The Family as Partner in Child Mental Health Care: Problem Perceptions and Challenges to Collaboration

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Abstract

Objective: The development of the health and social care system has made it increasingly specialized, decentralized and professionalized. Accordingly, demands of efficient approaches to collaboration and integration of services for children, adolescents and their family networks have emerged. The aim of this article is to present and analyze findings from a review of the literature on parents as collaboration partners with professionals. **Method:** A literature review was conducted in two databases. A multifaceted model was developed to depict and analyze collaboration complexity. **Results:** Preliminary application of the multifaceted collaboration model suggests that first- and second-order therapy positions have different impact on collaborative relationships. **Conclusion:** It is suggested that professionals may want to acknowledge the different impact of first- and second-order positions in interprofessional collaboration involving parents. This may be accomplished by staging a routine requirement for discussion of meta-positions as an introductory theme in the opening stages and as a recurrent theme throughout the collaboration process.

Key words: collaboration, child and adolescent, second-order change, mental health

Résumé

Objectif: le développement des soins de santé et des services sociaux a donné lieu à des services de plus en plus spécialisés, décentralisés et professionnalisés. C'est pourquoi il a été nécessaire d'instaurer des méthodes de collaboration et d'intégration des services aux enfants, aux adolescents et à leur famille, et de créer des réseaux. Cet article présente les conclusions tirées d'une revue de la littérature sur la collaboration des parents avec les professionnels. **Méthodologie:** analyse de la littérature dans deux bases de données; développement d'un modèle multi-facettes pour illustrer et analyser la complexité de la collaboration. **Résultats:** l'application préliminaire du modèle de collaboration multi-facettes permet de conclure que la collaboration diffère selon que la thérapie de changement porte sur la réalité de premier ou de second ordre. **Conclusion:** les professionnels qui le souhaitent peuvent informer de cette constatation leurs collaborateurs et les parents, en discutant systématiquement des méta-positions au début de la thérapie, puis régulièrement pendant toute la durée de celle-ci.

Mots-clés: collaboration, enfant et adolescent, réalité de second ordre, santé mentale

Introduction

Service users and professionals/therapists may have different perceptions of what collaboration entails, once a child or adolescent is referred to specialist services. Rolland and Walsh (2005) document that there has been a growing interest in family-centred, collaborative and biopsychosocial models of health care over the last 25 years, and state that these models need to be further developed. Duncan and colleagues claim that therapy is a collaborative endeavour and that therapists should promote client involvement; "therapists are in line with the empirical evidence when they listen to clients, establish common ground, and work together to forge solutions" (Bohart & Tallman, 2010, p. 97). In this paper we present a multifaceted model for identifying different collaboration relationships. We suggest that the model may assist professionals in addressing service users' different expectations and perceptions of collaboration relationships in the field of child and adolescent mental health care. The implementation of new models for collaboration is important because there is a shift in service delivery in child and adolescent mental health; "... the medical model, wherein the physician dictates the treatment or

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leads the team, is giving way to models in which physicians work collaboratively with informed families and allied providers" (McCarthy, Abenojar, & Anders, 2009, p. 218).

Child mental health care in Norway

According to the Norwegian Department of Health and Social Affairs (Helsedepartementet, 2003) up to 20% of children and young people have psychosocial problems. It is estimated that 4-7% need professional help. This is in accordance with the prevalence of mental health problems in children and adolescents documented in international studies (Manikam, 2002). In the welfare sector in Norway, interprofessional collaboration has been emphasized and required in white papers as well as legal regulations during the last 25 years (NOU 1986:4; St.m. 47/2008-2009).

Generally, different professions are involved in the process of delivering health care in this context. The most common meeting place for this activity in Norway is in case conferences or review groups (Willumsen & Skivenes, 2005). Professionals and caregivers, and occasionally the child or adolescent, meet regularly to discuss problems and find appropriate solutions. The most central actors in the field of mental health for children and adolescents are child psychiatric clinics, school psychology services, child guidance centres, primary health nurses and general practitioners. In addition, teachers and special educators often play an important role in the process of treating the child. They are often the front-line referral link to services and have functional or dysfunctional relationships with caregivers. This may impact how caregivers and the child perceive the other professionals and how they perceive "the problem". Teachers may also be involved in implementation of interventions in the school context, and accordingly teachers and special educators may participate in meetings about the child. Moreover, professionals often have different clinical approaches due to professional training, experience and clinical preferences.

In many countries there appears to be a similar trend towards more specialized, decentralized and professionalized health and social care systems (Ahgren, 2007). The World Health Organization (WHO) also emphasizes the importance of collaboration to promote health and to deliver welfare services adapted to the needs of citizens (WHO, 1986). This development of the health care sector has undoubtedly promoted the health and wellbeing of populations as a whole as well as specifically in child and adolescent mental health care. One outcome of this development is that it has resulted in extensive collaboration challenges (Ahgren, 2010). This calls for increased efforts to integrate services and extend the use of collaboration between professionals, and between professionals and service users.

Interprofessional collaboration and integration of services

Professionals in clinical practice and in the educational system have gradually come to recognize the importance of learning more about interprofessional collaboration (IPC) (Barr, Koppel, Reeves, Hammick, & Freeth, 2005; D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; Reeves, Lewin, Espin, & Zwarenstein, 2010) and the integration of services (Ahgren, 2007; Ahgren & Axelsson, 2005). However, there is not one fixed definition of what IPC actually entails (Ødegård & Strype, 2009), and there are many definitions of collaboration and related concepts—all of which attempt to capture the complexity of professional interaction (Barr et al., 2005; Leathard, 2003; Reeves, Lewin, Espin, & Zwarenstein, 2010). Furthermore, approaches such as service user involvement and systemic understanding and intervention have put new demands on interprofessional work and integrated care. One proponent demand is to include family members/family systems as collaborating partners, once a child is referred to specialist services (Doherty & Beaton, 2000; Hernandez, Almeida, & Dolan-Del Vecchio, 2005; Hodges, Hernandez, & Nesman, 2003; Rolland & Walsh, 2005). Professionals therefore face the challenge of adapting to divergent expectations and cultures pertaining to professional and family systems (Abbott, 1988; Axelsson & Axelsson, 2006).

Payne proposed a relatively broad definition of collaboration that fits well with the complexities of child and adolescent mental health care: "The professional and multiprofessional teams and the network of people we link with in the community, and teamworking and networking together as an integrated form of practice" (Payne, 2000, p. 5). This definition includes the professional, professional relationships, as well as service users and their networks.

Family systems

The development of family theory and therapy from the 1960s and up to today has provided extensive perspectives on the understanding of mental problems and therapeutic interventions based on systemic reasoning. We give a brief overview of this development, because it is fundamental to the understanding of: a) families as systems; b) different professional positions and relations to family systems in child and adolescent mental health care; and, c) how collaboration between professionals and family systems may unfold.

Understanding families as systems came as a reaction to a dominant individual approach that had ignored the fact that family systems organize themselves to carry out daily challenges and to adjust to the developmental needs of its members (Hernandez et al., 2005). The first systemic approach has been labelled the *strategic model*. It emphasizes that

efforts to solve a problem may become a way to maintain the problem (Haley, 1963, Watzlawick, Beavin, & Jackson, 1967; Watzlawick, Weakland, Fisch, & Erickson, 1974). For example, if a child has a challenging behaviour, parents may contribute to maintaining the problem in the way that they try to reduce this behaviour. A second approach in understanding families, the *structural model*, was introduced by Minuchin and Fishman (1981). They claimed that family systems that experience problems may have or may develop a dysfunctional organization. For example, some children may hold an unnatural position in the family system, such as taking responsibilities that should belong to the caregivers. A third approach, the *systemic model*, emphasizes that the therapist is not a detached expert who observes and intervenes in the family system, but rather one that becomes a part of the system through interaction with the family (Hoffmann, 1985; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). This implies that therapists cannot predict how a family system will react because all systems are structurally closed (Maturana & Varela, 1992). Moreover, all systems construe their surroundings in the sense that every client or family system is an expert on the family's own constructions (Anderson & Goolishian, 1988). Hoffman describes this epistemological change as follows: "The emphasis shifts from a concern with the etiology of the problem to a concern with the meanings that are attached to it" (Hoffman, 1985). This shift has been described as a principal difference between first- and second-order perspectives.

Literature review

An update of searches in relevant databases (Medline and PsychINFO), concerning *family systems as collaborating partners* in child and adolescent mental health care confirmed that the theme has been of some concern among researchers and practitioners during the last decades (i.e. Rolland & Walsh, 2005). However, it is difficult to get a thorough overview of the field. Several search strategies were used, based on combining the following terms: a) child and adolescent psychiatry/mental health; b) families/parents/caregivers; c) collaboration/partnership; and, d) professional/health personnel. Each of the search terms was expanded by using synonyms and truncations, with the purpose of retrieving as many relevant studies in the literature as possible. An inspection of titles and relevant abstracts in the intersection of a-d yielded relatively few relevant references. For example, a search conducted in PsycINFO encompassing the years 2002 to June Week 1 2011, using a combination of search terms a-d above, resulted in 18 references, but only two were relevant. This invites more systematic research in the field. Even hand searches in the reference lists of relevant papers did not generate new publications. Still, in any literature search there is the possibility that flaws and limitations in the search strategy may impair the findings.

Aims

In the context of challenges related to user participation and second-order systemic perspectives, the main aims of this paper are to: a) present a multifaceted collaboration model; and, b) discuss possible implications and applications of the model to assess and enhance collaboration processes in clinical contexts. In the following sections of this paper we discuss new aspects and demands pertaining to parents as collaboration partners in a professional context, from the perspective of service user involvement (Part I); illustrate collaboration complexity with examples from case conferences with focus on differences between first- and second-order perspectives (Part II); and, introduce a multifaceted collaboration model (Part III).

Part I—New service user demands and new collaboration challenges

The family system as collaborating partner

Involving family systems in child and adolescent mental health care (Rolland & Walsh, 2005) and in a larger social and community context seems to have received increased interest among professionals, service users and policy makers (Doherty & Beaton, 2000; Fawcett et al., 1995; Hernandez et al., 2005; Rolland & Walsh, 2005). In general, psychotherapeutic evaluation studies report a strong and positive association between collaboration and outcomes (Duncan et al., 2010). This clearly underlines the importance of therapist focus on relationship with and position pertaining to the family system.

The term partner may be defined in different ways: a) used implicitly, as when professionals perceive parents as contributors who provide information about the child and their situation in a collaborative relationship with professionals; or, b) defined as a relationship where two (or more) parties, with compatible goals, agree to do something together (Frank & Smith, 2000). It is suggested that the difference between definition a and b may have a strong influence on how collaboration processes unfold. It is further suggested that these roles may be difficult to collate and integrate, as their implications with respect to collaboration processes are divergent: what does it mean to label family members (parents/caregivers/others) as collaborating partners in a mental health care setting; what expectations do the different parties have towards each other in the collaboration process; and, how do professionals empower family systems in collaboration processes?

In a survey and focus group study involving a total of 68 participants, Teggart and Linden (2006) found that both service users (child or adolescent) and caregivers (parents) expressed a willingness to work collaboratively with health

care providers. Participants were interested in "developing care and treatment plans and sharing information; models of treatment and service provision should be developed along lines that will facilitate such collaboration" (Teggart and Linden, 2006, p. 40).

Hodges and colleagues (Hodges, Hernandez, & Nesman, 2003) present five developmental stages of collaboration, based on a qualitative interview study of 98 professionals:

1. individual action (independent action on behalf of children and families, no specific collaborative activities);
2. one-to-one (several service delivery agencies are involved with the child/family, core groups may develop);
3. new service development (stronger child-centred approach to providing services and introduction of formal collaborative structure);
4. professional collaboration (well-developed professional collaborations among child-serving partners); and,
5. true collaboration (families fully involved in service delivery). True collaboration incorporates "qualities of role clarity for family and service providers, interdependence and shared responsibility among collaborating partners, vision-driven solutions, and focus on the whole child" (Hodges et al., 2003, p. 297).

Hart and colleagues (Hart, Saunders, & Thomas, 2005) investigated what service users thought about their therapeutic encounters. Twenty-seven teenagers (age 11-18) who were receiving help from specialist mental health services were interviewed, along with their parents (N=30). The results showed three main themes: a) core values involved in establishing a therapeutic alliance, in which both teenagers and parents wanted a friendly non-judgemental approach and an ability to empathize; b) both teenagers and parents wanted a proactive therapeutic approach from the therapist; and, c) which family members should be included in therapeutic sessions was a contentious issue, mainly for parents.

These studies, which may serve as examples of professional and family system collaboration perceptions and arrangements, indicate that family members/systems wish to be involved in mental health treatment processes, family members/systems may be involved in different phases of a treatment process, and the quality of therapeutic alliances has a major impact on how collaboration unfolds.

Part II—Collaboration complexity in case conferences and therapeutic change

Case conferences

Children and family networks are often transferred from one service to another, for example from school psychology services to a child guidance centre, or to mental health services. From the perspective of the family system, being shifted from one service to another may increase collaboration problems. Approximately 83 per cent of Norwegian communities use *case* conferences when a child needs help for mental problems (Myrvold, 2004). The main purpose of the case conference is to have an arena for sharing information and to clarify different roles in the process of providing help to the child and the family/network. However, user participation evaluations suggest that experiences with these arrangements are ambiguous (Andersson et al., 2005): who takes the initiative, decides the agenda, and has the responsibility to chair these meetings?

Systemic understanding and implementation

Differences in perception of what collaboration entails (for example in case conferences) are probably an under-communicated issue between service providers and service users (i.e. Sveaass & Reichelt, 2001). For example, research has indicated that teachers perceive some aspects of collaboration differently than health and social care professionals (Ødegård, Hagtvet, & Bjørkly, 2008). Research regarding these differences is in an exploratory phase and more studies are needed to investigate different perceptions of collaboration. It would also be interesting to investigate the impact teachers may have on the collaboration process. They are often the front-line referral link to services and have a collaborative or non-collaborative relationship to parents and this may impact how parents perceive the other professionals and how they perceive the "problem".

Some (professionals and/or family system members) may perceive "the problem" as something being wrong with the child or other parts of the family system. Therapists working within an epistemological framework that emphasizes that a problem can be fixed by an expert try to intervene in ways that change the causal factors that are thought to maintain the problem. For example, Sanders (2002), reviewed epidemiological studies and found that family risk factors are powerful predictors for the development and maintenance of mental health problem in children and adolescents. However, this way of thinking about the development of problems implies that the "system" creates the problem. Hoffman (1985, p. 386) states that: "the old idea of treating a psychiatric symptom was based on the medical notion of curing a part of the body. The illness is 'in some spatially defined, out-there unit". This "out-there unit" position has often been denoted as the *first order perspective*.

The new epistemological approach (*second order*) suggests that *the problem creates the system*: "The problem is the meaning system created by the distress and the treatment unit is everyone who is contributing to the meaning system. This includes the treating professional as soon as the client walks in the door" (Hoffman, 1985, p. 387). Thus, second-order epistemology implies that meaning is socially

Figure 1. Four collaborative relationships

1 = first-order perspective; 2 = second-order perspective
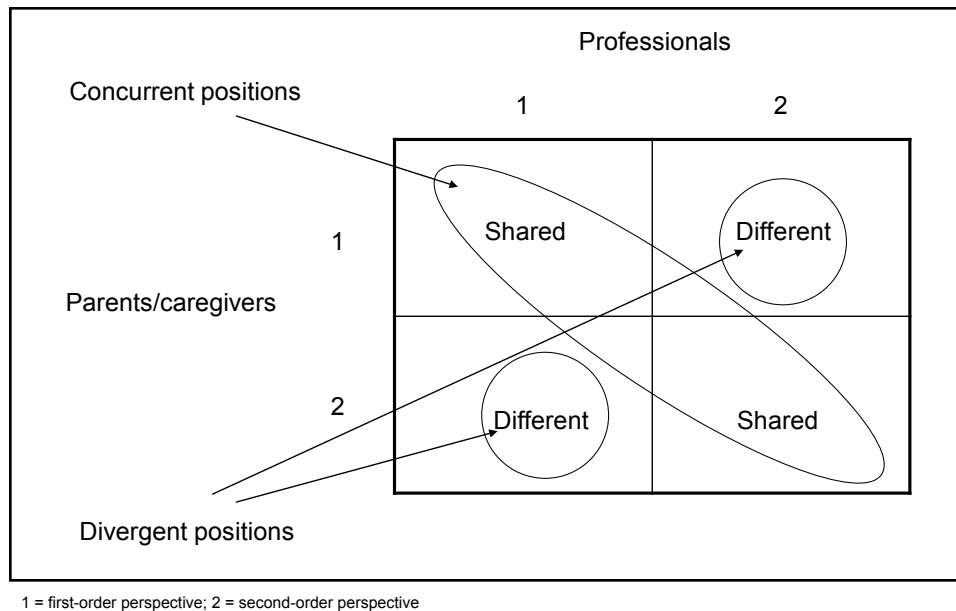
constructed and that new meaning is generated though dialogues. Anderson and Goolishian (1988, p. 13) talked about a reality that was "co-constructed by client and therapist in which they both participate, share, and develop meaning". According to Anderson and Goolishian (1988, p. 391), the process of therapy: "becomes the creation of a context or space for dialogical communication".

In this paper we suggest that differences between professionals holding either first- or second-order positions in therapeutic processes may produce different collaboration relationships. Professionals may or may not be reflectively aware of their epistemological position when engaging in collaboration processes with the family system. Notwithstanding, it appears reasonable to assume that divergent awareness and selection of meta-position result in different approaches to the collaboration process.

Part III—Presentation of a multifaceted collaboration model and clinical implications

It is suggested that the way actors position themselves (first- or second-order) may have a strong impact upon collaborating relationships. There appears to be a strong relationship between how a problem and its solution are understood and the unfolding of collaboration among all involved parties. This becomes even more evident in cases where professionals and the family system have different *expectations* about how the therapeutic process should be optimized.

There are basically four different ways professionals and family system members may meet according to the

expectations they have of the collaborative relationship. Two are concurrent expectations (positions 1/1 and 2/2), and two are divergent expectations (positions 1/2 and 2/1) (Figure 1).

Shared first-order perspective

In this position we would expect that the family system (for example parents/caregivers) acknowledges the expertise of the professionals and acts in accordance with this. The professional takes the role of an expert (position 1)—conducting the assessment and presenting results and relevant solutions to the problem. It is not likely that this relationship would cause conflict concerning expectations. The family system may, for example, accept that treatment is dependent on efforts from different specialist services, and thus agrees to move the child from one service to another (position 1). A psychiatrist's decision to start treatment of a child with neuroleptics may also be concurred by the family system. In case conferences, professionals from different services would probably present more or less concurrent expert solutions to the child's problem, with the risk of making family members passive service receivers. This may undermine service user participation and empowerment.

Shared second-order perspective

In this position the shared expectations are framed within a second-order perspective. Both therapists and the family system are interested in exploring the meaning system created among all the participating actors. This means that the family cannot be controlled from the outside by experts trying to fix what is wrong. Rather, therapy becomes a conversation where the actors participate and create dialogues,

to facilitate new meaning. Exploring new meaning becomes the main objective of the therapeutic process: how do you understand the situation; who would experience changes first; who (outside the family system) would most likely experience the change if/when it happens; and, how would others experience the change? Family system members may find questions like these interesting and inspiring, motivating further development in interaction with the therapeutic system. The mere conversation between professionals and family system members about what a collaboration process could mean may in and of itself catalyze new meaning: How do you understand collaboration as an activity, who should be involved in this collaboration process and how might they contribute to create new meaning? If the professional takes the role of an expert, it would be important for the family to know that their involvement in shared planning will be limited. This would allow them to choose another, and in their opinion, more relevant service.

Different perspectives (professionals take 1 and parents/caregivers take 2)

In this position caregivers and professionals take different positions with regard to how they understand the situation. If the professionals act as experts, they limit parents' possibility to influence what needs to be done. For example, parents may feel that there is little recognition of their view and collaboration efforts may be ignored by the experts. It is not given that professionals are explicit about their expert position (position 1). Hence family systems members may have expectations (position 2) that are divergent from those of the professionals with regard to both the understanding of the situation and to collaboration arrangements. In this regard, service user participation is expected by family system members, but is not facilitated by professionals. It is very likely that the potential for conflicts (for example during case conferences) between professionals and caregivers will increase due to divergent expectations about each other's roles.

Different perspectives (professionals take 2 and parents/caregivers take 1)

In this position, the family system may expect expert solutions from experts (position 1) who do not want to, or cannot, meet their demands (position 2). Professionals may find it more relevant to reflect on the situation—for example by trying to engage parents to explore new meaning through dialogues. Caregivers may experience that their expectations are not met, as professionals "refuse" to take the expert position. After having waited six months "to get the help and the specialised treatment we need" the family finally meets experts that decline "to explain and provide treatment to solve the problem". Hence, conflict may arise due to contradictory role expectations. However, different expectations may also generate positive effects. Conflicting

views may allow change to take place when the family struggles to understand the contradictions. For example, an open dialogue concerning conflicting expectations can be an opportunity for challenging both the family's and the professional's notion of where the problem resides. By leaving inflexible positions, both parties may learn how to progress in the relationship.

The four collaborative relationships presented above illustrate some of the complexity related to professional and family system interactions and collaboration. User participation and empowerment becomes increasingly more important in the field of health and social care. Accordingly, there is a need for more knowledge about such collaborative relationships.

Concluding remarks and some implications for clinical practice

Our main concern with regard to collaboration processes between actors belonging to treatment systems and/or family systems is that initial expectations towards therapeutic processes are under-communicated. It is our view that therapists should repeatedly address and deal with the expectations of the members of the family system during the therapeutic process. This is supported by Duncan and colleagues (2010, p. 122) who suggest that clinicians should "...encourage a process of shared decision making in which goals are frequently discussed, re-evaluated, and agreed on".

It is likely that during a therapeutic process different actors may shift between first- and second-order positions. For example, family system members may initially want professionals to examine the child with regard to neuropsychological dysfunction (first-order position). During the therapeutic process, however, new meaning may evolve as family members and professionals engage in dialogue about their situation (second-order position). In our opinion it is not shifting role expectations, but rather the lack of an outspoken and shared awareness of the dynamics of these meta-positions, that constitutes a threat to efficient treatment collaboration.

In this paper contextual issues that may impact the model have not been discussed. For example, access to services, transition planning and collaboration between professionals may be pertinent to whether families are perceived as partners or not in the mental health system.

In conclusion, interprofessional collaboration in mental health services for children and adolescents may profit from enhanced awareness and communication concerning first- and second-order positions. This may be accomplished by staging a discussion of meta-positions as a routine requirement in interprofessional collaboration work: a) as an

introductory theme in the opening stages of the collaboration between professionals; b) as an introductory theme in the first meeting with the child and the family system; and, c) as a theme throughout the course of treatment for both professionals and the family network.

Acknowledgments/Conflict of interest

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