of a known entity and less a group of unfamiliar individuals struggling to get to grips with the organisation.

(3) Members of the visiting team would be chosen not so much—or not only—for their experience in the Health Service but for their skill in understanding organisational processes. If it is unrealistic to expect such expertise in all team members, each team could be accompanied or advised by an organisation consultant.

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The Marlborough Family Day Unit

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The Marlborough Family Day Unit has been in existence for 10 years. It is part of the Marlborough Family Service, a community-based psychiatric service for patients of all ages. Its location is the site of the former Marlborough Day Hospital in London NW8. The Day Unit was created in 1977 by Dr Alan Cooklin who is still the consultant in charge of the whole service. The reason for setting up such a unit was to experiment with new ways of dealing with what is now so fashionably termed 'multi-problem families'. These are families where one or more members have been in extensive contact with psychiatric and social services. Multiple hospitalisations, removal of children into care, and general chaotic behaviour are the presenting 'symptoms'. Such families have unrivalled skills in collecting agencies and professionals like flypaper and making it very difficult for anyone to leave the field given the enormous anxiety created all round.

Historical development

At the very beginning the Service encountered predictable difficulties. The Marlborough Day, as it was known locally, had been until then a somewhat controversial therapeutic community. The arrival of a new consultant signalled change: his idea was to admit whole families rather than just the 'identified' patient. A maximum of eight families started attending the Day Unit at the same time, five days a week for six hours a day. The day then consisted of community meetings, group activities, individual psychotherapy for some of the parents and child psychotherapy for some of the children. Patients were seen in three different contexts: as individuals within the therapeutic community (receiving group therapy); as members of families (receiving family therapy); and as individuals in their own right (receiving individual psychotherapy). The co-existence of three different models of how therapeutic change could be effected resulted in 'eclectic' practice combining a family systems approach with psychodynamic principles and group work.

Families usually stayed for about 18 months. This was in line with the then fashionable notion that change was a slow process and that patients needed to be allowed to 'grow' in their own time which meant 'slowly'. By 1981 we were ready to review our work and decided to shorten admission periods. This was based on the frequent observation that families had a tendency to settle down after initial difficulties and to become 'good members of the community', but that about one month before discharge they would act disturbed and go into a crisis. This observation led staff to cut down admission to one month only in the first instance, so as to keep up the pressure for change on families. The Day Unit no longer defined itself as a containing environment but rather a 'pressure cooker'. At the same time it was also

https://doi.org/10.1192/S014007890002126X Published online by Cambridge University Press

decided to abandon an on-call duty rota whereby families in crisis could bleep staff members at night or on weekends. Apart from this system lending itself to abuse it was noticed that families behaved as if they had become extremely dependent on us; by instituting a procedure whereby there was a potential round the clock assurance or crisis intervention we had colluded with the families' belief that they were not able to cope by themselves. Giving the message that it was the parents who were in charge of themselves and their children redefined the role of the staff. They no longer saw themselves as 'therapists' but rather as catalysts for change, enabling families to make possible reactions and interactions that would have otherwise not been possible or extremely slow.

Adopting just one model of change, the family systems approach, led to instituting specific reading seminars, teaching occasions and regular events involving distinguished family therapy teachers. The input in 1981/82 of S. Minuchin who spent a sabbatical at the Marlborough Family Service became a major source for establishing a coherent model of theory and practice. Having clear goals and well defined treatment strategies enabled the staff to leave the ghost of the old Marlborough Day behind and convince referrers that we had something new and worthwhile to offer.

Present structure and aims of the Unit

The Day Unit is now staffed by three full-time nurses (senior nurse and two charge nurses). In addition, there is a one session per week input by a psychiatrist (the author) as well as one session with a social worker, both of whom act in a supervisory/consultative role. The unit is located in the basement of the Marlborough Family Service and comprises six rooms: meeting/dining-room, children's playroom, parents' room, baby room, staff room and a kitchen. There is also a big garden/playground as well as a school (Education Unit) at the end of the garden where school age children attending with their families might be placed for part of the day. One-way screens and video cameras make it possible to observe and record the work in different rooms from a central video room (with the full knowledge of the families, of course).

The unit currently runs a multi-family assessment and treatment programme for four days each week from 9.15 a.m. to 3.15 p.m. On Wednesdays no families attend and the day is used for administrative tasks, teaching and new assessments. A maximum of 30 persons. adults and children can attend at any one time. Depending on the size of the families concerned, this means a maximum number of up to 10 families. Families initially attend four days a week but the frequency is gradually decreased. Attendance is regularly reviewed and renegotiated at monthly intervals, a new 'contract' being agreed on each occasion. Only very rarely do families stay for more than three months.

The aim of the unit is to provide more intensive assessment and treatment for children and families than can be provided on an out-patient basis. One of the major aspects of the work is to assess how individuals and families respond to family therapy interventions and whether sufficient change is possible for 'good enough parenting' to take place. The family programme of the Day Unit is designed to assess family functioning in a variety of different contexts. By providing an intensive living experience, drawing on 'real life situations', it is possible to study patterns of family interaction *in vivo*. An attempt is made to enable families to experience as far as possible familiar problems, whilst at the same time providing an opportunity to identify and rehearse alternative solutions. The fact that there are quite a number of families with similar problems present means that peer support and criticism can be used both to relieve isolation as well as to solve problems jointly: many parents find it easier to listen to other parents rather than staff. For many isolated families it provides a point of first social contact which can be built upon after discharge.

The programme is designed in such a way as to require multiple shifts of context, repeated transitions from one activity to another involving different family groupings and tasks: the family can be seen alone or in conjunction with others; it may work together in a large structured group with other families; it may work in informal unstructured settings engaging in play activities with other families and staff; it can be split up or enlarged—the adults can meet together while the children enjoy a peer activity; or some parents can have temporary responsibility for other children as well as their own. These changing contexts and groupings require families to be able to change their behaviours and expectations of each other, challenging familiar ways of behaving and encouraging new ways of experimenting.

The differing demands made in the different settings generate stress: it is precisely an assessment of the family under stress which can provide new data. It is, after all, the repetitive sequences of crises that bring these families into such frequent contact with psychiatric and social services.

The daily programme

Families arrive from 9 a.m. onwards—often their children are brought separately by the foster parent(s) to be reunited with their parents for the day in the unit. The day begins with parents settling their children after the journey to the unit. This provides an opportunity to study how different families are able to calm down their children, how they feed them after the journey or settle them for a nap. It is often here already that exhausted or exasperated parents demonstrate the reasons why they were referred to the unit (e.g. smacking children, ramming bottles in their mouths, parents arguing with one another in the presence of a distressed toddler).

At 10 o'clock there is a 30 minute planning meeting which is chaired by one of the Day Unit workers. All the families are present, young and old, mothers and fathers and, at times, grandparents or other relations. Each family states why they have come that day and what particular problem areas they wish to tackle. This could include getting little Johnny to play with other children; to get Mary to eat her dinner; for parents to discuss their marriage; or to work out

https://doi.org/10.1192/S014007890002126X Published online by Cambridge University Press

how one could stop Granny from taking over and thus avoid the habitual rivalry over little Sally, etc. During the meeting each family then decides (often with some advice from other parents) how these self-stated aims can be implemented during the course of the day. The programme provides a few anchor points (a daily parent and child activity, a twice weekly parents' group, nursery activities, etc.) where some of the self-set tasks can be addressed.

In addition, 'free' time can be structured in such a way so as to suit the individual needs of each family. Meal-times, cooking (for which the parents are responsible) and feeding times all represent key points around which assessment and treatment can be structured as well as dealing with issues such as nappy changing, washing, playing, etc. These experiences within the unit can be supplemented to create or seek out such situations that habitually pose problems for families. An outing to the park, the swimming pool, the Zoo, or a shopping centre, may all provide situations where families can try out new behaviours. If a parent says that she feels most murderous towards little Peter in the supermarket because he throws an embarrassing tantrum on the sweet counter by the till, then staff will go with the family to a supermarket and help to recreate the scene, or, to put it more technically, have the family 're-enact' it. This usually needs very little prompting by staff, as children are highly reliable 'co-therapists', dying to give their parents yet another chance to demonstrate how they fail to 'tame the monster', thus allowing their parents to experiment with new ways of handling or preventing potential tantrums. The close proximity of two pubs (one minute walk from the unit) provides ample opportunity for family scenarios to evolve around alcohol-related problems. Observing and intervening in such interactions, 'live' or *in vivo*, as it were, is a very powerful assessment method lending itself well to potentially therapeutic interventions.

Recent developments

Short admission periods have meant that an increasing number of families can be seen. Currently there are between two and three referrals per week of which 80% attend the unit after having been seen for an initial assessment. Initial assessments usually involve the referrers (mostly Social Services) and the family. This meeting is designed to provide a clear idea of what the reason for referral is, what the purpose of an admission should be and whether anything would be gained from such an admission. In the wake of the Jasmine Beckford case more and more complicated child abuse cases have been referred to the unit. Social Services mostly request the unit to assess whether the abused child or children should be reunited or permanently separated from the family. Attendance at the day unit is not framed in terms of giving Social Services evidence that they were right in removing the children, but rather as giving the family the possibility of demonstrating to Social Services that they are good enough parents. Social Services are required by us to put in concrete language, that is in the language of observable behaviours, what sort of changes they would need to see for them to be sufficiently convinced that the parents could have their children living with them. In such cases families see attendance at the unit as their last chance of getting their children back. The families are aware that any observations being made during their stay at the unit are being fed back to Social Services, positive or negative, and that Social Services or the families themselves might be able to use the assessment report in the often inevitable court hearings which ensue.

At the end of the one month assessment period there is a review meeting and our observations shared with the professional network. These observations, of course, contain the families' responses to our interventions—which often deliberately put them in some kind of controlled 'therapeutic' crisis. It is *not* an aim of the unit to keep families together, but rather to generate information that enables Social Services and Courts to make informed decisions.

One major goal is to make sure that the decision is reached as quickly as possible so that the child can be placed permanently either in his/her own home or with foster/adoptive parents. Currently in about one third of the cases referred, the unit's recommendation is for children to be permanently removed from their parents.

The unit has devised a way of assessing the likelihood of further re-abuse or serious neglect and is currently involved in a research project evaluating the usefulness and predictive accuracy of their assessment method. A number of similar units based upon the principles of the Marlborough Family Day Unit have been created both in this country (mostly in Social Services settings), as well as in Europe, particularly in Scandinavia and Holland.

An **Examination Techniques Workship for MRCPsych Parts I and II** will be held on 16 April 1988 in the Department of Psychiatry, 3 North, Charing Cross Hospital. Enquiries and registration: Wendy Hood, 24 St Dunstan's Road, London W6 8RP (telephone 01 748 2040, extension 3010).

The East Anglian Branch of the Association of Child Psychology and Psychiatry are holding a conference on **'Child Sexual Abuse—Recent Developments in Research & Policy'** on 28 April 1988 at the Talk Electric Centre, Constantine Road, Ipswich. Further details and application forms: Dr G. Lemmens, The Institute of Family Psychiatry, 23 Henley Road, Ipswich IP1 3TF. (*Closing date: 31 March 1988*).

A national conference entitled **'Managing Violence at Work'** will be held at the University of Lancaster from 11–13 April 1988. Further information: Information Systems (Lancaster), Caton House, High Casterton, Kirkby Lonsdale, Cumbria LA6 2SD (telephone 05242 71434).

The next meeting of the **Buddhism, Psychology & Psychiatry Group** will be held on 26 March 1988 at St Crispin Hospital, Northampton. Further information: Dr K. N. Dwivedi, Psychiatric Tutor, Springfield, Cliftonville, Northampton (telephone 0604 30082).

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