid		X					
Neutral				X			
Content				X			
Happy			X				

7. How satisfied were you with your therapist's treatment of your problem?

Completely satisfied	Very satisfied	Fairly well satisfied	Somewhat dissatisfied	Very dissatisfied	Completely dissatisfied
	X				

8. What would have made you feel more satisfied? (Use back of sheet if necessary)

....

....

Thank you for taking the time to fill in this questionnaire.

Appendix D

Recent treatment approaches for eating disorders

A number of treatment approaches have been developed to treat young eating-disorder patients. However, more and more it has been recognized, that AN and BN are very complex. They are not simply medical or psychological, or psychiatric disorders but involve all 3 elements. As well, the treatments have to bring about the restoration of a body that is in *extremis* nutritionally. The treatments outlined below show that not all aspects are covered in each treatment. Other recent treatments have attempted to incorporate all these elements. Some of the treatments are outlined next.

Medical approaches

Eating disorders such as food faddism in early childhood and childhood are most often treated by paediatricians, but disorders like BN and AN, because they can be life-threatening, often require a period of hospitalization. Many treatment approaches have been tried. Some were predominantly medical programmes, using bed-rest and force feeding.

Behavioural approaches

A second approach, which was popular for many years, used an approach based on strict behaviourist principals. It used punishment and loss of privileges for non-compliance, and rewards and privileges for compliance with treatment.

Family therapy approaches

Family therapy has also been used to treat young patients with eating disorders. Family therapy looks at the relationships between members of the family both as the cause and the cure of the problem. Uncovering these family dynamics are an important aspect of treatment. The treatment involves looking at each set of relationships in the family, which means that this is a long-term treatment.

Cognitive approaches

Recent treatments emphasize the usual treatment principles found in most CBT treatments. For example, in the first phase they emphasize: building a therapeutic relationship, increasing motivation for treatment, providing education about starvation symptoms, evaluating and treating medical complications, presenting the cognitive rationale for treatment and for restoring normal nutrition and weight, implementing self-monitoring and meal planning, prescribing normal eating patterns (interrupting bingeing and vomiting in BN), and later increasing motivation for maintaining change, challenging cultural values regarding weight and shape, determining optimal family involvement. In the second phase, attention is given to reframing relapses, identifying dysfunctional thoughts, schemas and thinking patterns, developing cognitive restructuring skills, modifying self-concept, involving the family in therapy. In the third phase, attention is given to summarizing progress, reviewing fundamentals of continued progress, summarizing areas of continued vulnerability, reviewing the warning signs of relapse, clarifying when to return to treatment (Garner & Needleman, 1997).

Garner and Blanch (2001) recommended at 'two track' approach. The first track relates to behaviour issues around weight, bingeing and vomiting, strenuous dieting and weight control. This physiological approach has an increased awareness of the perpetuating effects of starvation, with its psychological, emotional, and physical consequences (Garner et al, 1997). The second track relates to more psychological issues such as the underlying assumptions or beliefs which are relevant to the development or the maintenance of the disorder. The early stages of treatment mainly relate to the first track and gradually treatment shifts to the second track as well.

Treatments have also been based on 'stepped care' or 'integration' models that rely on fixed or variable rules for the delivery of the various treatments (Garner et al., 1997). The one developed by Garner et al. (1997), is a multidimensional model of treatment which emphasizes three elements, cultural, individual (psychological and biological) and familial.

Recent Physiological Approaches

Another approach developed by Soedersten (2003) uses a neuro-endocrinological model rather than a psychological model. His model suggests that once an individual diets to the point of starvation, this has impacts on their neuro-endocrinology. Because the person is not eating enough, they cannot generate body heat, which, in turn, leads to the characteristic, excessive physical activity associated with these disorders. The details of some of these treatments are discussed now.

Details of Treatments

The details of some of the previous treatments will now be described.

Researched treatments for Bulimia (and anorexia)

Typically the treatment for BN takes place over about 20 weeks, whereas treatment for AN typically lasts 1 – 2 years (Garner et al 1997). This greater length for the treatment for anorexia patients appears to be because of the greater time it takes to overcome motivational obstacles, to achieve appropriate weight gain, and because there is often a period of hospitalization to treat physical deterioration.

Bulimia has been successfully treated with a structured CBT programme (Fairburn, Marcus, & Wilson, 1993) which has been found to be 'probably effective.' Garner et al (1997) have developed a similar structured treatment for AN. Both programmes share elements, such as, in each session: '…1) an agenda is set, 2) self-monitoring is reviewed, 3) dysfunctional behaviours and schemas are identified and changed, 4) the session is summarized, and homework assignments are specified' (Garner & Blanch, 2001, p.175).

For AN patients there would also be weight checking, a discussion of their weight in the context of the goals that have been set for them, a review of physical complications, and meal planning. As well, depending on the age of the patient, there might be a mix of formal individual sessions, family meetings, or a mix of both.

Physiological Approaches Soedersten's treatment (2003) uses both a physiological and an educational approach. The former addresses the issue of hypothermia in starvation, the latter involves a 'behavioural' eating training (using a computer based feedback feeding programme).

Soedersten takes an endocrinological approach, and treats the hypothermia that is experienced, using warmth and by slowing down physical activity. In addition, he adds eating-training with computer support. Finally, he works on restoring the patient's social life.

The eating training consists of putting food on a plate which is put onto a scale that is connected to a computer. This records how much food is eaten and how quickly it is eaten. This is plotted on a graph against the amount that 'normal' people eat and the speed at which they eat. The task for the patient is to try and to match their eating rate and amount to the norm (i.e., to achieve the average speed and amount). This means that this 'gives them a completely unemotional way to control their eating,' until they can consume 300 grams in 15 minutes (Soedersten, 2003, p.6). There are many changes that the patient makes in this treatment, e.g. stomach has to be re-trained to accept the amount of food, and to re-learn 'normal' satiety levels.

The 'warming' part of the treatment is provided by a battery heated jacket or wind-cheater (which is worn night and day), and whilst this treatment was instituted to address the problem of hyperthermia found in AN, it alone, has been found also to reduce anxiety. The jacket is worn until the hyperthermia goes away and the patient gains weight and attains a normal BMI (Body Mass Index). There is no additional pharmacological treatment. During the treatment the social integration part of the programme starts with contact with hairdressers, dentists and then widens to include friends and new contacts.

Soedersten (2003) reported that the remission rate with his treatment is about 75%, with another 15% going into partial remission, and only about 10% not recovering. The risk of relapse has been found to be only 7% (this compares more than favourably with CBT treatments, where as many as 30% - 50% AN patients relapse, and 35% to 45% of BN patients relapse (Soedersten, 2003). If the effectiveness of the Soedersten treatment is as great as he suggests, it would obviously be enormously beneficial for the individual and their quality of life and health, and for the savings in the health budget (Swedish estimates show the average treatment for each AN patient is about $US 400,000).

As yet, there are still unanswered questions about which are the most effective treatments for eating disorders. Yet, whilst these are being sought, there are still those patients whose health becomes dangerously compromised, and who require critical treatment.

Cornell University Eating Disorder program

Some other international programmes were also viewed on the internet, one was the *Cornell University Medical College Eating Disorders Program*, which, like the Monash programmes emphasized nursing care of severely emaciated and incapacitated AN patients. The Cornell programme also included school and weekly family therapy, vocational planning, social skills training and therapeutic recreational activities and intensive after-care planning.

There were 3 levels of programme, (1) a longer treatment programme for patients in a dangerous medical condition who required more extensive medical and nutritional rehabilitation; (2) a 7-14 day treatment programme for those patients who need short-term stabilization; and (3) a partial hospitalization programme for transition from intensive inpatient treatment which provides a continuity of medical care, plus group therapy group counselling and family therapy whilst starting to care for themselves.

Avalon Hills Programme.

The *Avalon Hills* is a private treatment facility. The programme used at Avalon Hills takes a 'holistic approach,' and is obviously directed at less incapacitated patients. The programme focuses on insight development, cognitive training (looking at thinking styles), skills development for stress management, and animal assisted therapy (where pets are used in the therapy room). It includes a programme of pet rescue and rehabilitation, and equine therapy activities (where patients are involved in the care of horses, grooming, lunging and leading) plus the 'therapeutic use of outdoor experiences ... to provide opportunities for discovery and growth' (e.g., learning horsemanship skills, trail riding). There is also a focus on developing psychosocial skills in communication, self-confidence, and learning to be in the moment and self-acceptance (Avalon Information, 2003).

University of Pittsburgh Centre for Overcoming Problem Eating

The Department of Psychiatry of the University of Pittsburgh, School of Medicine also has a *Centre for Overcoming Problem Eating* (COPE) and an *Eating Disorder Clinic* (ESC). These include: (1) inpatient treatment, (2) a day treatment programme, (3) an evening partial hospitalization programme, (4) a Dialectical Behaviour Therapy group and (5) an outpatient treatment. These programmes included an educational component, CBT, skills training, planning, cooking, and relapse prevention training. The Dialectical Behaviour Therapy group involves one evening a week for those who struggle with chronic and refractory problems and involves intensive skills training, plus individual therapy for 1 hour a week.

Appendix E

Booklet for child and adolescent eating disorder patients at Ballarat Health Services

Ballarat Health Services
Paediatric and Adolescent Unit
Grampians Psychiatric and
Clinical Health Psychology Units

WELCOME

Welcome to the Paediatric and Adolescent Unit.

You have been diagnosed as having **Anorexia Nervosa** and/or **Bulimia**.

These are serious conditions that can lead to many complications.
You have been admitted to hospital because these can put your health and wellbeing at risk. While you are here we will help you to overcome these.

YOUR SUPPORT TEAM

You will be introduced to your support team. This will include nurses, doctors, paediatrician, dietician, psychologist, and may include other members like a social worker and occupational therapist and physiotherapist.

Together we will work with you and your family to help you get over the eating disorder and get your health back.

WHAT YOU WILL DO WHILE YOU ARE HERE

During your stay you may need to start with strict bed rest. This means that you will stay in bed ALL THE TIME for at leat 48 hours.

When you start to get better you will be allowed to go to the toilet once a day and have a shower once a day. For the rest of the time you will use the bedpan.

You will meet with **your dietician** who will help you set up a structured meal plan. Your treatment team will decide whether or not you will be told your weight at your weekly weighing (in consultation with you).

You are not allowed to do any form of exercise while you are here until you start to get better. A graded exercise programme may be introduced, as decided by your treatment team.

OBSERVATIONS

While you are on bed rest, you will have your pulse, breathing rate and blood pressure checked every 4 hours.

You will be weighed twice a week. This will be after you have used the bedpan and before breakfast. You will wear only your hospital gown.

Your urine will be checked each day.

MEALS

When you come in you will meet with your dietician and you will be given your own meal plan. Once you have your plan you must stick to it. As you improve, the plan will be checked regularly and changed to meet your needs.

- No food is to be brought into the hospital unless your treating team has agreed to this.
- Unless a mistake has been made, food will not be changed or swapped. So please don't ask the Nurses or Kitchen Staff.
- The aim is that you will develop a pattern of eating 3 meals and 3 snacks a day.
- A Nurse will supervise all your meals and snacks. The Nurse will be there to support you, not to force you.
- All meals must be eaten in 30 minutes. All snacks must be eaten in 15 minutes. Meals and snacks will be removed if they are not eaten in the required time.
- After a snack or meal, you will lie down for 45 minutes of bed rest. The Nurse will supervise this.

- Some patients may need to be fed through a nasal-gastric tube. Your medical team, with the dietician, nursing staff will decide whether you need this treatment.

TREATMENT ISSUES

All decisions about your care will be discussed at the team meeting.

At the meeting we will talk about how you are progressing. If we think that changes are needed, we will decide that at the meeting. Any issues you have raised will be taken to the meeting. After the team meeting, you and your parents will meet with the team or with the Doctor, who will talk to you about any changes that have been decided by your treatment team.

During weekdays you will meet with **your dietician**.

- You will also meet and work with staff from the **Child and Adolescent Mental Health Service (CAMHS), our hospital clinical psychology team, your private accredited counsellor or psychiatrist**. They will help you to understand anorexia or bulimia, so that you can help yourself to get well.

- If you are involved with CAMHS, you may have to go to another area in the hospital for sessions. These will involve you, your parents and family.

HOUSE RULES

Visiting Hours During your stay in hospital you may only have visitors from 4 - 8 p.m. so as to leave you time for school work and treatments.

Weekend visitors On weekends, you may have visitors between 2.30 p.m. and 8 p.m. During the bed rest after tea and supper, only your parents can be present. This time is supervised by a Nurse.

No visitors or telephone calls are allowed during meal or snack times or during the 45 minutes bed rest after meals.
Phone-calls are not allowed during meals and rest times and may be restricted at times to allow for study and treatment.

Televisions are allowed. Televisions are not allowed to be turned on during meal times.

WHILE YOU ARE HERE

Members of your team will discuss how you are progressing and how to manage your illness, this will be treated confidentially, as required by the Privacy Guidelines.

You can list your team members on the back of this brochure.

NO CHANGES WILL BE MADE TO WHAT HAS BEEN AGREED TO AT THE WEEKLY MEETING (UNLESS YOUR CONDITION GETS WORSE).

GOING HOME

Once your illness has stabilised, and if your treatment team think you are ready, you may be allowed to have some leave from the hospital.

Once your health has improved and you are physically stable, you will be allowed to go home.

After you go home, you will still continue to see the doctors and other members of your Team regularly. If your physical health goes down and you do not continue to improve while you are at home you may have to go back into hospital.

TREATMENT AGREEMENT

Please read and sign.

I have read and understood the treatment conditions.
I agree to do what is written in this agreement.

Patient .... Date

Parent .... Date

Witness .... Date
For Ballarat Health service

WHAT WE DO

Doctors find out what is wrong with you and decide what treatment you need.

Paediatrician is a doctor who mainly treats children

Psychiatrist is a doctor who assesses and treats diseases psychiatric conditions.

Dietician is a person who is trained to work out the nutritional needs that a person has. They work out what food the person needs to eat to keep healthy.

Psychologist is a person who is trained to help people understand and change their behaviour.

Nurse is the every day carer who is trained to look after patients on the ward.

YOUR TEAM

Who will be looking after you while you are here, will be:

Support Nurses ……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

Paediatrician ……………………………………………………………………

Medical Officer ……………………………………………………………………

Dietician ……………………………………………………………………

Psychiatrist ……………………………………………………………………

Psychologist ……………………………………………………………………

CAMHS Worker ……………………………………………………………………

Appendix F
Nursing Guidelines for Adolescent and Children with eating disorders

Ballarat Health Services
Paediatric and Adolescent Unit
Nursing Guidelines
Anorexia Nervosa/ Bulimia Nervosa

Rationale: To provide guidelines to enable successful management during the acute stage until the patient is medically stable

Applies to All Medical, Nursing and Allied Health staff on PAU.

On admission

- Seen by Resident Medical Officer and allocated Nurse
- Assessment of medical status

- Seen by dietician for assessment of nutritional status

- Nurse gives information letter to parents and welcome to patient and discusses this with them
- Patient and parents sign agreement
- Resident Medical Officer to notify CAMHS Intake Worker if CAMHS is to be involved
- Nurse informs Psychology department, if they are to be involved
- Nurse ensures that patient's bed is not near sink or wash basin.

Ongoing Care

Observations

- 4/24 Observations

1. Lying and standing BP
2. Record and report any abnormalities/ irregularities with pulse or BP.
3. Note and treat hyperthermia.

- Bloods - FBE, U+E, LFT, calcium, Phosphate, Magnesium.

Care

- First 48 hours, strict bed-rest (No shower or toilet).
- Thereafter, fully supervised shower (10 minutes) and toilet once a day.
- To use pan or bottle at all other times.

Feeding

- NG feeds (if required, as decided by treatment team)
- Meals after consultation with Dietician ONLY.
- Meals to be consumed within 30 minutes and snacks within 15 minutes. Food is them removed from patient, regardless of what has been eaten.
- After all meals and snacks, the patient must have 45 minutes of supervised bed-rest.
- No television or telephone calls during meal times or bed rest.

Food and water

- No changes to food plan except as modified by Dietician
- No food swapping at meal times
- No food brought into the ward, except with permission of Dietician.
- **Water jugs** changed and measured at midnight and withheld on Sunday and Wednesday nights prior to weighing on Monday and Thursday mornings.

Feeding record

- Strict food and fluid balance chart

1. Write meals consumed in BLACK
2. Write meals part or not consumed in RED

Visiting Hours

Weekdays- All visitors, including parents, ONLY between 4 - 8 pm (EXCLUDING meal times and 45 minutes bed rest after meals and snacks)

Weekends - **Parents** at any time (EXCULDING meal times).

Other visitors, 2.30 - 8.pm (EXCLUDING meal times and bed rest after meals and snacks).

Television and telephone calls

Televisions are allowed. These should be turned off during meal times.

Telephone calls No bedside telephones.

Incoming calls are taken on the portable phone.

Two outgoing calls allowed each day.

NO calls are allowed during meal times or bed rest times after meals.

Weighing

Patient will be weighed **before breakfast** on Monday and Thursday mornings

- Before weighing patient will void in bedpan
- **Urine checked** for specific gravity
- Patient will wear only hospital gown for weighing
- Patient's weight reported to Dietician ONLY.
- **Dietician** will report/not report weight to patient, as negotiated at commencement of treatment.

Weekly Team Meeting

- Each Monday morning the patient's TEAM will meet.
- Nurse to meet with patient and parents on Sunday evening to take any concerns, queries or requests to the team meeting.
- RMO to document meeting in the patient's history.
- Briefing to patient at end of meeting with full team present
- All decisions made at meeting are to be communicated to the patient and parents by RMO.

Changes to Schedule

NO CHANGES to be made to this schedule.

Changes are discussed at the weekly team meeting.

Changes can ONLY be made once agreed to by the team.

Appendix G
Eating and Toilet Record

EATING AND TOILET RECORD

Date ……………………………………………

EATING RECORD

Breakfast	Morning snack	Lunch	Afternoon snack	Dinner	Evening snack
Food eaten					
Food left					

TOILET RECORD

1 Toilet Visit …..………………….
I Shower ………………………

Appendix H

Short History of Mental Health Services in Ballarat

The history of psychiatric services in Victoria shows that there has been much change in recent times. In the 19th century the era of the 'great institution,' many large custom built institutions were erected to meet the needs of specific groups. For example, orphanages, schools, hospitals and 'mental asylums were opened, and in Britain, even 'poor houses' were opened.

In Ballarat, one of these grand institutions was the Lakeside Mental Hospital. It housed thousands of chronic, long-term patients from Ballarat and the surrounding area. In fact, at one time, Lakeside was the biggest employer in Ballarat. To provide this care for long-term patients, it employed thousands of people, as well as nursing, they catered, grew food for patients, provided milk, washed and cleaned for them, did their laundry, tended the gardens and farms, and maintained hospital vehicles. This huge staff reflected the fact that many patients, once admitted, spent the rest of their lives at the hospital, because there was little chance of the person's mental health being regained, or of any rehabilitation.

There have been many recent advances in psychiatry. Now, there is a greater understanding of the major psychiatric illnesses and the factors that underlie and contribute to psychosis, depression, anxiety and other disorders. Since the development of anti-psychotic drugs, and of effective anti-depressants and anti-anxiety drugs, there has been a move towards 'deinstitutionalization' of patients, that is, taking people out of psychiatric 'asylum' and returning them to the community. Many former patients have since been returned to their communities to be maintained by their GPs, psychiatrists or psychologists or not, as the case may be. Psychology has also advanced, so that now there are effective non-drug treatments to assist patients who might previously have been hospitalized for anxiety, depression, obsessive-compulsive anxiety, bi-polar disorders or personality disorders and even schizophrenia.

With the push for deinstitutionalization, Lakeside Hospital was closed in the late 1980s and the psychiatric services were incorporated into the newly amalgamated Ballarat Health Service (BHS). When the services were integrated, acute psychiatric patients were now treated in a very small facility with only 35 beds. There is also some supported accommodation in the community for persons who are discharged from hospital and who do not have suitable support to return to. As part of the BHS service, there is also a Crisis Assessment Team (CAT) which is on-call to members of the community who are experiencing an acute psychiatric episode that might result in them endangering themselves or others. The Peter Heinz Centre at the BHS provides some psychological support, though this is mainly restricted to patients who are already patients of the Ballarat Health Service, such as patients who are depressed as the result of a limb amputation. In addition, there is CASA - a specialized sexual assault counselling service. The Community Health Services also provide some counselling, however, there are often a long waiting lists before this can be accessed.

In addition to these public services, some private hospital care has been available through the St John of God Hospital. Supported accommodation and support programmes for those recovering or living with psychiatric problems are also provided by ‘Centacare.’ There are also numerous psychiatrists working in private practice who provide support for some former patients living in the community. Whilst at one stage there were no psychologists in private practice, with the only psychological service provided by the Child Guidance Centre of the Education Department, there are now many psychologists in private practice. Mental health services are also provided privately by social workers, psychiatric nurses, family counsellors, and welfare workers such as Drugs and Alcohol Counsellors. From this, it appears that Ballarat's citizenry are well catered for.

Yet, despite this apparent abundance of services, there are still persons who miss out. These persons were identified in the mental health programme 'Beyond Blue' - a national mental health initiative. They are those who are less affluent, and so cannot access the services that are available (Sweet, 2002).

In addition, there has also been a growing public awareness about mental health issues. In recent years there have been a number of pushes to bring the state of mental health to public notice. 'Beyond Blue' has researched the effects of not receiving treatment. In their bulletin board '*beyondblue*' website, they showed that when depression and bipolar problems were not managed successfully the effects are felt in the wider family, neighbourhood and community. The National Mental Health Strategy publication 'Promotion, Prevention and Early Intervention for Mental Health – A Monograph 2000' showed that early detection and early intervention minimised the effects of mental illness, reduced the subsequent damage to the person's quality of life. Where there was no access to appropriate services there were pervasive ramifications not only for patients, but to their families, their fellow workers, and the wider community. For example, not receiving adequate treatment greatly reduced their earning power.

The Mental Health Needs and Expenditure in Australia Report (2002 July) was the first exhaustive attempt to map out the national spending on mental health in the public and private sectors, and to correlate these findings with needs for such services. The repost showed that there was an inequitable distribution of services, with more wealthy areas having better access to all sorts of services not available in other areas. Public spending for psychiatric services and mental health varies between states, and between urban and rural areas. The greatest inequity was in the private sector, 'with more than 500 times more spent per capita on government rebates for private psychiatry in some city areas relative to some country areas' (Sweet, 2002, p.34).

Whilst many patients with mental disorders are treated in their community by their G.Ps, some go on to seek psychiatric help, and others may be admitted to hospital. Others neither seek nor receive any help. Where GPs saw that their patients were not coping, they were able to refer them either to the public health service if they had private health insurance to private hospitals like St John of God. For those with restricted finances there was no choice.

Appendix I

Partners involved in Pomegranate House

There are 4 partners involved in the setting up of the Pomegranate House.

(1) St John of God Hospital

Is a private hospital in Ballarat. It is a '24 hour- 7 day a week Department of emergency Medicine' (p. 6 Revised Draft 17.10.02);

(2) Centacare,

is a Welfare agency which provides a number of welfare programmes: **Jobs Placement Employment and Training (JPET)** a programme for adolescents and young adults who are unemployed and homeless or at risk of homelessness and who are seeking one-to-one assistance to find some stability in their present and future lives; **Personal Support Programme (PSP)** which is for adults and older persons with significant barriers to gaining employment and/or maintaining stability in their families and lifestyles; **Peplow House** which is a short term accommodation, longer term support and outreach services to homeless men; **Psychiatric Disability Support Services** which offers supported accommodation, home-based outreach and planned respite care services to people primarily aged between 16-64 with a serious mental illness; and a **Residential Rehabilitation programme** for young people with a mental illness which offers up to two years residential rehabilitation and outreach for 10 people primarily aged 18-24, on a regional basis; **Strengthening families** which is a case management and service brokerage for families at risk of entering the judicial child protection system; **Disability, Allied Health and Supported Housing (DASH)** which is also a case management, service development ad brokerage service for marginalized individuals with complex needs, including frail aged, adults with disabilities, and deinstitutionalized people with psychiatric disabilities living in transient accommodation. These programmes are essentially outreach-based and supportive but are not designed to be one-to-one therapeutic interventions.

(3) The Ballarat and District Division of General Practice has been actively engaged in shared care mental health projects including *More Allied Health Services (MAHS), Clinical Psychology in Rural General Practice Project* and the *Primary Mental Health and Early Intervention Initiative.* They undertook a needs analysis and identified that access to psychology services was a priority service gap for General Practitioners and the communities in the division's catchment areas. They decided to seek funding for a pilot programme under the *Better Outcomes in metal Health Care*. Patients identified by their GPs as treatment for a mental health disorder could be referred to an allied health service for a restricted service (a maximum of 6 time-limited sessions, with an option for a further 6 sessions following a mental health review by the referring GP).

(4) *Ballarat University* is a regional university in Victoria. The Department of Psychology had a number of post-graduate programmes, including Doctor of Psychology (Clinical) and Masters of Psychology. Students from these courses are required to undertake up to 200 days of practical placements in professional settings where there is a registered psychologist who can supervise the student.

Appendix J

Health of a Nation Survey (HONOS)

The Royal College of Psychiatrists (1996) developed the Health of a Nation Survey (HONOS) for adults and for children. In the adult scale there are the 12 scales used to rate mental health service users of working age adults. They consider different aspects of mental and social health, each on a scale of 0-4. They are designed to be used by clinicians before and after interventions, so that changes attributable to the interventions (outcomes) can be measured. The scales are as follows:

1. Overactive, aggressive, disruptive or agitated behaviour
2. Non-accidental self-injury
3. Problem drinking or drug-taking
4. Cognitive problems
5. Physical illness or disability problems
6. Problems associated with hallucinations and delusions
7. Problems with depressed mood
8. Other mental and behavioural problems
9. Problems with relationships
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and activities

Each scale is rated as follows:

1. No problem,

2. Minor problem requiring no action,

3. Mild problem but definitely present,

4. Moderately severe problem,

5. Severe to very severe problem.