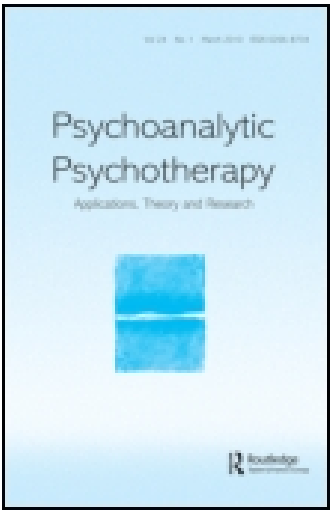

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Evaluating the outcome of a community-based psychoanalytic psychotherapy service for young people between 12 and 25 years old: Work in progress

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EVALUATING THE OUTCOME OF A COMMUNITY-BASED PSYCHOANALYTIC PSYCHOTHERAPY SERVICE FOR YOUNG PEOPLE BETWEEN 12 AND 25 YEARS OLD: WORK IN PROGRESS[1]

GEOFFREY BARUCH[2]

SUMMARY

The paper describes a clinical audit of a community-based psychoanalytic psychotherapy service for young people between 12 and 25 years old. The process of managing the incorporation of the audit into the clinical sphere at the Brandon Centre is discussed. The author then focuses on the evaluation of the outcome of the psychotherapy service. The measures used are presented; the results of the data collected twenty months after the start of the project are reported, including a follow-up analysis of new patients three months after intake, based on self-report forms filled out by the young people. The tentative implications of the audit for the pattern of service delivery at the Brandon Centre, and its impact on the Centre's work, are discussed. The work presented in this paper shows that the methodologies of audit can be successfully integrated with clinical work without harming psychotherapeutic practice, and can make an important contribution to planning the direction of the clinical service.

INTRODUCTION

The paper describes a clinical audit of the psychotherapy service which was introduced at the Brandon Centre in April 1993. The Centre is a well-established, community-based clinic in the voluntary sector, offering a number of services for young people between 12 and 25 years old, and including a self-referral psychother-

[1]A version of this paper was presented at the Audit and Psychotherapy Workshop on 27 January 1995, organised by the Tavistock and Portman NHS Trust. I would like to acknowledge the generous support given to the project by Dr Margaret Thornley, Regional Coordinator for Audit and Quality, North Thames Regional Health Authority. I would also like to thank Professor Peter Fonagy, Dr Mary Target and Andrew Gerber from the Anna Freud Centre, who advised me in the choice of measures, and without whose help the analysis of the data would have been very rudimentary.

[2]The author is director of the Brandon Centre and is responsible for setting up the project, and, with the staff, for implementing the project.

apy service, a self-referral birth-control service, and an information and advice service[3,4].

There is no prior screening of the young people who refer themselves for psychotherapy[5]. They are placed on a waiting-list and are usually seen for an assessment interview three-to-four weeks later. Following this interview, once-weekly individual psychoanalytic psychotherapy follows immediately, with the assessing psychotherapist.

The Centre had a tradition of clinical audit before I was appointed director in 1992. Data routinely collected by the clinical staff included the ethnic background of the young person, the source of referral, demographic information and diagnostic information, using a non-standardised system. The staff also used a non-standardised rating scale to evaluate treatment outcome. There was case-supervision, a regular review of case-notes, and detailed examination of negative outcomes.

Two findings from this previous audit helped us to think about the pattern of service-delivery. Contrary to the expectation of the psychotherapists who believed most patients were long-term, the majority (66%) stayed for up to nine sessions of open-ended, once-weekly individual psychoanalytic psychotherapy. Also we found that the younger patients attended fewer sessions than did older patients. However, two fundamental weaknesses of the audit, the system of diagnosis and the measure of outcome, meant that a proper reappraisal of the clinical service was not possible.

A need to review the methodologies of the audit was prompted by other factors.

Firstly, there was pressure on purchasers and charitable-trust administrators to provide empirical evidence about how grants to providers were being used. In turn, they were demanding from providers evidence of mechanisms for measuring the quality of health-care being delivered, including qualities of relevance, accessibility and acceptability, equitability, effectiveness and efficiency.

Secondly, there was a proliferation of counselling services for young people which were seeking funding. Charitable-trust administrators were being inundated with requests from youth-counselling projects for financial support. They had no way of judging which services provided good-quality care and met genuine need; hence which deserved support. The proliferation of youth-counselling projects posed a potential threat to the survival of an established professional psychotherapy clinic, like the Brandon Centre, if, despite its reputation for acceptability and accessibility, it could not demonstrate empirically the quality of its work.

Thirdly, there was the matter of professional conscience. As director of the Centre, I was promoting individual psychoanalytic psychotherapy as a treatment of choice for damaged young people, but I did not know what impact our work was having

[3]The audit reported in this paper is an evaluation of the psychotherapy service.

[4]In 1994, the total number of people who used the centre was 404. Of these, 232 used the medical service and 172, including ten parents, used the psychotherapy service. The main sources from which young people heard about the service were GPs (33%), advice agencies (13%), friends (12%) and school-teachers (10%). The Centre offered over 3,000 appointments, of which 70% were taken up by young people. Over 21% came from the ethnic minorities. The Centre is financially supported by voluntary contributions from public authorities, charitable trusts and corporations.

[5]James Rose, a member of staff, organised this work in collaboration with my predecessor, Peter Wilson.

on our patient population as a whole. I therefore wanted to find out about the outcome of our intervention on a population of patients who, for developmental reasons to do with separating from their primary objects, are difficult to engage in psychotherapy, and who often terminate treatment prematurely without the agreement of the psychotherapist. Also, as a result of a decade of working with troubled adolescents in community-based psychoanalytic psychotherapy clinics, I felt that there was a need to adapt clinical practice, because of the multiple nature of the problems presented by many adolescents, some of whom were clearly not benefiting from treatment. Although I had clinical evidence to support this view, I did not have the type of evidence that the methodologies of an audit can provide. I also began to see the damage being done to the reputation of our profession by *ex cathedra* statements made by many clinicians, including myself, about the success of our work with troubled young people (as a population) without empirical evidence to support these claims.

Managing change

The proposed incorporation into the clinical sphere of work of a self-report form filled out by the young person and a form filled out by a significant-other at intake, and then followed up periodically, posed the greatest difficulty for clinical practice. (see METHOD below for a description of these and other measures introduced in 1993). There was a great deal of anxiety, which I shared with the clinical staff, about whether the forms would deter young people from coming to the Centre, and how much the forms would interfere with the therapeutic process.

There were three matters which helped in the management of change.

Firstly, because the Centre is in the voluntary sector and therefore dependent for its survival on voluntary financial contributions, the staff have a stake in any activity which contributes to the Centre's future.

Secondly, over a period of six months I ran a pilot study, administering the forms to all my new patients. This was helpful in giving the staff confidence that the forms could be introduced without damaging the therapeutic relationship. The pilot study enabled me to learn about the problems of administration, and so develop a procedure based on this experience.

Thirdly, the psychotherapists have been permitted a certain flexibility as to how they administer the forms. For instance, some young people are asked to complete the form at home and return it at the next session; whereas others fill in the form during the session. The psychotherapist can exclude young people who are unwilling to participate, or who are unable to fill in the form because they are severely disturbed and in crisis. Since the audit began, only a handful of adolescents have been excluded on these grounds. Several young people with learning difficulties have been helped by their psychotherapist to read the questions.

The introduction of the forms had to be ratified by the Centre's Council of Management, which is composed of lay people and mental-health professionals. Strikingly, some of the latter proved most resistant to and skeptical about their

introduction. A subcommittee was formed in order to examine the issues, which were similar to the anxieties of the staff mentioned earlier. The subcommittee members gave me permission to proceed with the project, and after a year they have been converted, having seen the benefits gained from auditing the service.

In managing the process of change, it was also important that as project leader I had the advice and support from mental-health researchers who are expert in audit and outcome work. This has been provided by the Research Department of the Anna Freud Centre.

In April 1993, our Centre was ready to introduce the new audit of the psychotherapy service. The major components of the audit are:

- routine questionnaires to young people on their satisfaction with the service;
- measures of mental health outcome;
- ethnic monitoring;
- regular surveys of referrers' perception of the service;
- regular review of case-notes, case-supervision, and detailed examination of all complaints and negative outcomes;
- characterisation of young people who use the Centre, by age, diagnosis, problem presented, and treatment.

I shall now focus on the evaluation of the outcome of the psychotherapy service.

METHOD

Design

All new patients attending the Centre for the first time since 1 April 1993 have participated in the present study. The design of the study involves assessing them at intake, at three months, at six months, at one year, and annually thereafter. Patients who are too disturbed, or are unwilling or unable to participate, have been excluded.

Subjects

Information about the patient population is based on an analysis of the data twenty months after the commencement of the audit. We intend to run the audit for three years. 106 young people are included in the study. **Table 1** presents demographic information which is obtained as part of the intake procedure. The therapist completes a standard form (**Appendix I**, p.261 below) for personal details of the patient (demographic, familial, occupation, educational attainment, where living, etc.).

Table 1 shows the demographic characteristics of the patient population at intake. Over 70% of young people are aged between 17 and 25. This is the target population for the Brandon Centre's psychotherapy service, which is aimed at young people who are too old for child guidance services and for whom adult NHS mental-health services are inappropriate. The high percentage of young women having psychotherapy may be accounted for partly by the existence of the birth-control service at

the Centre. The findings about young people's living arrangements show that nearly 60% live with a single parent, live alone or live in a hostel. This population is commonly considered to be at great risk from mental disorder. Our audit also shows that living with both parents, as opposed to living with a single parent, does not necessarily protect the young person from being at risk from mental-health problems. Over 90% of young people report family problems.

Table 2 shows where patients learned about the Centre's psychotherapy service. Nearly 25% learn about the Centre from their GP. GPs usually encourage self-referral to the Brandon Centre.

Table 3 shows the number of weeks in treatment and attendance by age. The median number of weeks in treatment was seventeen. 50% stayed for up to seventeen weeks and 50% stayed for seventeen weeks or more. 38% stayed for between one

Table 1 Some Demographic characteristics of young people at intake (N = 106).

Mean age, years	18.7 (3.2)
(standard deviation)	%
12–16 years	29.2
17–21 years	44.5
22–25 years	26.3
Female	73.8
Male	26.2
Ethnic minorities	22.0
Living arrangement:	
With single parent	36.8
With both parents	15.1
Alone	15.1
Co-habiting	9.4
Sharing	8.5
Hostel	7.5
Other	7.6
Occupation:	
School	34.9
Coll/Univ & Training	24.5
Employed	19.8
Unemployed	15.1
Other	5.7

Table 2 Where Patients learned about the Brandon Centre (N = 106).

	%
GP	24.5
Agencies (advice, Police, Citizens Advice Bureaux, library, probation service)	18.9
Friend	16.0
Parent	12.3
Psychiatry, psychotherapy, counselling	6.6
Teacher	6.6
Social Services	3.8
Walk-in	0.9
Other	10.4

Table 3 No. of weeks in treatment (N = 95) and Attendance by age (N = 106).

	%
1 – 5 weeks	22.1
6 – 10 weeks	18.9
11 – 15 weeks	7.4
16 – 20 weeks	9.5
21 – 25 weeks	6.3
26 – 29 weeks	6.3
30 – 35 weeks	2.1
36 – 40 weeks	7.4
41 – 45 weeks	2.1
46 – 50 weeks	3.2
51 – 55 weeks	2.1
56 – 60 weeks	2.1
61 – 65 weeks	6.3
66 – weeks	4.2

		%		%		%
1 – 2 sessions	12–16yrs	10.4	17–21yrs	11.3	22–25yrs	3.8
3 – 5 sessions	12–16yrs	4.7	17–21yrs	6.6	22–25yrs	1.9
6 – 10 sessions	12–16yrs	9.4	17–21yrs	9.4	22–25yrs	5.7
11 – 15 sessions	12–16yrs	3.8	17–21yrs	7.5	22–25yrs	2.8
16 – 20 sessions	12–16yrs	0.9	17–21yrs	3.8	22–25yrs	0.9
21 – sessions	12–16yrs	0.0	17–21yrs	5.7	22–25yrs	11.4

and ten weeks. The older subjects were more likely to attend a high number of sessions, whereas the younger subjects tended to have fewer sessions.

Measures

(see **Table 4** for clinical characteristics of the patient population at intake)

At the beginning of treatment, the adolescent is assessed by the therapist using the **Global Assessment of Functioning** Scale (GAF). The GAF is a condensed version of the Global Assessment Scale (GAS) and Children's Assessment Scale included in DSM-IIIR and DSM-IV as Axis V (American Psychiatric Association 1994). The therapist rates the adolescent's level of functioning according to guidelines on a scale of 1-to-100 of decreasing severity. The reliability of the therapists' judgment of thirty patients was independently checked by a senior clinician at the Centre. The interjudge agreement on a series of thirty patients was high ($r = 0.8$). The median score for the total patient population was 51.1, ie moderate symptoms (eg flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school-functioning (eg few friends, conflicts with co-workers). A score of 70 is normally considered to be the cut-off point between the normal and clinical ranges.

The young person is also rated for the severity of psychosocial and environmental stresses on a scale of 1-to-6 of increasing severity, using the **Severity of Psychosocial Stressors** Scale for Children and Adolescents (SPS). The scale is taken from Axis IV of the DSM-IIIR. The interjudge agreement on a series of thirty patients was high ($r = 0.8$). The median stressor for the total patient population was 4, that is severe events or circumstances, eg: divorce of parents, unwanted pregnancy, arrest, harsh or rejecting parents, chronic life-threatening illness in a parent, or multiple foster-home placements.

The therapist assigns a diagnosis using a slightly modified version of **ICD-10** following two clinical interviews. There are nine commonly used diagnostic groupings describing psychological problems, all of which are rated by the therapist on a scale of 0 (None) to 3 (Severe). The therapist also assigns a principal diagnosis. All the psychotherapists assigning this diagnosis and the other measures had advanced postgraduate clinical training. They had been instructed in **ICD-10**, using categories and sub-categories laid down in guidelines in the 1990 Draft of Chapter V. Excluding any diagnostic grouping for with there were fewer than three positive ratings, reliability was reasonably high. K ranged between 0.6 and 1.0 for the remaining eight groupings. The highest frequencies for the total sample were recorded for mood disorder and then for neurotic disorder. Most young people presented with more than one diagnosis; the median number of diagnoses was three.

The therapist also fills out our own **Presentation of Problems** Form, comprising thirty-nine items from which the problems describing the adolescent's current situation are noted (see **Appendix 2**, p.266 below for a list of these problems). The overall reliability of this measure was variable, with some items showing low reliability. K ranged between 0.143 and 0.464; and other items showed satisfactory-

Table 4 Some Clinical characteristics of young people at intake (N = 106).

Severity of Psychosocial Stressors Scale (SPS):	%
1 No acute events or enduring circumstances	2.8
2 Mild events or enduring circumstances	7.5
3 Moderate events or enduring circumstances	20.8
4 Severe events or enduring circumstances	41.5
5 Extreme events or enduring circumstances	25.5
6 Catastrophic events or enduring circumstances	1.9
Global Assessment of Functioning Scale (GAF):	%
10–19	2.8
20–29	1.9
30–39	7.3
40–49	20.2
50–59	38.7
60–69	24.4
70– (normal range)	4.7
ICD-10 Diagnostic categories (frequencies):	%
1 Neurotic, stress-related or somatoform disorder	66.0
2 Other mood disorder (depression or hypomania – single-episode or persistent)	84.0
3 Hyperkinetic or conduct disorder	17.9
4 Specific developmental disorder	6.6
5 Other disorder with childhood onset (eg tics, mutism)	2.8
6 Substance abuse	33.9
7 Psychosis, organic syndrome, pervasive developmental disorder or mental handicap	8.4
8 Syndromes with physiological symptoms (eating, sleeping and sexual dysfunction)	48.2
9 (Adolescents or adults) personality disorder, disorder of gender identity or sexual orientation, habit/impulse disorder	42.4
Principal ICD-10 Diagnosis:	%
1 Neurotic, stress-related or somatoform disorder	21.7
2 Other mood disorder (depression or hypomania – single-episode or persistent)	38.7
3 Hyperkinetic or conduct disorder	11.3
4 Specific developmental disorder	–
5 Other disorder with childhood onset (eg tics, mutism)	–
6 Substance abuse	2.8

Table 4 (*continued*)

7 Psychosis, organic syndrome, pervasive developmental disorder or mental handicap	2.8
8 Syndromes with physiological symptoms (eating, sleeping and sexual dysfunction)	8.5
9 (Adolescents or adults) personality disorder, disorder of gender identity or sexual orientation, habit/impulse disorder	14.2

Problems presented (frequencies):	%
Sexual problems	20.8
Isolation	46.2
Family problems	88.7
Substance misuse	30.2
Delinquency	22.6
Eating problems	18.9
Attempted suicide & deliberate self-harm	20.8
Physical and sexual abuse	17.0
Bereavement	27.4
School problems	10.4
Learning difficulties	21.7
Employment problems	23.6
Abortion	8.9
Developmental problems	47.2
Sleeping problems	35.8
Somatic problems	29.2

to-excellent reliability, K ranging from 0.6 to 1.00. young people presented with multiple problems; the median number was four problems.

Outcome Measures

All new patients are administered two modified versions of the **Child Behaviour Checklist** (CBCL) developed by Achenbach and Edelbrock (1986, 1987).

The **Youth Self Report Form** (YSR) was designed for adolescents between 11 and 18 years old. We have modified the form slightly to make it easier to fill out for young people who are not used to 'American' English, and also to make it more appropriate for older adolescents. For instance, reference to 'kids' was changed to 'young people'. The YSR presents the adolescent with 118 statements which are rated according to whether the statement is not true, sometimes true, or very true/often true.

The **Teacher's Report Form** was developed by Achenbach and Edelbrock, because teachers, next to parents, are usually the most important adults in children's lives, and also because school is a significant setting in which children exhibit normal

and problem behaviours. We have modified this form, and called it the **Significant Other Form** (SOF). The SOF is filled out by a significant other, for instance a friend, parent, sibling, GP, or teacher chosen by the young person.

The great strength of these measures is the way they allow a wide range of adolescent disorders to be assessed. Eight syndrome scales have been empirically identified, each of which is associated with a cluster of items on the questionnaire and reflect a common theme such as anxiety/depression, aggression, etc. Norms for each syndrome scale, which take account of age and gender, have been calculated by Achenbach and Edelbrock from a carefully chosen sample designed to reflect a cross-section of the US population. Using these norms, it is possible to assign a T-score to the raw scores of each scale, which indicates whether the young person is within the normal or the clinical range on a given syndrome scale. For the scales, a T-score of 67 (the 95th percentile) is normally considered to mark the cut-off point between the normal and the clinical ranges.

The syndromes have also been banded together so that scores exist for the total of the Internalising scales (including Withdrawn, Somatic Complaints and Anxiety/Depression), the total of the Externalising scales (including Aggressive Behaviour and Delinquent Behaviour), and the Total of all the scales. Norms have been calculated for these scales and the cut-off between the non-clinical and clinical populations is 60.

One-week test-retest reliabilities have been calculated for the YSR syndromes and their totals. The correlation for the Internalising, Externalising and Total Problems scales was very high ($r = 0.91$) (Achenbach, 1991a). TRF fifteen-day test-retest reliabilities for these scales were also high, respectively $r = 0.91$, $r = 0.92$, $r = 0.95$ (Achenbach 1991b).

The CBCL has been widely praised in the literature as a highly reliable and valid means for assessing child and adolescent psychopathology, and is relatively easy to administer. Many researchers stress the difficulties, particularly in child and adolescent disorders, of assessing behaviours that are deviant only when seen in combination and when compared in severity with norms for their age and gender (King & Noshpitz 1991). The CBCL solves this problem by basing its entire set of results on comparisons with appropriately-matched norms. Verhulst and colleagues (1989) also point to the usefulness of the CBCL questionnaire in eliciting descriptions of behaviour from adolescents that they might not reveal in clinical interviews. The YSR is the only self-report questionnaire for adolescents which looks at a broad and meaningful range of disturbing behaviours and feelings, and organises them into relevant disorders.

Our experience certainly bears out the views found in the literature. After looking at several self-report measures, and considering the possibility of finding an alternative to the YSR for older adolescents (19–25-year-olds), we rejected the idea because we felt that the items were sufficiently close to the experiences of these young people, and on the whole would be meaningful to them. Generally this has proved to be the case.

The YSR is administered by the patient's therapist who also gives the young

person the SOF to be filled out by a significant other. The forms are administered to all new patients at the beginning of treatment (no later than the second appointment) with follow-ups after three months, six months, a year, and thereafter annually. If the young person has finished, or dropped out of, treatment, the forms are sent to her/him for completion. The therapist also fills out an SOF after three appointments; and then, if the young person is in treatment, completes one after three months, six months, etc. This was introduced nine months after the study had started because we were worried about the rate of attrition of SOFs.

Table 5 shows the percentage scores of young people in the clinical range at intake for YSR, SOF and TRF, Internalising, Externalising and Total Problems scales. Caution is required in comparing the scores, since the numbers are different. Cross-informant correspondence is lowest for the Externalising scale, with Significant Others and Therapists, as opposed to young people, seeing the majority of the young people in the clinical range.

The breakdown of Significant Other informants was[6]:

Mothers, fathers and grandparents	40%
Friends	35%
Partners	22%
Others (including GPs, teachers)	3%

- Significant Others rated young people significantly higher than the young people themselves on the total-problems scale;
- Significant Others tended to rate young people higher on externalising scales, such as social problems, than on internalising scales, such as withdrawn and anxious/depressed;
- cross-informant correspondence was highest between self and Significant Other for those young people who selected friends to fill out the Significant Other form, second highest for those young people who selected parents, and lowest for those young people who selected partners;
- therapist diagnoses (GAF, ICD diagnostic categories, and total number of therapist-reported problems) correlated better with young people's self-report problem scores than they did with Significant Other scores.

Three ways of measuring outcome are used in this report, which presents findings for YSR scores at intake and then at three months. Twenty months after starting the study, we have follow-up data for forty-nine patients out of 106.[7]:

The first way outcome has been assessed is to look at the change in mean YSR

[6]This analysis is based on work carried out by Gerber (1994).

[7]The follow-up sample of forty-nine is partly because of attrition and partly because a number of patients in treatment at the time this preliminary analysis was carried out had not reached three months. At this stage of the study, we have not enough data to carry out a statistically meaningful analysis for the six-months follow-up. Hopefully, we shall be able to present these results at a later stage.

Table 5 Young people in the clinical range at intake for YSR (N = 108), SOF (N = 77) and TRF (N = 49) Internalising, Externalising and Total Problems Scores.

Internalising Problems score in Clinical Range	%
YSR	72.2
SOF	87.0
Therapist	98.0
Externalising Problems score in Clinical Range	%
YSR	33.3
SOF	72.2
Therapist	67.3
Total Problems score in Clinical Range	%
YSR	72.2
SOF	83.1
Therapist	95.9

Internalising, Externalising and Total Problems scores. The advantage of this method of assessing outcome is that it is sensitive to relative change; for instance, the young person who has a very high clinical score at intake and improves substantially, but does not improve enough to get into the non-clinical population.

The second way outcome is considered is to look at the change in numbers from the clinical to the non-clinical range, or *vice versa*. The advantage of this method is that a clinically reliable and valid distinction established by Achenbach and Edelbrock and many others is used. The disadvantage of this method is its insensitivity to relative change.

The third way of assessing outcome is to categorise cases according to the presence of statistically reliable change in adaptation level, using the method proposed by Jacobson and colleagues (1984), and modified by Christensen & Mendoza (1986). This uses the standard deviation for each scale, together with the interjudge reliability of the measure, to indicate the size of change necessary to identify cases where change could not be due to measurement error and chance. The index of reliable change in YSR and TRF ratings is given by the formula:

reliable change = $1.96 \times \sqrt{2} \times s \times \sqrt{1(1-Rxx)}$

where Rxx is the best estimate of interrater reliability. In our data this gives the following reliable change index:

	YSR (points)
— Total Problems: Reliable change	9
— Internalising Problems: Reliable change	10
— Externalising Problems: Reliable change	8

The differences between ratings at intake and at three months is taken to indicate a statistically significant change.

Results

Changes in mean YSR scores showed a statistically significant improvement for Internalising Problems and Total Problems (see **Table 6**).

Using a T-score of 60, which Achenbach and Edelbrock established as the cut-off between the clinical and non-clinical population, we found that there was a significant decrease in the number in the clinical range for the Internalising and Total Problems scales. There was a small increase of patients in the clinical range for the Externalising scale (**Table 7**).

Table 6 Change in Mean YSR (N = 49) Internalising, Externalising and Total Problems scores after three months.

	Mean (Intake)	SD	Mean (Three months)	SD	T
Internalising problems score: YSR	67	11.6	63	12.3	2.97**
Externalising problems score: YSR	56	9.0	55	11.8	1.16ns
Total problems score: YSR	63	10.7	59	12.02	2.97**

**p <.01, ns = not significant, SD = standard deviation

Table 7 Change in YSR (N = 49) Internalising, Externalising and Total Problems scores after three months.

	Intake	3 months	Pearson Chisquare	df
Internalising problems score in clinical range: YSR	71.4	59.2	4.63*	1
Externalising problems score in clinical range: YSR	26.5	28.6	0.18ns	1
Total problems score in clinical range: YSR	73.5	51.0	16.03***	1

*p < 0.05, ***p < 0.001, ns = not significant

Table 8 shows YSR syndrome scores in the clinical range at intake and after three months. Apart from delinquent behaviour and aggressive behaviour, which are externalising scales and somatic complaints, statistically significant change occurred for the remaining scales in the reduction of the number of young people in the clinical range at the three-month follow-up.

When the presence of statistically reliable change is considered, improvement in YSR Internalising, Externalising and Total Problems scores is comparable. However, deterioration for Externalising Problems score is much greater than for Internalising and Total problems scores (**Table 9**).

Predictors of reliable change in YSR scores

A logistic regression analysis was used in order to identify predictors of reliable improvement. For Internalising Problems, the following, in descending order of reliability were very good predictors of reliable improvement:

Predictor of Reliable Improvement	Odds ratio
— Negative answer to YSR question on substance abuse	149
— Absence of somatic problems	103

Table 8 YSR Problem scores (N = 49) in the Clinical Range at Intake and after three months.

	Intake %	3-mths follow-up %
Withdrawn	38.7**	24.5
Somatic complaints	28.6	26.5
Anxious/Depressed	59.0***	38.8
Social problems	20.4***	6.1
Thought problems	22.4**	10.2
Attention problems	36.7**	20.4
Delinquent behaviour	24.5ns	16.3
Aggressive behaviour	12.2ns	10.2

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$, ns = not significant

Table 9 Statistically reliable change for YSR (N = 49), Internalising, Externalising and Total Problems Scores after three months

	No change %	Improvement %	Deterioration %
Internalising problems	69.4	24.5	6.1
Externalising problems	57.0	26.5	16.3
Total problems	63.3	28.6	8.2

— High internalising YSR problem score at intake 54.5
— Absence of learning difficulties 17
— Therapist diagnosis of disorders with physiological symptoms 13.3
— Abortion 9.1

Using these criteria, 92% of improvers were predicted correctly and 76% of non-improvers were predicted correctly.

For Externalising Problems, a good predictor of reliable deterioration was therapist diagnosis of personality disorder. Using this criterion, 75% of deteriorators were predicted correctly and 68% of non-deteriorators were predicted correctly.

Discussion and implications of the audit for the pattern of service delivery at the Brandon Centre

The presence of statistically reliable change for improvement for Externalising Problems appears to contradict the results from the two methods of measuring change also reported. They show that Externalising Problems show little or no improvement. However, when the results of the reliable change method are examined more closely, we find:

- the majority of subjects who improve for Externalising Problems also improve for Internalising Problems — nine out of thirteen young people;
- the majority who deteriorate for Externalising Problems do not deteriorate for Internalising Problems — six out of eight young people.

Recent work by Fonagy & Target (1994) and Target & Fonagy (1994) suggests that for an adolescent with Externalising Problems, such as disruptive disorders, an additional emotional disorder makes the natural history (Verhulst & van der Emde 1993) and the response to psychodynamic treatment more favourable. We think that those young people with Externalising Problems who show reliable improvement in our audit did so in part because of the presence of Internalising Problems, and that the absence of these problems would have meant fewer improving reliably.

A crucial issue for any evaluation of treatment outcome, including Brandon Centre treatment, is whether improvement is the result of therapeutic input rather than 'regression to the mean'. It can be argued that the young people seen at the Brandon Centre present in a state of crisis, and so would be expected to some degree to improve spontaneously. By the use of the presence of statistically reliable change as a means of measuring outcome, the possibility of spontaneous improvement is taken account of by the consideration of text-retest reliability. Furthermore, Luborsky and his colleagues (1993) examined a number of well-known studies of change in functioning in the course of psychotherapy, and concluded that the greatest change in psychotherapy was by individuals with a higher starting level of adaptation. Given the low level of functioning of our patient population, our results are against this trend. We therefore think that improvement occurred because of treatment.

The findings presented here are preliminary, and a snapshot from an ongoing audit. Thus far, outcome has been based on data from the YSR only, and a follow-up of

the patient population at three months. It was noted that cross-informant correspondence for Externalising Problems was poor, with Significant Others placing a far greater number of young people in the clinical range for Externalising Problems than the young people rate themselves. It will be very important to examine the follow-up data from the SOFs for Externalising Problems when there are sufficient numbers, and also from YSRs and SOFs beyond three months. Hence caution needs to be exercised in applying the present results to our pattern of service-delivery. The following conclusions can be drawn:

- the Brandon Centre psychotherapy service serves a target population of young people who predominantly fall in the clinical range according to the assessment of the therapists, of the young people themselves (except for Externalising Problems) and of their Significant Others;
- the audit shows the critical importance of having multiple sources of assessment and perspectives of change, especially with regard to Externalising Problems;
- young people usually present with more than one diagnosis and present with multiple problems;
- the psychotherapy service appears most effective for young people who present with Internalising Problems or Internalising Problems and Externalising Problems;
- the service is least effective for young people whose principal problems are Externalising Problems.

The tentative implications for the service are:

- therapeutic strategies need to be devised around and targeted at the problems presented, rather than at the young person as a whole;
- innovative therapeutic responses to Externalising Problems, including substance-abuse, which are inter-disciplinary and have multiple components involving the family, the school and the community, need to be developed;
- measures of change which can be applied on a session-by-session basis need to be implemented in order to find out what happens to young people who terminate treatment before three months.

CONCLUSION

The audit, including the administration of forms to young people and their Significant Other, has become an established feature of the Centre's activity. Fears about the possible harmful effect on the clinical work, although absolutely appropriate, have proved unfounded. There is no evidence to suggest that young people are deterred from attending the Centre because they are asked to fill in forms.

The psychotherapists have been able to incorporate the forms into their clinical practice. In this respect, the accumulation of experience of administering the forms has been important. Like many clinicians (see Verhulst *et al.* 1989), they have found the self-report and Significant Other questionnaires extremely useful in eliciting descriptions of behaviour from adolescents and young people that they do not reveal

in the assessment interview. This has been particularly the case for those adolescents and young people who have great difficulty in describing their thoughts, feelings and actions. For instance, several adolescents have revealed suicidal and self-harming behaviour in the self-report form, having denied such behaviour during the assessment interview.

The forms have been valuable for staff morale. The clinician who works with troubled adolescents inevitably is the focus of the young person's negative projections and attacks against the therapeutic setting, such as unexplained non-attendance. This can leave a sense of hopelessness in the clinician about the value of the work. By evaluating outcome, the psychotherapist gets a picture of the effectiveness of the clinical work which is not 'contaminated' by the hopelessness that can be engendered by the troubled adolescent or permeated by manic optimism which the therapist can use as a defence against hopelessness and as a denial of reality. The clinical picture which emerged from the forms, especially cross-informant variation, has enriched our clinical discussions.

Finally, the audit has been valuable in enabling me to present the work of the centre to purchasers in the public sector and administrators responsible to the Trustees of charitable trusts. In my experience, they are not looking for a picture of 'global' effectiveness; rather a demonstration of service assessment and evaluation that is then being used in a reflective way to plan the direction of the service. As clinicians, we underestimate, I think, the pressures on mental-health purchasers and charitable-trust administrators who are committed to psychoanalytic psychotherapy, but often have to face skeptical purchaser colleagues and trustees, and therefore need a commitment to audit in order to be able to support our work effectively.

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Appendix 1

1994/95

BRANDON CENTRE
PATIENT DETAILS

COUNSELLING

BOROUGH:
HEALTH AUTHORITY:

Patient No. | | | | | | | | |

Name (Family) _____

(Given) _____

Address _____

_____

_____ Post Code _____

Telephone _____ Work _____

Home Contact _____ Alt.Contact _____

G.P. _____

Address _____

_____

_____

Referred by _____

Learned of Centre

1. GP
2. Psychiatry
3. Social Work/Social Services
4. Parent
5. Friend
6. Boyfriend
7. Girlfriend
8. Relative
9. Teacher
10. Agencies (advice centre, CAB, library, police, probation service)
11. Walk-in
12. Other

	Sex	Age
Male - 1 Female - 2		
Date of birth		
Date first approached BC		
Date first appointment		
How many weeks between ↑		
Serial Number (from index card)		

Medical	M
Counselling	C
Medical/Counselling	MC
Group	G

1. Main Legal Carers (during patient lifetime)

Biological Parents	1	
Adoptive Parents	2	
Foster Parents	3	
Relatives	4	
Unrelated Adults	5	
Multiple Carers	6	
Children's Home	7	
D/K	8	

2. Siblings

NUMBERS OF:

Natural Brothers

Natural Sisters

Half Brothers

Half Sisters

Step Brothers

Step Sisters

3. Is/Does Patient

(Mark ONE/YES TWO/NO THREE/DON'T KNOW)

an eldest child

an only child

a younger child

a middle child

a twin (homozygous)

a twin (heterozygous)

have half siblings

have step siblings

4. Where Living

With both natural parents	1
With both adoptive parents	2
Father	3
Mother	4
Relatives	5
Sharing	6
Co-Habiting	7
Married	8
Alone	9
Hostel	10
Fostered	11
Children's Home	12
Employer's Accommodation	13
NFA	14
D/K	15

5. Occupation

School	1
College	2
University	3
Other Training (eg. YTS)	4
Unemployed	5
Employed	6
House Person	7
D/K	8

If employed state occupation_____ SE

6. Educational Attainment

At school	1
Left school at 16	2
GCSE (or equivalent)	3
'A' Levels	4
Further Education (eg BTEC GEN, etc.)	5
Higher Education (eg Degree, BTEC, Higher, etc.)	6
Other	7
D/K	8

7. Partner Relationship

Married	1
Separated	2
Divorced	3
Boyfriend	4
Girlfriend	5
None	6
D/K	7

Utilization of Centre

Total number of sessions offered
by 31 March 1994 ☐☐

Total number of sessions attended
by 31 March 1994 ☐☐

Number of sessions offered
1 April 1994 - 31 March 1995 ☐☐

Number of sessions attended
1 April 1994 - 31 March 1995 ☐☐

Total number of session offered
by 31 March 1995 ☐☐☐

Total number of sessions attended
by 31 March 1995 ☐☐☐

Attendance throughout year was:

Regular	1	☐
Unpredictable	2	
Sporadic but with pattern	3	
Poor around separation	4	
Not applicable	5	

Any significant breaks in treatment?

Yes	1
No	2
N/A	3

☐

Is treatment ongoing?

Yes = 1
No = 2 ☐

Was treatment ended

by mutual agreement	1	☐
at patient's initiative	2	
at therapist's initiative	3	
because of external circumstances	4	
not applicable	5	

Appendix 2

Problems presented
1-Yes 2-No 0-D/K

Mood/mental disturbance	
Sexual problems	
Social isolation	
Family problems in an intact family	
Family problems in a disrupted family	
Alcohol misuse	
Drug and solvent misuse	
Delinquency	
Violence towards others	
Eating problems	
Suicide attempt(s) (number)	
Thoughts of attacks against the body	
Physically disabled	
Sexual abuse	
Bereavement	
School refusal	
Learning difficulties	
Exam difficulties	
Adopted	
Self mutilation	

Employment problems ☐

In care ☐

Teenage mother ☐

Boyfriend/girlfriend problems ☐

Anxieties about choice of sexual partner ☐

Anxieties about sexual functioning ☐

Anxieties about being sexual ☐

Significant illness involving hospital ☐

Abortion ☐

Pregnant ☐

Separation anxiety ☐

Developmental issues ☐

Sleep disturbance ☐

Homeless ☐

Somatic symptoms ☐

Conduct disorder ☐

Physical abuse ☐

Parents: married/divorced/separated/lone
(delete not applicable)

Parent(s): misuse drugs/misuse alcohol/have a psychiatric history
(delete not applicable)

Other (state):

Other (state):