The fact that Finnish families consider the role of the whole family essential to the well-being of the children made it possible to plan new resources for family intervention.

Our family ward is a day ward with capacity for two families at a time. The staff consists of a child psychiatrist and a head nurse, who have joint responsibility for the ward; a junior child psychiatrist who is undergoing specialist training, a psychologist and a social worker, who are highly qualified family therapists, and five nurses with child psychiatric and adult psychiatric expertise. The ward has nicely decorated homelike premises with a living room, a kitchen, two family rooms, family and interactional therapy room with a one-way mirror and video equipment, a water playroom for young children, a multipurpose room for different kinds of activities, and some office facilities.[8]

In Finland the costs of children's hospital treatments for the family are quite low. So, the three weeks' family ward treatment costs for the family about FIM 430 (US$80). The overall costs of this treatment are about FIM 73,500 (US$13,675) which is paid by community's tax money. Most of the parents apply during the treatment period for three weeks' unpaid leave from their work and the National Insurance Institute recompenses them for the loss of earnings. Some parents use their vacation, some parents are unemployed.

Theoretical background

The theoretical background for our integrated treatment model in the family ward is, first, based on systems theory and on its family therapeutical modifications. The other cornerstone for the treatment model is, of course, psychoanalytical theory. Psychoanalytical thinking offers possibilities to understand human beings as individuals and systems theory helps to understand the relationship context in which interventions are carried out. Also cognitive learning theories and their behavioural modifications are included in our integrated treatment model to make practical working in the ward possible.

Our bridge between different theories, especially between systems and psychoanalytical theories is in the first place based on interaction and relationships. We have found therapeutically useful integration between Wynne's[9,10] views on relational systems and Emde's[11,12] ideas on the parent-child relationship. In our treatment model, we make considerable use of interaction and relationships as tools to understand and intervene in interaction and relationships. In our family ward the staff works in pairs at all levels: a pair of primary nurses, a pair of family therapists, and a pair of persons in charge interact with the family and with each other at all time. We also use trios and bigger teams to make a more complex interaction and relationship context possible, but working pairs (like couples) is the basis.

To make this integration concrete and therapeutic, we have found Tomm's[13] views on reflective working most useful. The pair of primary nurses and the family in the ward work together through a circular reflective process using two-way "feedback" discussions. The family therapists also use a reflective working model during their sessions, and in case conferences the whole staff uses reflective double teams.[14]

The second mode of integration in our treatment model is based on the developmental viewpoint.[15] The developmental phase of a family and developmental stage of a child are combined and parallelly proceeding processes, which continuously have impact and reflections on each other. Parenthood is also seen as a growth process in adults influenced by a child's psychobiological maturing. The parent-child relationship is a developmentally changing relationship and this special inbuilt reality offers a family natural possibilities for changes.

The third mode of integration deals with combining theoretical thinking and practical working. It is not just using a theory and its therapeutical techniques in therapy sessions. This integration means more profoundly and concretely combining shared live interaction between the family and staff members and using theoretical thinking to achieve joint understanding. In this integration openness is essential, actually, we think that openness is a key element in our treatment approach.

The Family Ward Treatment Model

This model consists of four separate phases. First, the preadmission phase; second, the family inpatient period; following that the information transfer meetings; and finally, the follow-up phase (Fig. 1).

Preadmission phase

The referral starts the preadmission phase, during which the family is seen four times. The first family visit to the ward is an interview, in which the referring team members also participate. In the interview led by the senior child psychiatrist and the head nurse, the family and the referring team openly discuss the problems they are concerned about and that have given rise to the referral. All participants together assess the problems and evaluate the suitability and effectiveness of this treatment approach. The aims and objectives for the treatment are jointly defined by the family and the professionals and the decision about coming to the ward is made.

The other family meetings during the preadmission