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Hospital Topics

Family Unit in a Children's Psychiatric Hospital

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British Medical Journal, 1975, 2, 127-129

Summary

The need for effective management of disorders of parent/child relationships is repeatedly stressed. Despite the bulk of theoretical work on the subject there is little information on the practical management of the clinical problems that arise. We describe a unit designed and staffed for the management of such disorders. In our view it meets a need in a way that could be difficult or impossible for most paediatric, psychiatric, and social services as they are at present organized.

Introduction

Inpatient facilities for the assessment and management of problems that arise between parent and child are uncommon despite the importance of family interrelationships in all aspects of child health. There is also growing concern about some specific clinical problems, particularly child neglect and abuse, but little information on constructive methods by which such problems can be met.

For the past eight years the Park Hospital has been admitting mothers with their children and concentrating on the psychotherapy of the family problems that underly baby battering and the distress generated in the families of children with developmental disorders. Altogether over 250 families have been admitted. The hospital has 30 beds for children with psychiatric abnormalities, epilepsy, and other developmental disorders and was opened in 1958. In 1964 a unit for mothers was built.

Mothers' Unit

The unit is a modern bungalow set in a garden a few yards from the main hospital building and shares with it pleasant park-like

grounds (see fig.). It has bedrooms for three mothers and communal domestic facilities. There is room for the child and any siblings to stay with mother or the children may sleep in the main hospital nursery. The hospital contains departments appropriate for a developmental medicine unit, including bedrooms, nurseries, occupational therapy, psychological and electroencephalographic facilities, and a school. Children are also admitted without their mothers to the main hospital. The age range of children admitted is from birth to early adolescence; the mother-and-child unit is concerned mainly with the younger age groups.

Mother-and-baby unit.

Staffing

A consultant with paediatric and psychiatric experience is in overall charge and supervises the two senior registrars who manage the unit on a day-to-day basis. One senior registrar's basic training is in psychiatry and the other's is in paediatrics. A nursing sister with an assistant takes a special interest in the unit and its children, as do a senior occupational therapist, a psychologist, and a social worker. This team is usually joined by a community social worker who is already or will be dealing with the family's case.

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Admission and Assessment Procedure

Referrals are from various sources, the agreement of the family doctor invariably being sought. Admission may be from a lengthy waiting list or as a matter of acute urgency—for example, when a child comes in on a place of safety order from a local casualty department. A few children are admitted briefly for special investigations when it is felt that they should be accompanied by their mothers. The consultant or one of the senior registrars is available to see urgent referrals on request, which may come from casualty departments, paediatric wards, family doctors, or community workers.

The large number of referrals makes selection for admission difficult.

On admission the child and his or her family undergo full developmental and psychiatric assessment with special reference to the pattern of parent/child, parent/parent, and parent/staff interaction. The father's work commitments and the shortage of space usually prevent his admission but he is seen on his visits and attends a fathers' psychotherapy group taken at weekends by the consultant.

The nature of the work done with various members of the family separately and together is of central importance and is still evolving with experience.

The team works closely together and its members share information and feelings frequently, both informally and in staff groups. Invariably it takes days or weeks for a comprehensive picture of the families' attitudes and interpersonal relationships to be built up and for the relevance of this to each member's development to be assessed. The picture is augmented by the social worker's contact with the extended family; a special effort is made to form an impression of the grandparents on both sides of the family and their children's early handling and development.

Legal Aspects

When a child is at risk and a place of safety or care order is appropriate the legal position of the child is made clear to all concerned. An understanding of the social and legal aspects in such cases is considered essential on psychotherapeutic as well as administrative grounds. Thus occasionally a parent may not be allowed to remove his or her child from the hospital if the child is thought to be in danger. It has rarely been necessary to seek help from the police in such cases, though when this possibility arises it must be faced without prevarication. Honesty with the family, full communication between staff members, and scrupulous note-keeping are essential, and when a clash of expressed interest seems to arise between the team and the parent this policy becomes of forensic importance. In our experience such clashes have been rare. In the past two years, for example, 14 care orders have been made on children who have been treated as inpatients, and in only three of these have the parents opposed the care proceedings when the matter has come to court.

Hospital's Image

Neither the hospital as a whole nor the mother-and-child unit can be categorized as any particular type. The main building is an old, converted and modernized family house, largely domestic in decoration; uniforms are not worn. It is not clearly a psychiatric hospital, a paediatric unit, or a unit for the mentally handicapped. This ambiguity is not a pretence, because it enables the well-documented deficiencies of such special units to be so far as possible minimized. The hospital's theoretical standpoint is that of developmental medicine.

This adaptability is carried through to the therapeutic programme. Thus a mother staying in the mothers' unit may be experiencing family psychotherapy or group psychotherapy, or receiving marital counselling or straightforward instruction in child care, or may be taking a well-earned rest or simply

using the unit for an "overnight stay." Inevitably there is a combination of management and therapeutic goals.

Treatment Programme

There are three main aims of management: (1) the diagnoses, assessment, and management of specific problems, such as intellectual retardation or abuse of the child or a similar problem in the parent or sibling; (2) practical, social, and educational help—for example, in trying to initiate improvement in housing or teaching a mother how to hold and feed her baby; and (3) the formation of a therapeutic relationship between the unit staff and the parents in the hope that the experience of care and skill, often not previously experienced in the parents' own lives, will augment their total resources in caring for their children.

These therapeutic "strands" are inextricably interwoven. Thus the first unambiguous statement about a retarded child's prognosis, or facing a court of law with the unit team's support, or being taught how to put a child to bed all have important parts to play in the emotional development of the mother and hence of her child. These aspects of management are co-ordinated at the staff meetings, where information is exchanged, situations are clarified and demystified, and mutual support in difficult clinical situations is given. Not all hospital staff, feel able to help in some situations—for example, because of anger aroused by abuse. These feelings are respected, and hospital staff unable or unwilling to modify them do not take a direct part in the unit's programme.

At present most of the team's efforts are directed towards the mothers and children in the hospital and their follow-up after discharge. How much this intensive approach can stand "dilution" in the outpatient clinics and how thinly the unit's team could spread itself in a community without staff communication and support being jeopardized are discussed below.

Referral and Length of Stay

Children referred to the unit have been aged 11 days to 12 years, boys outnumbering girls two to one. This sex ratio is the same for all children referred to the hospital. Most children came from sibships of two or three, and in social class (according to father's occupation) there was little difference from a control group. About half of the children were referred by paediatricians, a quarter from family doctors, and the rest from adult and child psychiatrists, social services, and the N.S.P.C.C. Most immediate admissions were of children considered to be at risk from physical abuse; the rest had to wait from two weeks to many months for admission. The length of stay excluding brief overnight admissions for special investigations or dental treatment ranged from a few days to several months with a mean of about three months.

Children's Diagnoses

The children fell into the following four main categories, in so far as they could be diagnostically separated from the totality of the family problems. (1) Those considered to be at risk from physical abuse (baby battering). About half of all admissions to the unit were found to be in this category. This represented nearly twice the numbers who seemed to be at risk from abuse on admission. The others had been admitted for other reasons initially. (2) Children with behaviour disorders. (3) Children with developmental delay. (4) Children with seizure disorders.

Family Diagnoses

Severely disturbed family relationships, in addition to the reason for referral, were found in two-thirds of the families,

These included a history of previous marital or social crisis. Unsatisfactory housing, severe financial problems, and physical ill health were all prominent. Such problems were present in all groups and not only those presenting as cases of child abuse.

On admission many mothers were found to have physical disorders, particularly "minor health problems" such as iron-deficiency anaemia and severe dental caries. Many complained of headaches, typically described as "migraine." Many had minor gynaecological problems and were in need of contraceptive advice. Some were found to be pregnant at the time of admission. Other serious maternal diagnoses included chronic renal disease, thyrotoxicosis, benign intracranial hypertension, and bird-like dwarfism. One mother died of a cerebral tumour some months after discharge.

More than three-quarters of the mothers complained of distressing anxiety or depressive symptoms. The vast majority of this group fell into an ill-defined category of emotional distress where the distress felt seemed appropriate to the domestic and social circumstances and yet where there was also evidence of some personality disorder. About a quarter had disabling psychiatric symptoms out of proportion to their social circumstances. The incidence of severe mental illness, schizophrenia, and psychotic depression was about the same as in the general population (about 2%). Only a few mentally ill mothers (about 1%) were transferred to the associated adult psychiatric hospital. Some of those managed in the unit, however, presented the formidable problems common to distressed, psychoneurotic people—for example, threats of suicide, sometimes accompanied by threats of aggressive behaviour towards the child; outbursts of anger, despair, or anxiety of considerable severity, often with a threat of self-discharge, when inappropriate and sometimes infantile demands were not immediately met. There were occasional demands for immediate readmission from ex-patients presenting in a distraught state at nights or weekends.

Psychiatric data on the fathers are incomplete, but at least a quarter were thought to show varying degrees of psychiatric disorder. Occasionally they presented the sort of emergencies outlined above, often with aggression and aggressive threats, sometimes directed towards the staff and often accompanied by evidence of pathological jealousy.

Outcome

As the unit is still developing and modifying its techniques, statistical assessment of the results is difficult. Our impression is that the service prevents baby battering or its recurrence and enables parents of children with developmental disorders to make a realistic adjustment to them.

Of all the cases of child abuse that have passed through the hospital (now well over 150) one-third proved to be untreatable, so that permanent removal of the proband under a care order was necessary. Of the remainder sufficient improvement in family dynamics occurred to allow the children home.¹ Detailed follow-up studies of these families are in progress. In cases in which one child was removed there was often noticeable improvement in the functioning of the rest of the family.

Out of 50 cases in all categories admitted to the unit during 1971 and 1972 and followed up from one to three years 60%—half of which were in the "at-risk" category—showed maintained improvement in family relationships. In a further 30% deterioration seemed to have been prevented and in only 10% had the family situation become worse.

Discussion

Our patients constitute a highly disturbed group and present diagnostic and management problems which do not fall readily into the areas of care provided by paediatric, psychiatric, and social services as traditionally organized. Our aim is to contain the whole range of paediatric, psychiatric, social, and legal

problems within the scope of one closely integrated team. This gives it the authority to provide comprehensive help to each family and to deal with the closely interrelated emotional, practical, and medical problems. A prominent task, for example, is to separate fantasy from reality. Parents may have the fantasy of an overwhelmingly unmanageable "monstrous" child or that a severely handicapped child might recover, or the fantasy, still often reinforced by professionals, that an attack on a child did not really happen. Without this mutually agreed and shared perception between the family and all members of the team psychotherapy may well prove impossible.

In our view this approach cannot be met by a system of inter-departmental or interdisciplinary communications—by memos, phone messages, and referral slips—which is so often the reality of the so-called "multidisciplinary approach."

The unit faces difficulties with regard to its admission policy. Real or threatened baby battering is an urgent crisis and requires a team which can rapidly mobilize community and hospital resources. This results in a lengthening waiting list for other cases. Hard-pressed social services are often unable to help until a crisis forces the issue. And often, for the reasons given above, these services cannot cope with the wide range of problems leading up to admission or occurring after discharge. Another problem is that such clinical work is time-consuming and emotionally demanding. The importance of a confident and mutually supporting clinical team cannot be overemphasized. We have become aware of the importance of trying to look beyond parent and child relationships at other family relationships. It has also become increasingly clear that the unit needs to be able to admit more than three mothers or families. This number is too vulnerable to incompatible personalities, and for example, the discharge of therapeutically active and recovering patients. Five or seven places might well be ideal.

A unit of this sort learns by experience. It is important that it is able to pursue a research and teaching function, with time and space for teaching and consultation with "front-line" social and medical services. So far the unit's main purpose has been the urgent containment of potentially disastrous family situations, but the long-term goal of a service of this sort should be the early recognition and prevention of these forms of family maladaptation and the minimization of the likelihood of para-genetic inheritance of such problems; ultimately this is an educational issue.

Conclusion

We feel that there is a need for more units like the one described. At present, however, such units are inevitably experimental and the results need careful evaluation.

In many areas such facilities are provided in theory by services which are geographically and ideologically widely separated. For treatment of the child and family to be effective these problems need to be dealt with by a team with a diversity of skills and which is able to work together on a day-to-day or even hour-to-hour basis.

Paediatric units admitting mothers may have excellent diagnostic and assessment facilities but few if any will have the time or expertise available to deal with the disturbed family dynamics of the kind we have discussed. Child psychiatric units, too, do not traditionally admit whole families and may not have free access to clinical diagnostic facilities, and they are unlikely to have a paediatrician as a constant daily member of the team.

Often the community social worker is isolated and yet is made responsible for much of the family's follow-up. It would be of mutual benefit if social workers could be fully involved in the type of team we have described and not simply "seconded" on a part-time and possibly transient and uncertain basis.

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