Intensive inpatient family work with families of children with emotional and behavioural difficulties: an Australian experience

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Children with severe emotional or behavioural difficulties are notoriously difficult to treat. When outpatient interventions employing various modalities fail or are not available clinicians have limited options and families are often left despairing. In this paper, we report the experience of intensive inpatient family work in an Australian Child and Adolescent Mental Health Service (CAMHS).

the context

The Coral Tree Family Service in Sydney, Australia, is part of Northern Sydney Central Coast CAMHS. Coral Tree provides five-day, intensive family admissions for families with a child aged twelve years or under with emotional and behavioural difficulties. The current model of care is the result of an ongoing change process that commenced in the early-1990s, when the focus of our service shifted from a residential and day programme for individual children to a family focussed intervention. We now provide a service to families from all corners of New South Wales, a state more than three times larger in land area than the United Kingdom. The family admission process allows rural families to receive an intensive intervention which is not available locally, and augments often stretched local clinical resources. Rural and regional families are assessed and followed up by video-conference in partnership with local clinicians, and receive government financial assistance with travel costs to and from our service. We also provide a service to families from the Sydney metropolitan region, most of whom will have already received significant outpatient family, parenting and/or psychiatric input.

We find a one week admission to be long enough to effect change with a significant burst of intensive input, and short enough to maintain the focus of family and staff, and not get too ahead of the 'reality' of the need to return home to put things into practice. We are mindful of the need to make efficient use of this scarce resource so as to allow as many families as possible to benefit from it. Coral Tree staff provide telephone support to families after their admission, and liaise with referrers, who provide ongoing follow-up. Families can return for a second and third admission over about a one-year period, if required.

In 2005 our statewide tertiary service provided 121 family admissions, with 27% of these being for families from our own area health service, 43% from elsewhere in the Sydney metropolitan area, and 30% from rural and regional New South Wales; 66% were first admissions, 29% second, and 5% third.

the coral tree family admission programme

Our five-day family admission programme incorporates a number of structured and unstructured components. Three families at a time stay at Coral Tree in their own flat around a central courtyard from Monday to Friday, with the unit closing over weekends. Treatment is provided by a multi-disciplinary team of a child and adolescent psychiatrist, nurses, psychologists and social workers.

The programme incorporates elements of systemic family therapy, parent management training, couples therapy, and parent child interaction therapy, in the context of a therapeutic community. During family and parent sessions on Monday, the family sets goals in collaboration with their therapists, the progress towards which are reviewed on Wednesday and again on Friday. On Friday, we spend time discussing with the family the potential challenges of taking home what they've gained at Coral Tree, and persisting with changes over time.

Table 1 lists the most frequent goals set by a consecutive sample of 28 families admitted from March to May 2006. Influenced by narrative therapy concepts and practice, we endeavour to articulate each family's goals in the way that they have come forth in the session, showing respect for that family's choice of language. The goal-setting process is collaborative, with input from the family as well as staff making suggestions based on what we feel will assist the family. As Table 1 (see overleaf) suggests, parental priorities often reflect their awareness of an inverted hierarchy within the family, marital conflict over parenting issues, and their mourning the loss of family fun times.

Parent sessions are used to build rapport with the parent/s, to build on their strengths and address their vulnerabilities, and to address couple/ co-parenting issues. This includes the discussion with parents, particularly single parents, of their support networks and how these can be broadened.

All family members are seen individually. Individual sessions with parents are an opportunity to discuss

Table 1: 'Top Ten' goals set by a consecutive sample of 28 families admitted to Coral Tree in early 2006 (the exact wording of goal varied between families; the family is Alison and James, the parents, and Jesse and Amy, the children)

	Goal	No. of families (/28)
1.	Alison and James to be in charge	23
2.	For the family to have fun together	18
3.	Jesse and Amy to listen to mum and dad	16
4.	Parents to work together as a team	10
5.	Kids to keep their hands and feet to themselves	9
6.	Everyone to work on remaining calm	4
7.	Family to speak nicely to each other	4
8.	Family to practice politeness and respectfulness towards each other	4
9.	To work out routines for Jesse	4
10.	To think of ways to manage anger in the family	4

and encourage parents to address personal family of origin, medical, mental health or substance misuse issues which may be impacting on family relationships or parenting capacity. Where relevant, we will seek permission to liaise with professionals providing treatment to parents, advocating for what is needed and encouraging these professionals to view our client as a parent as well as a patient.

We note that in a recent meta-analysis of parent management training outcomes (Reyno & McGrath, 2006), the most salient correlates of response to treatment were not child factors but maternal mental health and socioeconomic status. These findings are consistent with our clinical experience that attention to parental mental health, social support and general life circumstances is often a key element in successful intervention with 'treatment-resistant' families.

At the end of children's individual sessions, therapists discuss with the child what they will feed back to the parents and how this will be done. This feedback can often powerfully augment family work, for example when a child has disclosed fear of, worry about, or a strong desire for more time with a parent.

These individual sessions are a setting where disclosure of violence or abuse may occur. We endeavour to make the subsequent mandatory notification to child protection authorities a therapeutic intervention which gives the parents an opportunity to join with us in addressing safety issues.

Parenting groups make use of material including video footage from the positive parenting programme (Saunders, 1999) as a springboard for discussion of parenting approaches, such as the use of specific praise, rewards, logical consequences, quiet time and time out. Many of the parents coming to Coral Tree have done one or more parenting courses and have 'tried everything', so these groups can serve as an opportunity to both empathise with parental struggles and to encourage a fresh look at the basics in a new context.

We aim to channel the potential benefits and manage the potential downsides of the communal setting by commencing each day with a brief community meeting, by fostering positive connections between families, and by addressing early any developing negative engagements.

working alongside the family during unstructured times

The structured elements of the programme are supported and put into practice during unstructured time by a process of family worker guidance or coaching of family members (particularly parents) to work towards agreed goals. One family worker (psychologist, social worker or registered nurse) is allocated to work alongside each family from around 7.30am to 10pm each day, these two shifts being covered by the same two family workers for the duration of the week. One of these two family workers will be the family's care co-ordinator, who has liaised with the family to arrange the admission, and is a co-therapist in all family and parent sessions. We see the family workers' active involvement in care planning and therapy as vital to the synergy between the structured and unstructured therapeutic input during the family admission.

The family workers have a dialogue with the parents during the week about what role they are to play with that family. Some families seek direct instruction/advice, others prefer the family worker to hang back and let them deal with things, then discuss issues later. In keeping with the 'change us/don't change us' paradox often faced in family therapy, family workers frequently find themselves engaged in a 'dance' of variously rolling with the family's way or challenging/confronting, depending on what they judge the family needs or can deal with at the time.

In order to work effectively with parents, the family workers find that in addition to the systemic practice underlying family/couple work and the social learning theory underlying parent management training, they need to have a good grasp of the psychodynamic concepts involved in parental defence mechanisms (Newman, 1991), the cognitive distortions arising from anxiety and depression, the principles of motivational interviewing for parents in the 'pre-contemplative' or 'contemplative' stages of change (Prochaska & DiClemente, 1982), the impact of family of origin experiences and state of mind about attachment on parental beliefs and behaviours, and the sequelae of trauma in individuals and families. The family workers back one another up and debrief with one another when necessary.

It is our perspective that this role of 'family coaching' is a core component of the programme, where fundamental changes in behaviour, attributions, affective responses and relationship dynamics can be effected. Family worker

interventions are provided in the context of family activities and this is a fundamental cornerstone of our approach; moving therapeutic concepts into practice in situ. When the process works well, we find that the structured sessions set the scene for the experiments with change in the unstructured time, then the processing of and reflecting on these experiments fuel the next structured session. In addition to putting into practice disciplinary or boundary-setting practices, many families appreciate and are lastingly impacted by our helping the parents to scaffold positive family fun times with their children.

We make use of a number of behavioural interventions which can assist families to understand themselves better and to move forward, in line with strategic family therapy concepts that a prescribed change in patterns of family behaviour can shake up the tendency for families to do 'more of the same', and can unearth new solutions. These interventions include practicing behavioural management techniques, parents taking turns in playing the 'in charge' or 'supporting' roles in half-day intervals, parents scheduling times to plan and review their strategies together, or parents scheduling one-on-one and whole-family unconditional special time with their children.

respectful and transparent engagement with families and referrers

We work from a position of respect for and honest, straightforward, collaborative engagement with families. During family admissions, we are mindful to support and scaffold parental authority rather than to replace or overtake it. Each family's flat is treated as their home, which we do not enter unless invited. Parents retain responsibility for monitoring and managing their children, including their being provided with the key to a locked cabinet in each flat so that they can administer any medication which the children require. We work in partnership with referring clinicians, who provide ongoing intervention for the family in the lead up to, and after, the family admission.

An important element of our partnerships with the family and the referrer is our process of timely and appropriate written communication with family and referrer during the family's engagement with Coral Tree. Thus, immediately after the initial assessment interview, staff write a letter to the family, with a copy to the referrer, summarising our impressions and particularly the agreed plan, for example whether or not to proceed to a family admission, or whether any issues need to be clarified. In a context where families may be ambivalent and referring clinicians may feel stuck, this immediate and transparent feedback of our plans following assessment aids us in working with the clinician to assist a family towards treatment decisions.

Like many tertiary services, we aim to provide comprehensive treatment summaries but at times struggle to produce these in a timely manner. We have addressed this issue by sending a one page summary of the family's progress towards their family admission goals on the Friday that the family go home, attached to which is a copy of the personalised laminated 'tip sheet' produced for each family to put up on their fridge or wall. This one page summary is sent to the referrer, other involved clinicians and the family. Our more comprehensive family admission summary then follows two weeks to two months later.

copying family admission summaries to the family

About two years ago, we began the routine practice of copying our family admission summaries to the families. Such a practice is not without precedent (Couper & Harari, 2004). Our practice grew out of a number of converging influences. First, it fit with our open and collaborative model in that we were tending to share our formulation with the family verbally during the week rather than to keep secrets. Second, we wanted to show respect for the parents' role in coordinating their child's care. In the high-needs, high-risk families seen at Coral Tree, there are often a number of professionals involved with the family, families often sack or move between professionals over time, and families are mobile in other ways, for example, changing schools or accommodation. It could thus be argued that the most important place for our report to be is in the parent's 'file' on their 'problem child' (which lands with a thump on the desk of each new paediatrician/counsellor), rather than filed away unperused in the notes of last year's therapist. Third, many families ended up reading reports through family court subpoenas or freedom of information requests, which proved an unproductive and hostile/defensive experience when reports were written with referrer rather than family in mind. Fourth, over recent years, we have been influenced by narrative therapy concepts and practices of making use of therapeutic documents (White & Epston, 1989).

A recent survey of a consecutive sample of parents and referrers found that both appreciated the parents receiving a copy of the family admission summary. 100% of parents felt that they preferred to receive a copy, 93% found the summary helpful (one had burnt it), and 79% had read it more than once. Thirty per cent had found parts of it upsetting or unhelpful, which in some ways we were heartened by, as we had not wanted to achieve transparency through avoiding saying difficult or challenging things. We were particularly heartened by the fact that in 43% of cases, the family admission summary had made it to the child's 'file' (we did not, unfortunately, clarify the denominator in this proportion by asking how many of the children had a 'file').

accessibility and management of risk

We aim to be accessible, particularly to rural and regional families and referrers. Referrals are accepted from a range of professionals including local child and adolescent mental health services, school counsellors, general practitioners, paediatricians and child and adolescent psychiatrists. We take seriously our role as an intensive tertiary service, and where possible aim to take on challenging families and assess and manage the risk, rather than to exclude them from the service on the basis of risk. When referrers are aware of this philosophy, we find that they are more open with us about risk, rather than 'buffing up' the family or minimising problems so as to get them accepted for admission. Specifically, we assess risks to staff, the referred and concurrently admitted families associated with parental mental health problems, substance misuse, domestic violence, other family violence, child protection issues, risk of exploitation, or risks associated with parents not being able to contain or not adequately monitoring their children.

what the families say

The following two anonymised extracts are taken from our family comments book, which families can read when they arrive and contribute to as they leave.

1. 'My name is Linda and I am a single mum. I have been at Coral Tree this past week with my boys Craig (10), Trevor (8) and my daughter Susie (6). When I first read this book on my first day, I read how families left here feeling empowered and in control of their children again. I was sceptical about this happening for us after only five days, but I can honestly say that I do feel I have the tools to be 'in charge' of my little family. We have had a very turbulent last 12 months, escaping a long history of domestic violence. We have literally been in hiding since I separated. Naturally, the children have a number of emotional and behavioural issues from the trauma.

When we arrived here, the children actually behaved worse than ever. They certainly didn't appreciate my setting limits and being consistent with consequences. I realised how inconsistent I had been with the kids and it was little wonder they had been running the roost. It was hard for me to acknowledge that I had lost control of my children and I didn't like hearing it. I made myself accept this and took courage in the fact that I could change this. I believe this was the first step. I then had to deal with the guilt of feeling 'mean' by enforcing limits and I reminded myself it was necessary for them as well as myself. The staff helped me realise that kids need help at times with controlling their anger and to step in isn't wrong when done correctly. Coming from a violent history, I had to get used to the idea of restraint when the kids behaved unsafe(ly).

Most importantly, I have re-connected with the kids by spending special time with each of them. I was surprised at how satisfied I felt after I had given them this special attention. Of course, this will be harder to do next week when we are back at home, but I am determined to stick it out.

The staff were great, very sensitive and understanding. It was wonderful to have a break from cooking and cleaning (the food was wonderful). It's wonderful to have this facility available where someone else can see how home life is and offer practical solutions. We still have a long way to go but I don't feel hopeless anymore.'

2. 'We are the Lawson family. Me (Tania), Griffin and (our son) Adrian, who is 10 years old. This is our second visit to Coral Tree. Our first one was [four months ago]. If you had told us six months ago that life could begin to be almost normal we would not have believed it. Adrian has behaviour problems which escalate to violent outbursts and end with someone getting hurt. All three of us usually ended up arguing as Adrian was very good at playing Griffin and I off each other.

We have been given so much help, advice and encouragement here. We learnt that Griffin and I also had many things that needed to change to help Adrian and bring us together as a family. It is very hard to change ten years of 'life', but we are doing it. Step-by-step. Griffin and I now feel that we are able to be 'parents'.

After our first visit, we went home with hope – something we had not had for a long time. Adrian has worked so very hard to improve his behaviour and it has become so obvious this visit, Adrian has been fantastic this week. This visit has reinforced what we have learnt and the help and praise given by all the staff makes us feel like we are going to get there. Thank you so very much [staff allocated to the family] – you are special, wonderful people. Many thanks to [certain staff member] – it meant a lot. [The kitchen staff] who kept us well fed, thank you for your delicious meals. Life would be very different if we hadn't come here. We can never thank you enough!'

These comments are encouraging in that they express positive experiences of change within the families, but also contain some suggestions of the intellectualising and idealising responses which can occur in intensive therapy and which clinically we seek to temper with a realistic appraisal of the potential roadblocks the family faces, and facilitation of appropriate outpatient follow up.

challenges and future directions

There are a number of areas where we are looking to improve on the service we provide. We are currently reviewing our practice of relying on the referrer to provide follow-up care after family admissions, as we find that often families do not re-engage with the referrer, or in other instances the referrer is not skilled in or theoretically oriented towards family work. We are considering the options of providing more follow-up ourselves (which has its own resource implications and risks to continuity of care), or more proactively engaging with referrers in the follow-up process.

Our processes of routinely measuring outcomes could be improved, which we are currently addressing, and we are also on the verge of carrying out a cross-sectional retrospective cohort study to examine outcomes and parental and child perceptions of their Coral Tree experience. In time, prospective studies will also be conducted.

Like many clinicians working with families, we have been influenced by attachment theory, and specifically the work of the 'circle of security' project (Cooper *et al.*, 1998) in articulating attachment concepts to parents. In this context, we are reviewing our parenting groups to look at better presenting the relationship/interactive aspects of parenting, without putting aside the behavioural management/social learning theory approaches which underpin the impressive evidence base for parent management training (Kazdin, 2005).

A final challenge relates to increasing pressure from key policy and decision-makers to demonstrate the value and cost-benefit of inpatient units for children and adolescents with emotional and/or behavioural problems. Reviews of studies on short-term psychiatric inpatient or day patient treatment of children (for example, Pfeiffer & Strezelecki, 1991; Green *et al.*, 2001) have suggested that such inpatient treatment is more likely to be effective when families are involved, and when there is a positive alliance between parents, child and treating team. Whilst such findings point towards the added effectiveness of our treatment model, we are aware of no published rigorous evaluations of units where the entire family is admitted for the treatment of childhood emotional and behavioural disturbance. Although the literature contains some interesting and informative descriptions of family admission practices in the UK (Asen *et al.*, 1982), Australia (Jackson, 1996; Bornstein *et al.*, 1985), Scandinavia (Tamminen & Kaukonen, 1999) and the US (Combrinck-Lee *et al.*, 1982), demonstrations of effectiveness and cost-effectiveness are yet to be forthcoming.

We hope, and anticipate, that findings from evaluations such as those proposed above, along with

continuing refinement of our methods, will promote and champion the cause of units like Coral Tree and the benefit that they – we – provide. It is our view that the statement a decade ago that 'a comprehensive and effective continuum of mental health services for children and adolescents will include residential and inpatient treatment options' (Lyman & Campbell, 1996, X) still applies.

summary

The Coral Tree Family Service is a busy, family-focussed tertiary service in Sydney, Australia, providing five-day intensive family admissions to families with children with emotional and behavioural difficulties, using a model which we enjoy providing and we believe to be effective. We are in the process of more formally evaluating the effectiveness of our service, from the perspective or parents, children, clinicians and 'objective' clinical outcomes.

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