FAMILY THERAPY IN CHILD AND ADOLESCENT MENTAL HEALTH:

A DESCRIPTIVE SUMMARY OF EFFECTIVENESS RESEARCH AND PRACTICE PERSPECTIVES TO INFORM TRAINING AND WORKFORCE DEVELOPMENT PLANNING IN NEW ZEALAND

The Werry Centre
For Child and Adolescent Mental Health
Workforce Development

www.werrycentre.org.nz
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ACKNOWLEDGEMENTS

This report has been prepared by the Werry Centre for Child and Adolescent Mental Health Workforce Development. We would like to give special thanks to the members of the reference group for their immensely valuable contribution, in agreeing to be interviewed as part of the development of this survey, and in providing valuable feedback and support in the completion of this report.

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EXECUTIVE SUMMARY

This report aims to provide a comprehensive review of effectiveness research and practice perspectives drawn from the family therapy literature, and from interviews with nine selected key informant/stakeholder family therapists practicing in New Zealand. It is anticipated that findings and recommendations drawn from the survey will provide a platform to inform training and workforce development planning for family therapists, and for family therapy, in New Zealand.

While the project brief originally focused on descriptions of effective, evidence based family therapy interventions and models utilised both internationally and within New Zealand, this brief proved difficult to achieve for a number of reasons — namely the lack of quality research available which compares and contrasts different models and approaches. In addition the general consensus, both in the literature and from the perspectives of the key informants, is that the service model approach forms only one aspect of best family therapy practice. While systemic family therapy and a handful of specific family therapy models (Multi Systemic Therapy (MST) and Functional Family Therapy (FFT); Multidimensional Family Therapy; Brief Strategic Family Therapy; and the Maudsley Model for children and adolescents with Eating Disorders), are deemed “evidence based” by this review, recognition of the significant number of influences on effective family-based intervention means that it may be unwise to endorse any specific model or training programme. As such, it may be more prudent, to recognize that family therapy is undoubtedly effective, and cost effective, in the treatment of families and children/young people presenting to mental health services; acknowledge the unique cultural context in which family therapists working in New Zealand practice; appreciate the significant impact that service design and philosophy has on ensuring that families are able to access and engage with mental health services; and understand the significant challenges faced in making family therapy practice visible in child and adolescent mental health settings in New Zealand.

As a result, this report recommends that family therapists practicing in New Zealand are provided with a number of opportunities to “become more visible” within child and adolescent mental health services. These opportunities could include:

- A symposium for key stakeholders in family therapy to promote collaboration and learning opportunities
- Working with child and adolescent service management to develop role descriptions and career pathways to develop specialist family therapy roles
- Working with tertiary education providers to develop and promote family therapy courses at post graduate level supported by Skills Matter funding
- Development of a national family therapy Association.
- Development of a web-based national clearinghouse to ensure a centralised and coordinated approach to the dissemination of research, training, and leadership information.
- Promotion of national training programmes in Family Therapy which recognise the unique cultural context in which family therapists working in New Zealand practice, ranging from short orientation courses to comprehensive training courses with a practicum component.
• Promotion and provision of training in family engagement and family support strategies for all CAMH and AOD workers
• Professional development of family therapy leaders including mentoring and supervision.
• Further research of both appropriate indigenous models and applicability of “introduced” models to the New Zealand context.
AN INTRODUCTION TO FAMILY THERAPY
AND THE FAMILY THERAPY PROJECT

An initial perusal of the research and theoretical literature informing the field of family therapy reveals an uncomfortable history between family therapy, research and evidence based practice. While there is a growing sense of “professional resignation” to the need for the development of a sound evidence base to demonstrate both efficacy and effectiveness, the family therapy literature is full of references to the immense challenges faced by researchers in scientifically measuring the effectiveness of psychotherapeutic models and approaches. While these concerns are undoubtedly valid, more recent publications, such as Rivett (2008) and Messent (2008), essentially urge family therapists and researchers to get on with the task of developing a robust evidence base for family therapy. This report aims to take on that challenge by providing a summary of the primary evidence base for family therapy practice with families of children and young people referred to child and adolescent mental health services. This report is one of a number of strategies being undertaken by the Werry Centre for Workforce Development in Child and Adolescent Mental Health in determining the training needs for current and future family therapists working in child and adolescent mental health settings in New Zealand.

One of the primary challenges to any survey of the family therapy literature is agreeing on a definition of what constitutes family therapy. This task is compounded somewhat by a dramatic increase in recent times in the range of approaches which describe different aspects of working with families in child and adolescent mental health settings (such as family advocacy, family inclusion, and family centered care) many of which are not, nor claim to be, family therapy - and the vast number of approaches and techniques that do claim to be family therapy. The British Association of Family Therapy defines family therapy as “a distinctive psychological therapy for individuals and support networks, which aims to maximize family strengths and resilience to help people to overcome problems experienced by individual family members or the family as a whole.”
**Evidence Note: Family Resilience**

Family resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity (Luthar, Cicchetti & Becker, 2000). It incorporates consideration of risk and protective factors. Rutter (1999) and Hawley (2000) acknowledge the clinical implications of resilience concepts and findings to family therapy practice. Mackay (2003) reviews the research literature pertaining to family resilience and good outcomes for children, outlining evaluation findings across a number of parameters relating to five specific programmes, and determines that while it may be possible to bolster family resilience through “ordinary magic” (Masten, 2001), it is still not clear on how best to do this (p. 116). Walsh (2002) outlines a family resilience framework, whereby the focus of family therapy shifts from family deficits to family strengths (Nichols & Schwartz, 2000); stressful events and persistent challenges influence the whole family, with key family processes mediating the recovery and resilience of vulnerable family members and the family as a whole (p. 130). Walsh’s (2002) clinically-based and research-informed framework is based around three domains and nine key processes: Belief Systems (Making meaning of adversity; Positive outlook; and Transcendence and spirituality); Organisational Patterns (Flexibility; Connectedness; and Social and economic resources); and Communication Processes (Clarity; Open emotional sharing; and collaborative problem solving).

Developing a comprehensive schema of all the approaches and techniques which constitute family therapy is a task that is outside the scope of this survey. Asen (2002a) and Cottrell and Boston (2002) provide a comprehensive appraisal of the approaches which fall under the heading of “systemic family therapy”. Systemic family therapy refers to a diverse set of approaches that are essentially linked by a contextual element – that is, “seeing and treating people in context” (Asen, 2002a, p.230). Cottrell and Boston (2002) expand their definition of “classical” systemic family therapies to include therapies that draw on “systemic, cybernetic, narrative and constructivist/constructionist theories” (p. 573).

Major approaches that are clustered under the systemic “umbrella” include Structural, Strategic, Milan-systemic, Narrative, Psycho educational and Behavioural (Asen, 2002a) with Cottrell and Boston (2002) adding Brief Solution Focused Therapy and Psychoanalytic to the contemporary mix. In addition to defining and describing each of the approaches, both Asen (2002a) and Cottrell and Boston (2002) present a review of the evidence base for systemic therapy. From meta-analyses and controlled trials primarily published in the 1990’s, Asen (2002a p. 232-233) concluded that systemic therapy is more effective alone, or alongside other treatments, in a wide range of different conditions and presentations. These included conduct problems in children, drug and alcohol use in adolescents and adults, marital distress, childhood asthma, children with enuresis and soiling, children with oppositional survey problems, eating disorders, psychotic illnesses and mood disorders. Cottrell and Boston (2002)
are more critical in their review of the evidence, citing numerous methodological issues with the evidence base. They are therefore more cautious in being definitive about the efficacy or effectiveness of family therapy – however they do present a review of the evidence base for systemic family therapy with children with conduct and attention disorders; substance misuse; eating disorders; depression; and chronic physical conditions. Asen’s (2002a) review also cautions therapists to avoid one “brand of therapy” without consideration of the patient’s condition, their work context, and the intended outcomes of therapy.

**Evidence Note: Systemic Family Therapy**

Stratton (2005) in his comprehensive report on the evidence base for systemic family therapy determines that systemic therapy is effective, and often a cheaper alternative to standard therapies. For families with children with a range of mental health issues, he also concludes that there is little difference in the outcomes of different kinds of family therapy. He also concludes that as well as being effective with clients with a specific diagnosis, additional “family therapy” benefits include greater acceptability to clients and families, continued improvements post-discharge, and improved compliance with medication (p. 2). As such, Stratton (2005) suggests that keys to successful family therapy are; well trained practitioners who draw on a wide variety of approaches, depending on the needs of the client. He recommends that family therapists be employed in services to provide, in addition to family therapy, training and supervision for other family therapists; training, supervision, and support for mental health professionals working with families; and a research base for practice through participation in networked research (p.2).

**1.1 THE FAMILY THERAPY PROJECT BRIEF**

The development of the infant, child and adolescent mental health ICAMH/Alcohol and other Drug workforce and the capacity to provide quality professional development opportunities for ICAMH/AoD workers are key to service enhancement, and contribute to retention and development of the workforce. It is universally accepted that mental health services for infants, children and adolescents need to be provided in the context of the parent/child relationship. However, up until now workforce development has not been directed towards growing competence in family therapy and family engagement skills.

This report aims to explore the competencies (knowledge, skills and attitudes) needed to enhance family therapy/family engagement in ICAMH/AoD services throughout Aotearoa New Zealand. It is hoped that it will also be a starting point to guide services and training organisations on the best practice models within the New Zealand context. The aim of this survey is to provide information relating to the key
models used in family therapy practice in New Zealand, descriptions of effective interventions, models and supporting evidence inclusive of a developmental perspective, and identification of family therapy models currently practiced throughout New Zealand with particular attention on culturally competent models of family therapy within the New Zealand context. A survey of training opportunities currently provided within New Zealand and by recognized centres of excellence overseas is also included, as are recommendations to align with and guide the National Mental Health Training Plan (Te Pou, 2008), and future national service frameworks for ICAMH services.

1.2 SEARCH PARAMETERS, STRATEGY, AND LIMITATIONS OF THE LITERATURE

Given time constraints and the potentially unwieldy scope of a survey of this kind, this report primarily focuses on findings drawn from evidence base reviews, systematic reviews, and meta-analyses of the efficacy and effectiveness of family therapy and family therapy models/techniques in child and adolescent mental health. Similar to the review strategy employed by others, this literature survey involved five steps based around three key stages of search, assessment, and analysis.

Step one involved consideration of the purpose of the literature survey and search terms and parameters, specifically related to survey parameters (national and international evidence based reviews; effective/evidence based family therapy and family based interventions; specific family therapy models/techniques); settings (child and adolescent mental health services); and conditions (mental health problems and issues; emotional, behavioural and conduct disorders; PTSD and trauma; psychosis, substance abuse, co-occurring disorders).

In step two, the literature was searched using a variety of sources, including electronic databases available through the University of Auckland Library (specifically CINAHL, Evidence Based Medicine Reviews, PsychINFO, Medline, PubMed, Proquest, Informaworld, OVID, EBSCO Host, and EMBASE), internet-based and publication-based bibliographies and published content from a range of relevant organisations, including the Promising Practices Network and the Substance Abuse and Mental Health Services Administration (SAMHSA).

In order for studies to be considered for this report, they were required to be published between 1999 and 2009 in peer-reviewed, international, English language publications. However, key systematic reviews and meta-analyses published prior to 1999 and regularly cited in the current literature are also included in this survey. Approximately 250 publications were sourced.

In the third step, the publications were surveyed and filtered for those that best met the criteria for this survey. These publications were then summarised and themes drawn from the literature. Additional publications further detailing or supporting the evidence based interventions recommended in the Evidence Based Age Appropriate Interventions – A Guide for Child and Adolescent Mental Health Services (Dunnachie, 2007) were also accessed, analysed and summarised.
The fourth step included canvassing practice perspectives in New Zealand. This involved the selection and interviewing of nine key informants recognised as expert or experienced in the family therapy field in New Zealand. These informants were familiar with family therapy practice and training in both Australia and New Zealand. The nine informants were invited to participate through phone interviews. All nine informants indicated their willingness to participate in interviews. The interviews were conducted between April and May 2009, with interviewees asked to comment on:

- Training opportunities (in Australia and New Zealand) that are available to people wanting to become more skilled in family therapy
- Training opportunities (in Australia and New Zealand) that are available to people wanting to become family therapists
- Training opportunities (in Australia and New Zealand) that are available to develop the skills and knowledge of those who have training in family therapy.
- Key training and workforce development opportunities for family therapists working in New Zealand
- Key training and workforce development barriers and challenges for family therapists working in New Zealand.

Detailed notes were kept during the interviews and were analysed for key themes, with findings summarised later in this report.

The final step in the development of this survey was the compilation of this report. This included documentation and critique of the family therapy evidence base, an overview of findings regarding the efficacy and effectiveness of family therapy and family therapy techniques drawn from the literature, a review of family therapy training and practice perspectives unique to the New Zealand/Australasian context, and the provision of recommendations for future family therapy training and workforce development in New Zealand. This step also included requesting feedback from the key informants on the draft report.
1.3 LIMITATIONS

This report is not based on an exhaustive review of all of the research literature pertaining to the effectiveness and efficacy of family therapy. As mentioned previously, given the tight timeframe and the potentially unwieldy scope of a survey of this kind, the primary focus is on findings drawn from evidence base reviews, systematic reviews, and meta-analyses of the efficacy and effectiveness of family therapy and family therapy models/techniques in child and adolescent mental health. Additional constraints on this survey include search limitations, such as lack of access to full-text journal publications; the general paucity of rigorous, independent evaluation research, specifically around the effectiveness of different family therapy techniques/approaches with child and adolescent mental health populations and the well recognised “developers as publishers” issue; the prevalence of research in controlled rather than real-world settings; the significant number of US-based studies, initiatives, and publications; and the lack of New Zealand reporting around evidence based practices, evaluation, and research.
CHALLENGES TO DEVELOPING AN EVIDENCE BASE FOR FAMILY THERAPY IN ICAMH/AOD SERVICES

When faced with the prospect of identifying best practice in family therapy, a number of significant philosophical and methodological challenges emerge which warrant identification and further discussion. One of the primary barriers to identifying evidence based family therapy models or techniques is the recognized dearth of research which compares family therapy models and/or approaches when working with children and families. This comparative research simply does not exist.

2.1 TECHNIQUES OR COMMON FACTORS?

Of additional concern to the development of an evidence-base for family therapy is the challenge of attributing change within families to “family therapy”. Families, by definition, are complex and complicated, and small changes in one family member or interaction may significantly affect the way the family exists, works or communicates. Sprenkle and Blow (2004) and Larner (2004), in recognizing the need to measure which family therapy techniques work best for which families, have identified five common factors across the range of different family therapy techniques:

The client, the therapist, the therapeutic relationship, expectancy, and non-specific effects (behavioral regulation, cognitive mastery, and affective experiencing, as described by Karasu (1986).

2.2 WHOSE THERAPY? WHOSE OUTCOMES?

The third challenge to a survey of the family therapy evidence-base is the ongoing insistence of researchers to focus family therapy outcomes around the diagnosis of a targeted child when talking about the effectiveness of family therapy - for example, “family therapy is effective with children with conduct disorder”. While it is recognised that there is often one child who triggers a family’s access into a mental health service, and that the identified child may present as a manifestation of a family’s problems, the notion that Family therapy works for a Child with a specific disorder seems problematic. Perhaps the issue is simply one of semantics. In keeping with the presentation of population specific findings in a number of evidence reviews, this survey will present findings for specific populations with one small addition: the words “families of”.

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2.3 METHODOLOGICAL CONCERNS

The majority of publications included in this report identify significant issues in a considerable proportion of studies previously undertaken in family therapy. Cottrell and Boston (2002) provide a review of these methodological concerns relating to effectiveness research in family therapy in Child and Adolescent Mental Health settings, namely (p.577-578):

- The lack of consensus around valid research methods for measuring family interactions and a tendency to focus outcome measures on the identified child's symptoms, rather than the experience of other or all family members.
- Methodological flaws in the published research – including small sample sizes, lack of true randomization, lack of specification of technique, poor demonstration of treatment integrity and a lack of credible control treatments.
- Publication bias

2.4 FIDELITY, EFFICACY, EFFECTIVENESS, AND EVALUATION

Within the family therapy research literature, as with other disciplines, studies can generally be divided into two distinct categories: efficacy research, which addresses how to determine the efficacy of a particular model or technique (often prior to manualisation), and effectiveness research, which aims to review the effectiveness of a previously-determined efficacious model/technique in real-world settings (Pinsof and Wynne, 2000). These two distinctions are imperative to consider in a survey of the evidence base for family therapy, in that a proportion of publications focus on either one or the other. Efficacious programmes may not be effective in “real world settings”. Nelson and Steele (2006) further complicate the issue by proposing that family therapy move beyond “research evidence” and suggest the adoption of a multi-faceted outcome evaluation model, which incorporates outcome evaluation alongside recommendations for considering provider, consumer and economic factors. This proposal may go some way to addressing concerns raised in both the literature and by key informants/stakeholders interviewed as part of this survey, around the applicability of research findings in real-life.
2.5 COST EFFECTIVENESS

Crane (2008) provides a detailed summary of cost-effectiveness research data collected from four sources in the USA. While acknowledging issues with the presented research (primarily cause and effect relationships being unable to be established), Crane cautiously determines that participation in family therapy is likely to reduce healthcare use for high users of healthcare services, and the inclusion of family therapy in healthcare programmes does not seem to increase overall healthcare costs (p. 407).

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<th>Evidence Note: Multi-Family Therapy</th>
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<td>One of the potential ways to address any cost and cost-effectiveness concerns relating to family therapy (Asen &amp; Schuff, 2006), although not strictly a cost-reduction measure, is multi-family therapy. Asen (2002) provides an overview of the history of multi-family therapy and case examples of multi-family work in a range of different settings, including work with multi-problem families; with schools, parents and pupils; with adults with mental illness and their families; and with young people with eating disorders and their families. Additionally, Schaefer (2008) provides a description of multi-family group therapy in an alcohol and drug rehabilitation service in New Zealand (Higher Ground), which includes an analysis of the advantages and disadvantages of multi-family therapy drawn from the literature and reported by staff and clients. Advantages noted included exploration of entrenched family interactions without judgment, using the group itself as a therapeutic tool; consideration of the family as the central unit of care and acknowledgement of the family member’s inherent need for support (Lemmens et al., 2007); the psycho-educational aspects of the group process; opportunities to address responses to family conflict; the social context of the group which allows highly therapeutic connection with other families and family members (Bishop, Cliverd, Cooklin, &amp; Hunt, 2002); and improved use of the therapist’s time (Anderson, 2001, as cited by Schaefer, 2008). Disadvantages of this approach related mainly to the confidence, skill, and experience of the therapist - the centrality of the therapist within the group context; the creation of complex situations that may challenge and overwhelm the therapist; and potential confusion around the distinction between family therapy in a group, and group therapy with families (Saayman, Saayman, &amp; Weins, 2006). Other concerns related to identification and engagement of appropriate families and the lack of an empirical evidence base for multi-family therapy (Saayman et al., 2006, p. 22).</td>
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EFFECTIVELY ENGAGING FAMILIES

Critical to the effectiveness of family work with infants, children, young people and families, and indeed critical to the effectiveness of a significant proportion of interventions undertaken in the treatment of children, young people and families accessing ICAMH/AoD services, is ensuring that families are well engaged with services. McKay and Brannon (2004) reviewed the research relating to engagement of families in child mental health services, and more specifically, issues relating to the engagement of urban youth of colour and their families in service. One of the initial challenges faced by McKay and Brannon (2004) was defining child mental health service engagement. There is the need to balance the multiple conceptualisations of the process of engagement along with recognition of the related but independent constructs of family engagement steps detailed within the literature. These steps include initial attendance and ongoing engagement (“recruitment and retention”). Tying down a definition of family engagement proved to be one of the key challenges to measuring rates of service engagement. Precision of definition will ultimately result in more reliable evaluation strategies, findings, and generalisability (McKay and Brannon, 2004, p. 906).

Universally recognised as problematic, one of the key measurements of engagement appears to be attrition (dropout). In addressing the issues associated with attrition, while recognising the lack of research that links identified variables with service use patterns, McKay and Brannon (2004) identify poverty status and ethnicity as the two family characteristics that impact heavily on child mental health service engagement. Family characteristics that may influence family engagement include; differing levels of parent and family stress, single parenting, differing levels of discipline effectiveness, parents having a preferred form of child services, and family cohesion and organisation.

3.1 POTENTIAL BARRIERS

Watson (2005) determines four over-arching barriers that reduce the access that families have to services – practical barriers (such as cost, transport, operational hours, child care, eligibility criteria); cultural factors (such as language); personal factors (such as mental and cognitive function of parents); and stigma associated with mental health. Other identified barriers include a lack of confidence experienced by vulnerable families in accessing services; threat (specifically related to fear of removal of children); and a lack of trust in the usefulness of services (p.4).

Specific to service engagement strategies, McKay and Brannon (2004) also detail a similar range of factors which create barriers such as resources (lack of time and transportation), contextual (such as community violence), and agency obstacles (such as waiting lists and office hours). The authors also detail other barriers that impact on families accessing mental health services specifically related to issues such as parental expectations, family involvement in care, family stress, and parental attitudes to mental health. It is these logistical and perceptual barriers that interfere with a family’s ability to
engage with and use a service. Of note, the research around logistical and perceived barriers indicates that “perceived barriers are the most salient predictor of adherence to recommendations” and “continuity of care may be compromised seriously if the perception of barriers by families is high” (2004, p. 909).

Wang et al. (2006) in their exploratory study of why families fail to engage in family therapy, identified three key factors that contribute to non-engagement – client factors, therapist factors, and clinic factors. Specific to client factors, research and anecdotal evidence suggest that socio-economic status is the most highly correlated factor related to non-engagement (p. 213). Engaging minority families provides the greatest challenge for even the most culturally competent services and workers. With regard to therapist factors, the authors identify a lack of research relating to the link between therapist factors and non-engagement; however, therapist experience and mis-match are the most-cited reasons for early drop-out. Finally, regarding clinic factors, the authors reveal that the length of time between intake and first appointment is the key determinant in non-engagement.

McKay, Hoagwood, Murray, and Fernandez (2004) detail the effectiveness of a range of strategies for integrating evidence based engagement strategies into “real world” child and adolescent mental health outpatient settings. They suggest that, while the research is limited, family engagement strategies are best utilised at the initial points of contact with a family. Specific evidence based strategies suggested by the authors include using the telephone intake process to go beyond gathering personal contact details and focus on overcoming potential/identified barriers; reminding families of appointments; framing initial contact with adult caregivers as the beginning of service provision; and including the extended family. McKay, Nudelman, McCadam, and Gonzales (1996) detail the “telephone engagement intervention” further, with specific aims being to clarify for the provider and the caregiver/family why mental health treatment is being sought; maximise the families/caregivers investment with regard to help-seeking; identify attitudes and experiences which might dissuade caregivers/families from bringing a child or young person to a service; and develop strategies to overcome concrete barriers, such as lack of time, access to transport and childcare issues. With regard to engaging and retaining families in services, the authors suggest utilising the first face-to-face contact as an opportunity to clarify worker, agency, intake, and service options and roles; set the foundation for a collaborative working relationship; identify practical issues that can quickly be addressed; and develop a plan to overcome barriers to ongoing involvement with the agency.

The importance of this “initial engagement” phase as a significant contributor to successfully working with families in services is also a key consideration within the Choice and Partnership Approach (CAPA) (Kingsbury & York, 2006), a service delivery approach initially developed in the UK and currently offered by the Werry Centre. The CAPA approach actively encourages services to partner with families right from the beginning of the “therapeutic relationship” by offering “choice appointments” immediately following acceptance of a referral, and partnering children and families with a worker who has the right
core and specialist skills (The Werry Centre, 2008) to support and engage with the presenting child/young person and their family.

Watson (2005) in a review of the literature of active engagement strategies to increase service participation by vulnerable families accessing child maltreatment services in Australia, determined that active family engagement should be focused around three key issues. These are: high rates of refusal by some vulnerable families to participate in services; high rates of attrition by some vulnerable families; and barriers facing families in gaining access to services (p. iii).

3.2 STRATEGIES FOR ENGAGING FAMILIES IN CAMH/AOD SERVICES

Watson (2005) identifies active engagement “recruitment and retention” strategies in three categories (practice-based; promising practices; and evidence based) that can be undertaken at either a caseworker or agency level, or at the caseworker/agency interface.

FAMILY RECRUITMENT

The three evidence based strategies that caseworkers can utilise to assist with helping families to access services include prompt follow up (at least weekly), frequent maintenance of contact (at least weekly), and ensuring the contact is seen as supportive of the mother [parent]. Promising practices include partnering with a worker already known to the family at the initial point of contact, and following up with families at least three to four times following failure to return a phone call, keep an appointment, or not being at home at a pre-arranged time. Information drawn from practice suggests that assertive community outreach (actively seeing families in their own communities) and a prompt initial response (within 48 hours of referral) may contribute to the successful engagement of families. This can also include offering services at a time of transition, ensuring that services are non-stigmatising and partnering with agencies who can act as “non-threatening” ambassadors (such as schools and churches).

FAMILY RETENTION

When considering those strategies which will enable caseworkers to retain/engage families within services, Watson (2005) determines that the caseworker-family relationship is one of the most critical factors affecting family engagement. Communication style, provision of practical/material support, facilitation of ease of access to services, and development of strategies to maintain contact being key parameters. Specific strategies identified by Watson (2005) include:

- Being supportive and non punitive in communication
- Offering material and concrete supports
- Providing financial incentives to complete programme components
- Active community outreach
• Visiting on weekends and evenings
• Provision of transport for centre-based interventions
• Provision of free childcare during programmes
• Ensuring multiple contact points
• Reminding families of appointments (by letter or phone)
• Increasing frequency of contact.

Additional strategies drawn from practice include; respecting families, starting where the family “is at”, using verbal encouragement, including the family in all decisions, empowering parents, focusing on skills, support families to get ready and the provision of food and/or refreshments.

Promising strategies that agencies can employ to retain/engage families within services are: ensuring that services are located within the community, offering dedicated clinics, and evaluation of outcomes rather than throughputs. Other strategies drawn from practice include ensuring that families are aware of services, ensuring multiple gateways/portals into a service, reducing eligibility criteria, and ensuring as few referral pathways as possible. This is also consistent with Kingsbury and York’s (2006) Seven HELPFUL Habits of Effective CAMHS which promotes streamlining services and creating smooth pathways for improving the flow of service users.

At the agency/caseworker interface, evidence based family engagement strategies include: ensuring that caseloads are manageable, offering staff training opportunities, access to supervision, matching caseworkers with families of a similar background, and offering a toll-free phone number. Strategies drawn from practice which may enable families to better access and engage with services include: training staff in programmes that are culturally appropriate, the development of inter-agency practice protocols to ensure better information exchange and coordination across sectors and services.

**ENGAGING FATHERS**

Taking the active engagement issue one step further, Berlyn, Wise, and Soriano (2008) identify challenges and strategies to engaging fathers in child and family services in Australia. The authors identified a number of barriers experienced by fathers when accessing services. From the fathers’ perspective this included; their own traditional views about masculinity and a reluctance to seek help; a lack of knowledge about services, work as a barrier and transportation. There were also barriers associated with service provision such as gender stereotyped attitudes and values, a mother-oriented service culture and a lack of culturally appropriate services. As a result, Berlyn et al. (2008) highlight several key strategies which may be effective in supporting fathers to access child and family services including:

• Utilisation of key community-based services and organisations
• Passing of information from one father to another (“word of mouth”)
• Promotion of services in workplaces and other “male spaces”
• Effective marketing strategies
• Highlighting programme benefits.

Specific benefits for fathers, couples, families and children when fathers are engaged in child and family services, as determined by Berlyn et al., may include; increased parenting self-efficacy, skills and knowledge; increased involvement; improved relationships with children and partners; development of a support network; direct benefits for children; and building community connectedness.

**STAFF/AGENCY EXPERIENCES IN ENGAGING FAMILIES**

In addition to the range of barriers that families encounter and/or perceive in their attempts to engage with services in the treatment of children and young people with mental health disorders, McKay et al. (2004) recognised that there are a number of “real world” challenges experienced by services and workers in this process. These include the need for endorsement by managers and leaders; inclusion of all team members in any family engagement training or changes in organisational philosophy around family engagement; and the active provision of opportunities for staff to think innovatively about family engagement, including recognition of perceived/actual individual and agency barriers, and seeking feedback from service users.
CULTURAL COMPETENCE AND FAMILY THERAPY

The term “culturally competent family therapy” has particular relevance within the New Zealand practice context, given the commitment undertaken across sectors, settings, services and staff under Te Tiriti o Waitangi to work in partnership with Maori clients to achieve best health outcomes. This is also the case when working with Pacific and other minority clients. As such this section will outline a summary of the international research/perspectives relating to culturally competent family therapy, and will focus primarily on perspectives drawn from the writings of recognised cultural and research leaders from New Zealand relating to culturally competent practice.

The international literature available relating to cultural competence for family therapists and in family therapy practice is best described as “sparse”. Hardy and Laszloffy (1995) outline the cultural genogram as a tool for training culturally competent family therapists, which include consideration of both cultural awareness and cultural sensitivity to assist family therapy trainees to understand their own cultural identity. The genogram is designed to provide insight and appreciation into the ways that culture impacts on both the therapist role and the clients’ lives through:

- Illustration and clarification of the influence that culture has on a family system
- Assisting trainees to identify groups which contribute to their own cultural identity
- Encouraging candid discussions that reveal and challenge culturally based stereotypes and assumptions
- Assisting trainees to discover their own culturally based emotional triggers, and
- Assisting trainees to explore how their unique cultural identities may impact on therapeutic style and effectiveness.

With regard to multicultural perspectives of family therapy, Tamura and Lau (1992) explored the applicability of family therapy to Japanese families. They determined a number of clinical issues for family therapists working with Japanese families, in particular utilising an authoritative style, individual sessions, silence, and other non-verbal techniques. McKay et al. (2004) explored the impact that cultural factors have on predicting the premature termination of Mexican and African-American families from child mental health services in the USA. From the available research, the authors determined that the parents who were less well educated, and who felt that they and their child should be able to manage a child’s emotional and behavioural problems on their own, including increasing discipline, may be more likely to disengage with services prematurely. Additional influences on engagement specifically related to culture appear to be around family/parent attitudes and expectations of services. These effect both initial engagement and ongoing involvement in a child/young person’s mental health care. Durie and Munro (2008) add to this discussion, with a review of the valuable contribution that a Maori perspective can bring to crisis engagement in mental health. These authors recognise that engagement is a critical element in the achievement of success for clients, but that attempting engagement in crisis situations can prove detrimental to both the client and worker. The authors suggest that careful
consideration of “respect for other” and the art of hospitality and creating an atmosphere where the mana of all participants is enhanced, *manaaki tangata*, are integral to engagement with families and clients, particularly in crisis situations.

McKay et al. (2004) suggest that services need more “culturally sensitive” interventions to improve engagement and prevent drop-out, including collaborating with families/parents to ensure access to care, and actively working with families/parents to enhance attendance and involvement in care. This notion of “culturally sensitive practice” is both perplexing and intriguing; dialogue in the current literature encourages family therapists to be more “culturally sensitive” but not a lot of discussion about what this actually means or how to be “culturally sensitive”. There also appears to be a more recent shift in the literature, both in family therapy and in other disciplines, away from a “culturally sensitive practice” perspective (which implies a service/intervention delivery philosophy) to “culturally competent practice”, which implies a set of skills, abilities and attitudes of the therapist which will lead to culturally sensitive practice. Durie (2005) describes “cultural competence” as the acquisition of a set of skills to achieve a better understanding of other cultures, in an attempt to achieve the best possible health outcomes for the client (2001), while Nayer and Tse (2006) assert that cultural competence is a “journey not a destination” (p. 4).

Central to the competency of health professionals working in the child and adolescent mental health sector, in New Zealand the Werry Centre (2008) has recently launched *Real Skills Plus CAMHS*. The *Real Skills Plus CAMHS* competency framework is an extension of the “Let’s Get Real” framework for people working in mental health and addictions, developed by Ministry of Health (2008). The framework outlines the practitioner-core and practitioner-specialist skills recommended for CAMH workers focused on six skills (Children, youth and families; Working from a developmental perspective; Whanau; Community systems; Rights; and Advocacy) and six areas (Infant, Child and Youth, Family/Whanau; Maori; Pacific; and Community) across four intervention phases: Engagement, Assessment, Intervention, and Outcomes/Evaluation. All areas of the competency framework would be considered integral to the competent practice of family therapists working in the CAMH/AoD sector.

A summary of the practitioner-core and practitioner-specialist skills detailed with regard to Family/Whanau are outline below:
Engagement:

Core: Culturally appropriate engagement; language; openness to difference; concept of whanau and whanau dynamics; developmental stages of whanau; impact on whanau of caring for a child with a mental/AOD illness and attending a mental health service.

Specialist: Language skills to engage with whanau; a personal knowledge and awareness of specific cultures and whanau.

Assessment:

Core: Articulate and application of recovery and resilience principles and relationship with whanau; exploration of whanau dynamics and systemic impacts of mental health/AOD issues on all whanau members.

Specialist: Act as a resource on whanau dynamics and care and protection legislation; utilise specific knowledge and expertise.

Intervention:

Core: Interact with and support whanau; concept of whanau and whanau dynamics; coordination of culturally competent and responsive interventions; knowledge of a systemic approach in all whanau contacts.

Specialist: Specific knowledge and expertise in family/whanau therapy; working in partnership with whanau.

Outcomes/Evaluation

Core: Understanding of outcome measures

Specialist: Initiate and lead ethics approved research that is aimed at enhancing service provision and improving outcomes for service users

Tassell and Hirini (2004), in conjunction with Te Rau Matatini, the Maori mental health workforce development organisation, provide a review of the Maori child, adolescent, and whanau workforce. They emphasise that expertise in dual clinical and cultural competencies is one of the key concerns of the Maori CAMH workforce. More recently, Le Va, the Pacific arm of Te Pou, the national mental health research and workforce development centre, released Real Skills Plus Seitapu, working with pacific peoples (Le Va, 2009). The model includes a number of complex and inter-woven components, including four competency themes, with the first theme being “families”. Specific to levels of competency, core family competencies are based around cultural awareness and sensitivity (20 parameters), while advanced and specialist competencies include consideration of cultural and family engagement (14 parameters) and leadership (7 parameters). Workers are challenged to consider the
consumer’s sense of identity, status, and relationships; the potential impact of these on their survey; strategies for demonstrating respect; assessment of the impact of mental illness on family relationships; the consumer’s understanding of mental health and cultural values; utilisation of cultural knowledge in recovery; cultural concepts and protocols in dealing with conflict and transgenerational hurt; and engagement with the wider community.

Specific to cultural competence for workers working with Asian populations, Nayer and Tse (2006) identify a number of critical factors, drawn from the literature that will ensure that training in multicultural competence is effective and successful, including:

- Organisational support and commitment
- Guidelines and standards of cultural competence
- A variety of delivery modes
- Cultural awareness included in the training package
- Availability of resources, materials, information, follow-up, and assessment
- Recognition of the importance of skill development
- Communication skills and language skills

There are several references in the literature to Maori theoretical frameworks and the philosophies underpinning Maori Mental Health practice. Mason Durie (2003) discusses the concept of “whanau healing” when working with family issues which he sees as a specialized type of intervention involving five distinct processes. These are:

- Whakatau – laying the foundations
- Whakawhanaungatanga – affirmation of kinship bonds
- Whakataatau – analysis of problems
- Whakarorangia – resolution
- Whanau relationships – assess the relationship between the client & their whanau with a focus on issues of access & involvement.

Durie (2003) adds that “conventional family therapy is inadequate” for whanau mediation. He suggests that the therapist must have a knowledge of whanau dynamics based on immersion in Maori culture as well as an understanding of counselling and principles of Mental Health which then provides a basis for assessing whanau relationships and then mediating between the parties involved. Durie (2005) presents a number of exemplar whanau based models for early intervention with children and young people with conduct disorder, and includes descriptors of whanau, whanau models and whanau therapists. Durie (2005) describes the central role of the whanau therapist as three-fold: acting as an “agent at the interface”, mediating between systems and services alongside whanau, while encouraging positive relationships; establishment of a “kawa”, a set of guiding surveys based on tikanga and Maori values that are adaptive, positive and mutually reinforcing; and maximising engagement with families through the use of “tikanga, Maori communication styles, and culturally compatible interactions” (p. 9). Durie
(2005) describes the aims of the whanau programme being to reduce risk factors, enhance known protective factors (including family support and networks, positive community experiences, communication between home and school), and assisting in a child/young person’s acquisition of language, communication and problem solving skills.

Kina Families and Addiction Trust (2005), in their family inclusive practice guide for practitioners working with couples, families, and whanau in the addiction field, also include a very detailed section on whanau sessions (Section 3) which includes cautious consideration of the impact of cultural assumptions, as well as a range of strategies and approaches for welcoming, engaging with, and working alongside whanau. While content for four sessions is provided, initial priorities outlined within the guide include:

- Provision of information and education
- Opportunities for whanau to discuss fears and concerns
- Encouraging whanau to share their own whanau processes, such as those around decision-making, communication patterns, and responsibility.
- Determining other priorities which may exist for whanau, such as finances, housing, employment and transport.
WHAT WORKS FOR FAMILIES IN CHILD AND ADOLESCENT MENTAL HEALTH / ALCOHOL AND OTHER DRUG SETTINGS

When surveying efficacy and effectiveness findings by population, there is general consensus of strongly positive outcomes in CAMH settings for family therapy with families of children/young people with externalizing disorders (Carr, 2009; Diamond & Josephson, 2005; Asen, 2002a; Cottrell & Boston, 2002), specifically children/young people with (i) attention disorders, (ii) conduct and behavioural disorders, and (iii) substance misuse disorders. Additionally, there is a strong evidence base for the effectiveness of family therapy following family or child experiences of child abuse and neglect (Carr, 2009) and with families of young people with eating disorders (discussed in the following section). There is also an emerging evidence base for family therapy with families of children/adolescents with other internalizing disorders, such as depression, psychosis, Obsessive Compulsive Disorder (OCD), and anxiety, all of which are discussed in the following section.

While three key evidence reviews form the basis for this chapter, given their extensive reviewing of the family therapy literature and their focus on family therapy in child and adolescent mental health settings and populations (Carr, 2009; Diamond & Josephson, 2005; and Cottrell & Boston, 2002), each of these reviews is supplemented by evidence to support or detail findings and conclusions. In addition, (Appendix A) provides a summary matrix of the seven evidence reviews predominantly cited in the family therapy literature. Of the three utilized within this survey, Cottrell and Boston (2002), in their review of the effectiveness of systemic family therapy for children and adolescents (by diagnosis), identify a number of methodological limitations to the evidence base informing family therapy in child and youth services. However, despite initial concerns, the authors assert that there is “good evidence” for the effectiveness of systemic family therapies in the treatments of families with children with conduct and attention disorders, substance misuse, and eating disorders, and support for the family therapy as a second tier treatment in childhood depression and chronic illness. Diamond and Josephson (2005) present a 10-year update of family-based treatment quantitative research published in the Journal of the American Academy of Child and Adolescent Psychiatry (by diagnosis) and, in addition to providing a summary of family risk factors by diagnosis, also conclude that family based treatments have proven effective for children and young people with externalizing disorders, and in particular conduct, attention, and substance misuse disorders, while there is emerging evidence for the effectiveness of family treatments for depression and anxiety. Three themes dominate Diamond and Josephson’s (2005) review – a move away from a strict interpretation of “family systems theory”, more flexibility and integration of family based interventions and use of the term “family based interventions”, and acknowledgement that the growing evidence base for family interventions occurs alongside marginalization of psychotherapy from psychiatry. However, the authors aim to demonstrate that treatment of children and adolescents is enhanced by attention to the family context of a child’s problems (p. 874). Finally, Carr (2009), in an update of his 2000 review of meta-analyses, systemic literature reviews, and controlled trials for the effectiveness of family therapy and systemic
interventions for child focused problems (by diagnosis), determines that family therapy and family based interventions (such as parent training) are effective alone or as part of a multi-modal programme in sleep, feeding and attachment problems in infancy; child abuse and neglect; and families with children/adolescents conduct problems; emotional problems; eating disorders; and somatic problems.

5.1 FAMILIES OF CHILDREN/adolescents WITH EXTERNALISING DISORDERS

Carr (2009) in his review of the evidence base for family based systemic interventions with children and young people with conduct problems concludes that family based interventions are effective for a proportion of families with children/adolescents with externalizing disorders, such as children/young people with behavioural problems (oppositional defiant disorder), attention deficit disorder, pervasive adolescent conduct problems, and drug abuse. For the purpose of this survey, the evidence base for family therapy with families with children with attention and over-activity problems, young people with conduct and behavioural problems, and young people with substance misuse problems is described separately. Carr (2009) determines that behavioural parent training, such as Brinkmeyer and Eyberg’s (2003) Parent-Child Interaction Therapy and Incredible Years (Webster-Stratton & Reid, 2003) are evidence based, effective programmes for treating childhood survey problems in general. More specifically, Carr (2009) determines that efficacious treatment for children with attention and over-activity problems combines family therapy, school based programmes, and coping skills training within a multi-modal programme, alongside stimulant medication, with the family therapy component focused on helping families to develop patterns of organisation conducive to effective child management (Anastopoulos, Shelton & Barkley, 2005).

Bjornstad and Montgomery (2005) provide a comprehensive Cochrane review of the evidence base for family therapy for families of children/young people with attention deficit disorder or attention-deficit hyperactivity disorder which sits reasonably comfortably alongside Carr’s findings. Despite only two of 26 studies meeting criteria for inclusion in the review, the authors determine that a behaviourally-oriented, multi-component family therapy programme may be as effective as “normal treatment” for some children and families (who cannot or prefer not to use medication) and possibly more effective than a medication placebo (p.9). Of note, both studies selected for the review examined the effectiveness of behavioural family therapy (combining behavioural parent training with medication) for children diagnosed with ADHD and as such the authors were unable to recommend a specific treatment technique.

With regard to the effectiveness of family therapy for families of children/young people with conduct disorders, the evidence base is impressive – problematic, but impressive nonetheless. While there are the usual methodological concerns with the empirical research, such as sample size, true randomization, and clinical utility, there is also contention around the prolific evidence base for resource intensive programmes which may or may not fit under the realm of “family therapy”, such as Multi Systemic Therapy (MST). Given that MST is probably better classified as a “service delivery framework” as
opposed to a specific family therapy technique. However, given the significant following of MST within family therapy and the relative effectiveness of MST programmes both internationally and locally, a review of the evidence base for MST is included in this survey.

**Evidence Note: Multi Systemic Therapy (MST)**

MST is an intensive, multi-modal, family based treatment approach aimed to empower families to cope with the challenges of children with emotional and behavioural problems, and to empower young people to cope with family, peer, school, and neighbourhood influences (National Mental Health Association, 2004). Cited as one of the best available treatment approaches for youth with mental health issues who are involved in the juvenile justice system (National Mental Health Association, 2004), there is an extensive body of research supporting the short term effectiveness of MST with juvenile populations with emotional and behavioural problems (National Mental Health Association, 2004), with reductions of up to 70% in long-term rates of re-arrest, reductions of up to 64% in out-of-home placements, significant improvements in family functioning, and decreased mental health problems in serious juvenile offenders (Greenbaum, Foster-Johnson, & Petrila, 1996). Kazdin (2002) and Martens (1997) suggest that there is only mixed evidence for the long term success of MST, with Martens (2004) speculating a number of reasons for this, including a lack of attention to the neurologic treatment of neurobiological correlations with anti-social survey; co-occurring disorders; other evidence-based therapeutic treatment models; and environmental and cultural factors.

Martens (2004) offers a number of “evidence based suggestions” for improvement of MST with antisocial youth. These include careful consideration of the impact of a young person’s pro-social survey in their anti-social environment or the belief that many young people have that being pro-social is “boring”, offering specific retreatment of co-occurring mental health disorders including substance abuse, and a host of other suggestions around combination therapies, increased responsibilities, adequate housing and guidance, capturing important learning moments, and consideration of cultural influences. Martens (2004) also suggests adding a neurologist, a forensic psychiatrist, a neuro feedback specialist, a paediatrician, a trauma therapist, and a social worker to the standard MST team to enhance the effectiveness and improve the long term outcomes of MST (p. 392).

One of the key issues with the research around MST is that most studies have involved direct oversight of one or more of the principal developers of MST, Drs. Scott Henggeler and Charles Borduin (Timmons-Mitchell, Bender, Kishna, & Mitchell, 2006). Timmons-Mitchell et.al (2006) conducted the first trial of MST with juvenile offenders in a “real-world mental health setting “in the USA that did not involve oversight from the model developers. Outcomes measured included re-arrest and improvement in functioning, and both were partially supported by the research, although insufficient sample size (n=93), budgetary constraints, lack of specific information regarding” treatment as usual”, and generalisability of the programme were noted limitations of the study. One of the significant successes of the research
may be the independence of the investigators and recommendations gleaned for implementing MST in “real world settings”. These recommendations include securing adequate funding to support programme development, implementation, and evaluation; ensuring the implementation of the model with fidelity is a priority (as opposed to trying to make the model fit with “business as usual”); and following all the recommended programme practices, including employing dedicated MST therapists, providing cell phones to staff to facilitate access to families, and ensuring caseloads do not exceed six families/therapist (Timmons-Mitchell et al., 2006, p. 235).

Cottrell and Boston (2002), in their review of the effectiveness of systemic family therapy with children and adolescents, determined that Functional Family Therapy (FFT) and Multisystemic Therapy (MST) are two of the best supported family-based interventions in the treatment of young people with conduct problems. In addition, Eyberg, Nelson, and Boggs (2008) in their review of the literature published between 1996-2007 on psychosocial treatments for child and adolescent disruptive survey (including oppositional defiant disorder and conduct disorder), identified 16 evidence based treatments, with nine “possibly efficacious” treatments also included. While no single intervention emerges as “best” (p. 223) the 16 evidence based treatment protocols included Multidimensional Treatment Foster Care (Westermark, Hansson, & Vinnerljung, 2007) and Multisystemic Therapy (Henggeler & Lee, 2003), with Parent Management Training Oregon Model (Patterson, Reid, Jones, & Congor, 1975) being the only intervention to meet the criteria for a well-established treatment. Based on the evidence, the authors also recommend that clinicians consider parent-training as the first line approach for working with younger children and reserve direct child-training approaches for working with older children and youth (p.223).
Evidence Note: Functional Family Therapy (FFT)

FFT is a 90 day, intensive and comprehensive family based intervention programme for youth with behavioural problems, developed in 1969. It has a core set of theoretical principles in which behavioural problems are seen as a representation of the family relational system (Littell, Winsvold, Bjorndal & Hammerstrom, 2007). The overarching goals of FFT include changing the maladaptive behaviours of young people and families; reducing personal, societal, and economic consequences of disruptive behavioural disorders; and being more cost-effective than many other treatments available (Alexander & Sexton, 2002). Research indicates that FFT is particularly effective at reducing recidivism, with re-arrest rates being approximately 25% for youth who participate in FFT as compared with youth who receive no treatment, eclectic treatment, or appear in juvenile court (re-arrest rates range from 45%-70%). Sexton and Alexander (2000) in a five-year follow-up found that less than 10% of youth who participated in FFT had a subsequent arrest, as compared to almost 60% of re-arrests in youth who appeared in juvenile court. In addition, Sexton and Alexander’s (2000) research showcases the importance of training social workers in FFT as cost/case and rate of out-of-home placements are significantly less when workers are well trained in the model and can replicate it with fidelity.

Evidence Note: Multidimensional Treatment Foster Care (MTFC)

MTFC is an intensive, highly structured, goal oriented treatment programme (Westermark, Hansson, & Vinnerljung, 2007) based on the philosophy that for many young people with anti-social behaviour the most effective treatment is likely to take place in a family environment in which systematic control is exercised over the contingencies governing the young person’s behaviour (Fisher & Chamberlain, 2000, p. 3). The object of MTFC is to provide young people who have serious and chronic problems with delinquency, with close supervision, fair and consistent limits, predictable consequences, a supportive relationship with at least one mentoring adult, and limited exposure and access to antisocial peers. The aim is to decrease delinquent behaviour and increase participation in developmentally appropriate social activities (p.3). Evaluations of MTFC demonstrate that youth spent 60 fewer days incarcerated, had significantly fewer arrests, ran away 3 times less often, and had less hard drug use than a control group (Chamberlain & Reid, 1998; Eddy & Chamberlain, 2000; Leve, Chamberlain, & Reid, 2005; Chamberlain, Leve, & DeGarmo, 2007). Research cautiously recommends MTFC as an effective intervention for reducing criminal referrals, out-of-home placements, anti-social behaviour, and incarceration rates, for Caucasian youth, as compared with group (usual) care. Potential limitations with the research completed to date include the developers (Chamberlain & Reid, 1998) as principal researchers/researchers in all four cited studies; sample size and demographics; and initial studies requiring replication.
On a related note, although only a handful of studies - typically fraught with methodological limitations relating to sample size; gender and diagnosis of participants; and length of trial (Nickel et. al, 2005, p. 254) there is emerging evidence that family therapy may be effective in the treatment of children/adolescents engaging in bullying surveys. Nickel et al. (2005) measured the effectiveness of outpatient family therapy with 22 boys engaging in bullying surveys and 20 girls (Nichol et al., 2006), and found that engagement in outpatient FT (specifically Brief Strategic Family Therapy) may be effective in reducing anger and improving interpersonal relationships and health related quality of life in boys, and reduction of bullying and risk taking surveys, and expressive aggression in girls.

Specific to the effectiveness of family therapy with families of young people with substance abuse issues, Carr (2009) purports that, based primarily on the work of Williams and Chang (2000) and Liddle and his team (Liddle, 2004; Ozechowski & Liddle, 2000; Rowe & Liddle, 2003), family therapy is more effective in the treatment of families of young people with drug misuse issues, as compared to individual treatment, therapeutic communities, outward-bound programmes, and selected 12-step programmes. In addition, reviews found family therapy to more effective than other individual or group psychotherapies, across three variables (engaging and retaining young people in therapy; reduction of drug use; and improving adjustment), as well as demonstrating better outcomes long term, and being more cost-effective that alternate treatments, including residential treatment.

Specifically, the research indicates that effective family therapy in the treatment of young people with drug abuse issues requires regular family sessions over a 3-6 month period, in combination with direct multidisciplinary work with young people, with therapy intensity matched to severity of problems (Carr, 2009). Carr (2009) considers specific phases of treatment and recommends Liddle’s (2005) Multidimensional family therapy and Szapocznik, Hervis and, Schwartz’s (2002) Brief Strategic Family Therapy as strongly evidence-based, manualised techniques effective in family work with families with young people with drug abuse issues (Carr, 2009, p. 17).
Evidence Note: Multidimensional Family Therapy (MDFT)

MDFT (Liddle, 2002) is recognized as a model programme by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is a manualised treatment for adolescent drug abuse and related issues that aims to reduce psychological symptoms and enhance developmental functioning by facilitating change across a number of behavioural domains (Hogue and Liddle, 2006). MDFT has four interdependent treatment domains (adolescent; parent; interactional; and extra familial) that target multiple aspects of adolescent and family functioning, and provides assessment and intervention multisystemically with adolescents and parent/s individually, the family as an interactive system, and individuals in the family relative to their interactions with influential social systems that will impact on a young person’s development (SAMHSA, 2008b). With regard to research evidence, the effectiveness of the MDFT system has been ascertained by several RCT’s, as well as studies undertaken using a process methodology, economic analyses, and implementation of MFDT in clinical settings (SAMSHA, 2008b). Specific outcomes drawn for the research include decreases in substance use (up to 93% of young people receiving MDFT reported no substance related issues at one year post intake); reductions in negative attitudes and surveys and improvements in positive attitudes and surveys; and improvements in school functioning (SAMHSA, 2008b). Additional positive outcomes are related to cost (whereby MDFT costs significantly less than other standard treatments) and the successful engagement and retention of young people within the programme. Barriers to the programme noted by the SAMSHA (2008b) review include ensuring that therapists have access to quality training, support and supervision, and ensuring that services have adequate resources available to train staff and deliver the programme.
Evidence Note: Brief Strategic Family Therapy (BSFT)

BSFT is a model programme endorsed by SAMHSA (2008a), which aims to prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve prosocial behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school. BSFT is typically delivered in 12-16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family. Sessions are conducted at locations that are convenient to the family, including the family's home in some cases. Hispanic families have been the principal recipients of BSFT, but African American families have also participated in the intervention. Outcomes reported by SAMHSA are linked to five key variables; Engagement in therapy, conduct problems, socialized aggression (delinquency in the company of peers), substance use, and family functioning. Specific findings drawn from seven generally well designed studies include decreases in substance use (75% reduction in marijuana use); reductions in negative attitudes and survey (42% improvement in conduct problems and 58% reduction in association with antisocial peers); improvements in positive attitudes and surveys, specifically self-concept and family functioning; and increased family engagement and retention in therapy, increased parental involvement and more positive/effective parenting, and improved family cohesiveness and connectedness (p. 4). Three studies have replicated the efficacy of BSFT in increasing family participation in therapy. With regard to fidelity, in order to achieve outcomes cited by the developers the programme requires sufficient numbers of BSFT certified counsellors; a start-up period of one year; an administration agency to support families and facilitate sessions; intensive supervision, videotaping of sessions, and counsellor participation in training and technical assistance (SAMHSA, 2008a).

Just as it may be contentious to assert that family therapy is a promising practice in the treatment of childhood depression (see following section), it may also be contentious to assert that family therapy is an empirically supported intervention in the treatment of children and young people who have experienced abuse and neglect. However, Carr (2009) provides one of the most comprehensive reviews of the evidence base for family therapy in the treatment of child abuse and neglect, determining that systemic family interventions are effective in a proportion of physical abuse and neglect and sexual abuse cases. Specific to childhood physical abuse and neglect, Carr concludes that effective systemic therapy needs to be family based, structured, of six months duration or longer, and address specific concerns relating to a child or young person’s post-traumatic adjustment; parenting skills deficits; and overall supportiveness of family and social networks. Three empirically supported programmes for the treatment of families and children/young people following physical abuse and neglect are described: Cognitive Behavioural Family Therapy; Parent-Child Interaction Therapy; and MST.
Specific to childhood sexual abuse, Carr (2009) concludes that trauma-focused CBT is the treatment of choice for abused young people and their non-abusing parents, with child-focused individual therapy alongside concurrent family therapy sessions, focused on helping parents develop supportive and protective relationships with their children, and to develop support networks for themselves. Hetzel-Riggin, Brausch and Montgomery (2007) in their meta-analysis of 28 studies investigating independent effects of different therapy modalities for sexually abused children and adolescents, also determined that family therapy (in addition to cognitive-behavioural therapy and individual therapy) is the most effective intervention for children and young people experiencing psychological distress.

**Evidence Note: Just Therapy**

Just Therapy is a family therapy programme developed by the Family Centre (Lower Hutt, New Zealand) in 1979. The programme is described as a “reflective approach to therapy” and was developed by workers at the Centre to include consideration of the broad cultural, gender, social, spiritual, economic, and psychological influences which underlie the problems experienced by the people with whom family therapists work (Waldegrave & Tamasese, 1994; Waldegrave, 2005). Just Therapy is an extension of the Family Centre’s commitment to the eradication of racism, sexism, and poverty, and is a programme endorsed by UK Cabinet Office Social Exclusion Task Force (2008) as an effective programme addressing family issues associated with poverty, abuse and neglect.

### 5.2 FAMILIES OF CHILDREN/YOUNG PEOPLE WITH INTERNALIZING DISORDERS

As mentioned previously, there is generally an emerging evidence base for the effectiveness of family therapy with families of children/young people with internalizing disorders, specifically depression, borderline personality disorder, and obsessive-compulsive disorder, with one exception: a strong evidence base for the effectiveness of family therapy with families of young people with eating disorders.

Specific to the effectiveness of family therapy with families of young people with eating disorders, Diamond and Josephson (2005) present family risk factors for eating disorders based on four themes; parental modelling, parental reinforcement, general family discord (Littleton & Ollendick, 2003) and dysfunctional family interaction. Other risk factors may include insecure child attachment, parental criticism, parental intrusiveness and over-control, reduced family cohesion, and physical or sexual abuse (Polivy & Herman, 2002). Eisler (2007) appears to disagree with the somewhat rudimentary list of family risk factors for children and young people with eating disorders, stating that inconsistent and unwarranted conclusions drawn from a methodologically challenged evidence base, means that there is
no magical or consistent pattern of family structure or family functioning in families with a child/young person with an eating disorder (p. 110).

In terms of intervention, Robbins, Szapocznik, Alexander, and Miller (1998) identify promising findings for the effectiveness of strategic and structural family systems therapy in the treatment of psychosomatic disorders, including eating disorders, and, in particular, based on studies completed by Dare and colleagues (for example see Dare, Eisler, Russell, & Szmukler, 1990) which compares the efficacy of strategic/structural family therapy to individual therapy for children and young people with anorexia and bulimia nervosa. Diamond and Josephson (2005) outline four “well designed” family based studies of family therapy models/techniques used in the treatment of eating disorders published between 1995 and 2005. Specific models/techniques reviewed included Behavioural Family Systems Therapy (as compared to Ego-oriented Individual Therapy (Robin, Siegel, Loepke, Moye, & Tice, 1994; Robin et al., 1999)); conjoint and separated family therapy (Eisler et al., 2000); “family therapy” (as compared to family psychoeducation (Geist, Heinman, Stephens, Davies, Katzman, 2000)) and the Maude’sy Model (Le Grange, Binford & Loeb, 2005). Findings drawn from all four studies determined few differences in the effectiveness of each of the models, although all models are deemed effective. Eisler’s (2005) systematic narrative review of eleven treatment trials, six uncontrolled and five randomized, concluded that post family therapy treatment, up to two thirds of young people with eating disorders will regain a healthy weight, with full recovery in 60-90% of young people at 6 month-6 year follow up. There was a negligible relapse rate, which outweighs moderate outcomes for individual therapy and high relapse rates following inpatient treatment. Interestingly, Eisler’s (2007) more critical review of the evidence base for family therapy in clinical work with adolescents with anorexia nervosa, makes particular reference to 10 studies published between 1978 and 2004, and more specifically Minuchin and colleague’s studies (1975; 1978), which demonstrate the effectiveness of family therapy treatments with adolescents with anorexia nervosa, often without the need for inpatient or individual treatment (p. 106). Eisler (2005) is wary, however, of public assertions that family therapy should be the “treatment of choice” for families of children and young people with eating disorders given methodological limitations within the current research base; the lack of research comparing family therapy with other treatments; and the predominance of a “structural bias” in the current evidence base, often without systematic evaluation of other family therapy techniques used in the treatment of eating disorders (such as Milan Systemic, strategic, feminist, attachment, solution focused, and narrative) or comparison across the models (p. 109).
Evidence Note: The Maudsley Model

Gaining significant attention in the treatment of young people with eating disorders is the Maudsley Model, which offers a non-pathologising approach to families, standardization of treatment techniques, and a strong history of empirical support (Rhodes, 2003). The model is delivered in three distinct phases (Re-feeding the patient; Negotiating a new relationship; and Adolescent issues and termination). Rhodes (2003) details the theoretical foundations, stages of treatment, and empirical support for the Maudsley Model of family therapy for children and young people with eating disorders, suggesting that the development and evolution of the model alongside robust empirical review, and the integration of modern and postmodern influences within the model, are relatively rare occurrences within family therapy. Specific to the “robust empirical support” for the model, Rhodes (2003) summarizes the findings from nine studies, eight conducted at the Maudsley Hospital, which confirm the long term effectiveness of outpatient family therapy treatment, specifically utilizing the Maudsley Model, for families of young people with eating disorders.

With regard to the effectiveness and efficacy of family therapy with children and young people with other internalizing disorders, while it may prove contentious to place “childhood depression” in the emerging evidence section of this survey, Robbins et al. (1998) were unable to identify a single study examining the efficacy of family systems therapy with children/young people with depression, although two promising practices are identified. Cottrell and Boston (2002) cite a number of studies which conclude that while family therapy cannot be deemed ineffective in the treatment of families with children/adolescents with depression, it is too early to recommend family therapy as the treatment of choice (p.581). This is further substantiated by Cottrell’s (2003) review of outcome studies in child and adolescent depression and Diamond and Josephson’s (2005) research review. Diamond and Josephson (2005) identify a number of family risk factors associated with childhood depression, drawn from the literature, which include parental depression, marital conflict, ineffective parenting, loss, negative parent-child interaction, and insecure attachment (p.874). In terms of evidence based family interventions, Diamond and Josephson (2005) determine that while few family based treatments have been validated for this population, Attachment-Based Family Therapy (Diamond, Reis, Diamond, Siqueland & Isaacs, 2002) and Behavioural Family Therapy (Thompson, Pierre, Asarnow, McNeil, & Foggler, 2003) are promising practices. Multifamily, psycho educational group therapy (Fristad, Gavazzi, Centoella & Soldno, 1996) and Family CBT (Pavuluri et al., 2004) are promising adjunct practices, alongside medication treatment, for children and young people with mood disorders (including bipolar disorder and depression). Oswald and Mazefsky (2006) in their review of empirically supported interventions for internalizing disorders in children and adolescents, noted a number of efficacious individual treatments for childhood depression, and confirmed Diamond et al.’s (2002) Attachment-Based Family Therapy as a “promising practice” in the treatment of adolescents with depression.
Evidence Note: Attachment Based Family Therapy (ABFT)

Diamond et al., (2002) in their treatment development study of the design for a treatment manual and adherence measure for Attachment Based Family Therapy (ABFT) for adolescent depression, and the collection of pilot data regarding treatment efficacy, concluded that ABFT was a “promising treatment” in the treatment of young people with depression. ABFT focuses on helping families to identify and resolve core family conflicts that have inhibited young people from trusting their parents and using them as a source of emotional support (Diamond & Josephson, 2005). In Diamond et al.’s study in 2002, following 12 weeks of ABFT, 81% of participants no longer met the criteria for Major Depressive Disorder (as compared with 47% of minimal contact, waitlist control). Mixed factor analyses of variance showed that compared to the waitlist control, participants treated with ABFT showed a significant reduction in both depressive and anxiety symptoms and family conflict. In addition, of the 15 cases assessed at 6-months follow up, 87% continued to evade a diagnosis of MDD. While a pilot study, and fraught with limitations around the use of a waitlist control; sample size (n=32), and participant demographics, the authors believe that the findings from the study, in combination with the well-structured, easy to follow, manual and validated adherence measure, ABFT may be viewed as a viable and effective treatment for youth depression (p.1195). Pruitt’s (2007) comparison of the limited research base informing Structural Family Therapy, Interpersonal Family Therapy and Attachment-Based Family Therapy in the treatment of young men with depression, determined that each of the tools required significantly more research and review, but that each also provided a unique treatment focus – that is, assisting young men and their families to identify and change negative family structures using SFT; discovering and challenging maladaptive cognitions, relationships and behaviours in IFT; and noticing and repairing attachment injuries in ABFT (p. 79).

Diamond and Josephson (2005) identify two primary family risk factors associated with childhood anxiety, drawn from the literature, which include controlling and over-protective parenting, and parental modelling/reinforcement of anxious or avoidant behaviours. With regard to family therapy, Diamond and Josephson’s (2005) review of the use of individual and group CBT compared with CBT and a behavioural family intervention (BFI) across three studies (Barrett, Dadds & Rapee, 1996; Barrett, 1998; and Cobham, Dadds & Spence, 1998) concluded that the combination CBT and BFI package demonstrated superior outcomes for post-treatment diagnosis; at 6 months follow up; for girls and younger children in particular; on family related measures; and on internalizing and externalizing scores on the CBC, suggesting generalization of improvement (Barrett et al., 1996; Barrett, 1998). Cobham et al.’s (1998) replication of Barrett’s 1996 study concluded that family interventions for anxiety may be most effective when parents are anxious. Creswell and Cartwright-Hatton (2007) examined the efficacy of family-based cognitive therapy in the treatment of childhood anxiety and examined some of the factors that influence efficacy, including choice and timing of outcome measure, age and gender of the
identified child, level of parental anxiety; severity and type of child anxiety, and treatment format and content. While necessarily tentative in their conclusions, the authors determine that Family CBT is likely to be more efficacious than no treatment and for some outcomes, may be superior to Child CBT, with improved long-term outcomes for both children and families following Family CBT. Oswald and Mazefsky (2006) in their previously mentioned review of empirically supported interventions for internalizing disorders in children and adolescents, identify two promising family based interventions for families with children with anxiety; FRIENDS (Barrett & Shortt, 2003; Shortt, Barrett, & Fox, 2001) and Family Anxiety Management Treatment (Barrett et al., 1996).

The evidence for family therapy in the treatment of families of children and young people with OCD is best described as “lacking” although there are some promising practices identified in this area. Specific to older children and adolescents with OCD, Barratt et al. (2005) evaluated the long term effects of individual and group Cognitive Behavioral Family Therapy (CBFT) for childhood OCD, as well as investigating pre-treatment predictors of long term outcomes. Participants and parents were assessed at 12 and 18 month follow up, following participation in individual or group CBFT. The study found that CBFT for childhood OCD may provide long term relief equally effective to individual and group based therapy, and that focusing on addressing family dysfunction may improve a child’s long term prognosis. Despite this being the largest study published to date on childhood OCD (n=48), the authors acknowledge that statistical power was compromised by the small sample size.

While also acknowledging the lack of research on efficacious treatments for OCD in younger children, Oswald and Mazefsky (2006) in their previously mentioned review of empirically supported interventions for internalizing disorders in children and adolescents, identify Freeman et al.’s (2003) pilot of a family based treatment for children aged 5-8 years as a “promising approach” (p.444). The programme is based on an exposure and response prevention model, but incorporates behavioural management training for parents, and education on family management and reinforcement for anxiety, with parent participation viewed as integral to the treatment’s success (Freeman et al., 2003).

Santisteban, Muir, Mena, and Mitrani (2003) outline a promising integrated family therapy intervention in the treatment of young people diagnosed with borderline personality traits/disorder and drug misuse issues. There are few studies which measure the effectiveness of family therapy with young people with BPD, and indeed some debate regarding the appropriateness of diagnosing of young people with BPD. However, the authors have integrated DBT strategies with established structural, brief strategic and developmental family interventions to develop the Integrative Borderline Adolescent Family Therapy model (I-BAFT). While still very much in the early stages of development and testing, the strong empirical support for the models which the I-BAFT is based on mean that the authors consider I-BAFT to be a “promising intervention with high feasibility and acceptability” (p. 263).
5.3 FAMILY THERAPY AND INFANT MENTAL HEALTH

While outside the scope of this survey, but considering the ideal partnership between family therapy and infant mental health, few studies or publications were located as part of this survey which focused on the effectiveness of specific models of family therapy in addressing infant mental health issues. As mentioned previously, Carr’s review (2009) determined the effectiveness of family therapy and family based interventions for infants with sleeping, feeding, and attachment concerns. More specifically, Stores (2001) advocates for the use of family based behavioural interventions for settling and night waking problems, while Mindell (1999; 41 studies) and Ramchandani, Wiggs, Webb, and Stores (2000; 9 RCTs) reviews indicate that both family based and pharmacological interventions demonstrate effective outcomes in the short term, but only systemic interventions have positive effects on resolving sleep issues in the longer term (Carr, 2009). In terms of feeding, Kedesdy and Budd (1998) and Kerwin (1999; 29 studies) determined that family based interventions are effective in addressing severe feeding problems in infancy, such as those associated with failure to thrive, including food refusal, self feeding difficulties, swallowing problems, and vomiting (Carr, 2009). Finally, with regard to infant attachment, Bakermans-Kranenburg, Van Ijzendoorn and Juffer (2003) in their meta-analysis of 70 studies evaluating interventions which aim to reduce attachment insecurity, determined that brief, highly focused, family-based interventions specifically aimed to improve maternal sensitivity were particularly effective, with the most effective interventions being those that focused on coaching mothers to develop sensitivity to infant cues; involved fathers; and were no more that 15 sessions (Carr, 2009).
INNOVATIVE FAMILY PRACTICE AND PERSPECTIVES IN NEW ZEALAND

This section provides a brief summary of policy influences in family therapy practice in New Zealand. It also includes findings drawn from interviews with nine selected key informants/stakeholders in the family therapy field in New Zealand.

In terms of policy and context in New Zealand, recent highlights that pertain to this survey include the development of the Families Commission in 2004 with their most recent publication being Healthy Families, young minds and developing brains: Enabling all children to reach their potential by Charles Waldegrave and Kasia Waldegrave (2009), and the inclusion of Standard 10 (Family, Whanau Participation) in the National Mental Health Standards and Objective 3.3 in the National Mental Health Strategy, to improve the responsiveness of mental health services to families and caregivers. The Mental Health Commission (2008) suggests that while there is no external monitoring of standards implementation, all DHBs should have implemented Mental Health Standard 10 as a nationally recognized standard for DHB services. While not related directly to inclusion of family therapy in DHB ICAMH services, specific suggestions made by the Mental Health Commission for improving family/whanau participation in services include; policy development in the provision of support and information for families; involvement of families at the level of the individual service user; opportunities for families to provide feedback; collection of feedback from families; support for the organisation and staff from families (including appointment of a family advisor); and support for staff.

In light of these events, in 2007, the Werry Centre developed a comprehensive set of guidelines for services, to enable family whanau participation in child and adolescent mental health and AOD services in New Zealand. The guidelines advocate a “participating in partnership” approach to family whanau participation that services can utilise to move participation with families from “tokenistic to partnership”.

6.1 KEY INFORMANT INTERVIEWS

As mentioned above, nine key stakeholders/experts in the family therapy field in New Zealand participated in phone interviews, conducted between April 2009 - May 2009. Interviewees were asked to comment on training opportunities (in Australia and New Zealand) available to people wanting to become more skilled in family therapy, to become family therapists, or to develop skills and knowledge in family therapy; key training and workforce development barriers and challenges for family therapists working in New Zealand; and key training and workforce development opportunities for family therapists working in New Zealand. Detailed notes were kept throughout the interviews and analysed for key issues or themes, described below.
TRAINING

A comprehensive list detailing family therapy training available in both Australia and New Zealand is included in Appendix B. As well as “on the job” being recognised as one of the key areas where family therapists are trained in New Zealand, specific training opportunities that interviewees highlighted included the Bouverie Centre (Victoria, Australia); Australian University Programmes (Brisbane, New South Wales, Queensland); New Zealand University Courses (paper options offered at Canterbury, Waikato, Otago, Massey); Just Therapy – Family Centre, Lower Hutt; Human Development and Training; Solutions Un-Limited – Family Therapy 1-2-3 (Rick Whiteside); and Narrative Therapy – Johnella Bird/David Epston, Family Therapy Centre, Auckland. One informant is currently involved in development of a Postgraduate Diploma in Family Work, which is to be offered through Unitec in the near future.

BARRIERS AND CHALLENGES

When interviewees were asked to comment on barriers and challenges to family therapy workforce development and training in New Zealand, numerous issues were discussed, and four key themes emerged: 1) Access to training, exemplar programmes, research, and supervision; 2) Appreciation of “the bigger picture”; 3) A chequered past; and 4) Looking after our workforce.

Access to Training, Exemplar Programmes, Research, and Supervision

The lack of a range of family therapy training opportunities available in New Zealand, and the inadequate resourcing of the training that is available, appear to be the key challenges to the advancement of family therapy practice in New Zealand. Interviewees were in general agreement, however, that access to quality training opportunities is not the single answer to development of the family therapy workforce. Key to the success and the growth of family therapy in New Zealand is instead three-fold – that is, access to quality training, exemplar programmes and quality placements, research that is relevant to the New Zealand context, and quality supervision. One interviewee commented on the need for improved communication and planning between training providers (and in particular, tertiary education providers) and services, to ensure that there is a better fit between education, career pathways and opportunities, along with staffing requirements. Another interviewee expressed concern about the impact of an increased prevalence of US-developed programmes, such as MST, in New Zealand. Such programmes which are based on family therapy models may instead be service frameworks which offer “pragmatic strategies for brokering interventions with families”. The interviewee felt that this approach assumes clinicians offering these programmes will have a certain level of family therapy knowledge and skills without mandatory provision of appropriate training and support. A third interviewee questioned the value in offering a family therapy degree in New Zealand, given that family therapy is not a recognised profession in this country, and there is no compulsory accreditation or competency monitoring of family therapists under an Association or the HPCA Act (2004). The interviewee felt that it might be better to acknowledge that the majority of family therapists working in New Zealand have core training in another discipline (such as psychology, nursing, social
work, or occupational therapy) and that DHB’s are more likely to hire family therapists who are able to be accredited or monitored under the requirements of their core discipline. Another interviewee expressed significant concern around the lack of a “practice component” evident in a number of family therapy training programmes, and a lack of opportunities for students to be observed in practice and critiqued by a senior practitioner or mentor. It was also agreed that CAMH/AoD workers need to have core skills in engaging with and supporting families/Whanau.

**Appreciation of “The Bigger Picture”**

Many interviewees commented on the impact of current service delivery frameworks in ICAMH services that appear to favour “individualised, high risk, emergency focused” work. This included a tendency for services to isolate busy families by being inflexible about access to after-hours, weekend, and in-home care. One interviewee commented on the “burn-out” experienced by families forced to work with multiple agencies and professionals, especially when coping with complex mental health and care and protection issues, they also commented on the recognised value in engaging well with these families early on, to ensure best outcomes for families, children, and young people.

Another commented on the over-representation on the “bio” in biosychosocial models of practice evidenced in our services – an emphasis on diagnosis and medication, which has been influenced by a reliance on the DSM-IV as a diagnostic tool, and the perception that there is a link between diagnosis and funding.

**A Chequered Past**

A number of interviewees detailed their perspectives on the history of family therapy practice in New Zealand. They indicated the impacts that this history may have had on current values and beliefs associated with family therapy practice, and the “fragility” of the place of family therapy in the public health sector. Additionally, a number of interviewees commented on the negative impact that political aspirations, ideological splits and “preciousness” around specific models and techniques has had on the cohesiveness of the family therapy workforce. One interviewee commented on the “outdated” practice of referring families to “specialist family therapy teams”, believing that all staff should have some training in family therapy and that specialist teams would be better utilised to support families with complex needs, while also providing family therapy training, support, and supervision to the rest of the multi-disciplinary team. Another interviewee commented on the general perception within some teams that “working with families” is family therapy, and therefore no additional training/qualifications are required.

**Looking After Our Workforce**

While related to issues about access to quality training, exemplar programmes, relevant research, and quality supervision, many interviewees acknowledged the “underground” and covert experience of family therapy and family therapists working in New Zealand. In addition, high attrition, safety concerns, limited career pathways in public health services, lack of access to quality training and supervision, professional isolation, a perceived lack of respect from other mental health professionals,
and the lack of a National Association were key issues described as challenges met by the current family therapy workforce.

**OPPORTUNITIES**

When interviewees were asked to comment on opportunities for family therapy workforce development and training in New Zealand, three key themes emerged: The New Zealand Context; A Time for Change; and Evidence Based Practice.

**The New Zealand Context**

All interviewees commented on the current context being the perfect opportunity for re-developing family therapy in New Zealand – in particular, the emergence of service delivery initiatives that actively encourage family, whanau, engagement, participation, and retention. Opportunities for inter-sectoral collaboration in both practice and training were discussed, as was the genuine value that is felt by a number of family therapists when working in ICAMH services, and the general expectation that families should be included in the treatment of their child. One interviewee commented on the enormous potential for family therapy being the fit between health and social services for those groups in society who are marginalised and over-represented in these services.

**A Time for Change**

Many interviewees commented on a sense of an impending “uprising” for family therapy, particularly related to the recent visibility of family centred initiatives, such as the Families Commission and Working For Families; Standard 10 of the National Mental Health Standards (Family, Whanau Participation); the consumer movement; and acknowledgement of our unique cultural context.

**Evidence Based Practice**

While one interviewee described “evidence based practice” as a strategy to “stop conversations” around what works in family therapy and why, a number of other interviewees saw the emergence of the evidence based practice movement and the development of a strong evidence base for “family therapy” as a whole, and (as opposed to specific family therapy techniques or approaches) a real opportunity for family therapy. The availability of evidence-based family therapy programmes, such as MDFC, FFT and MST in New Zealand was generally viewed as a positive development, with the relative ease of implementation and the generally positive outcomes for families being seen as worth the expense of developing and implementing these programmes in New Zealand. A number of interviewees commented that the evidence that family therapy is generally more effective than no therapy, and in some cases (such as with prevention of relapse and remission and when working with children and young people with externalising disorders) more effective than individual therapy, has helped to bolster the profession.
IMPLICATIONS FOR RESEARCH, TRAINING AND WORKFORCE PLANNING

Almost every publication included in this survey contains a concluding section about the implications of findings on family therapy research and practice in the future. Many, such as Carr (2009) and Diamond and Josephson (2005), suggest development of an evidence base for family therapy outside the “top five” and a focus on the systematic evaluation of the effectiveness of different techniques and approaches in clinical settings.

7.1 FUTURE RESEARCH

Diamond and Josephson (2005, p. 882) include seven recommendations for future research in the field, including additional strategies to ensure more family based treatments qualify as empirically supported treatments; increased investigations that match treatment approach with clinical condition, focus on multi-agency, multi-modal collaboration to support service delivery system design, and reflect the “real world” utilization of treatment packages. Few treatment techniques are offered in isolation; increased investigation of common family risk factors across disorders and research on a range of core tenets of family based treatments; dissemination of empirically supported treatments into real world, clinical settings. The final recommendation has particular relevance with respect to the child and adolescent mental health workforce, whereby teams and services are encouraged to forgo an individually focused medical model in favour of a contextual approach to diagnosis and treatment, adopting a family systems approach and thus providing a more comprehensive and multidimensional system for assessment and intervention (p. 883). Additionally, Diamond and Josephson (2005, p. 883) encourage teams and services to choose manualised family treatments in favour of the “individual artistry of early family therapists” to improve intervention focus and structure, treatment outcomes and fidelity, and assert that a family based ICAMH practice may address some of the current concerns relating to the side effects of pharmacotherapy, such as suicidal ideation.

7.3 WORKFORCE DEVELOPMENT

Specific to the development of the family therapy workforce in the United Kingdom, Webster (2002) suggests that the tension between family therapy and evidence based practice, and the ambivalence within the field and within society regarding professionalism, can be addressed by a career structure that links family therapy with other disciplines (such as psychology and psychotherapy) and provision of a model that aligns workforce planning with education. Webster (2002) outlines the process for accreditation as a family therapist through the Association for Family Therapy in the UK (although accreditation and access to an association are not currently available in New Zealand) and suggests that family therapists utilise national mental health standards and plans to insist on acknowledgement of the
need for access to family therapy in clinical services. Webster’s (2002) third suggestion is the development of a career pathway or structure for family therapy that closely aligned with more established disciplines, such as clinical psychology and child psychotherapy pathways. Webster’s (2002) selection of these two exemplar disciplines is based on the leadership demonstrated by the Association of Child Psychotherapy in the UK in developing career structures and securing alignment between training and workforce planning, and the sheer number of clinical psychologists employed in the NHS. In order to successfully address the future training and workforce development needs for family therapy in the UK, Webster (2002) advocates for a national family therapy strategy and coordinated workforce development plans, with alignment evident between the needs of clinical services and family therapy education and training, secure funding available for training, and access to quality supervision.

7.3 TRAINING

Access to quality training and professional development opportunities is one of the key issues influencing the future of the family therapy workforce and is described in both the literature and the key informant interviews. As determined previously, family therapy is not currently a recognized or regulated profession within New Zealand, and there is some disagreement between the key informants as to whether or not it should be. Furthermore, there is some disagreement amongst key informants as to the most appropriate positioning of family therapy training in New Zealand – that is, within postgraduate programmes offered by universities, or through private providers. Proponents of postgraduate qualifications are in favour of family therapy being recognized as a “quality programme of study”, while concerns were expressed around limited access to postgraduate programmes; the potential loss of the “technical aspect of practice” due to a lack of access to exemplar programmes and placement opportunities; and the dilution of “family therapy” in postgraduate qualifications that include a family therapy component but are not a family therapy degree. Proponents of private training attest to the ease of access to family therapy training that is available in a range of settings and communities, and the focus on technical skills that can come from working with a smaller group in a practice setting or with an experienced family therapy mentor and trainer.

7.4 SUPERVISION

Access to quality supervision is another of the key issues influencing the future of the family therapy workforce, as described in both the literature and the key informant interviews. Liddle, Breunlin, Schwartz, and Constantine (1984) describe a programme for training advanced family therapists in the conceptual and technical skills of family therapy supervision, which would still be relevant to family therapy practice today. The Supervisor Extern Programme (SEP), based on the learning-by-doing philosophy, is an advanced, didactic, practice focused programme, committed to developing conceptual and pragmatic skills in family therapy supervision (p. 142). Liddle et al. (1984) provide a detailed
description of the programme but also address a number of key issues related to family therapy supervision, such as ensuring that supervision occurs both within and directly following practice; recognition of the safety and impact that direct supervision of practice will have on families; acknowledging developmental needs of the supervisee/s; addressing roles, expectations, and responsibilities of supervisors and supervisees; and determining the specific skills of quality supervision.

One of the key informants talked in-depth about some of the key barriers to quality supervision of family therapists and family therapy practice in New Zealand, in particular the “invisibility of practice” and “culture of fear” that infiltrated family therapy practice sometime in the last decade. The interviewee suggested that there are a large number of competent and quality supervisors available in the family therapy field in New Zealand, but that these people may not be skilled or confident in making their own practice visible or critiquing the practice of others.
CONCLUSIONS AND RECOMMENDATIONS

This summary of the evidence base for family therapy with families of children and young people referred to child and adolescent mental health/AoD services has revealed a number of unexpected challenges – primarily the uncomfortable history between family therapy and evidence based practice and the vast number of methodological concerns noted in the current reviews; the ongoing practice in the literature to focus and describe family therapy outcomes based on outcomes related to the presenting child; and the lack of research that compares and contrasts different family therapy techniques. Despite these challenges, careful analysis of the available efficacy and effectiveness research, and perspectives drawn from interviews with key informants/stakeholders in the family therapy field in New Zealand, leads to a conclusion– that family therapy is, often, a significantly more effective treatment than no treatment, and specifically effective in the treatment of families with children and young people with externalizing disorders (including attention disorders, conduct and behavioural disorders, substance misuse disorders); families of young people with eating disorders; and following family and childhood experiences of child abuse and neglect.

Acknowledging the lack of research comparing family therapy models and techniques as mentioned above, a review of the available evidence base looking more specifically at best practice family therapy techniques for use in child and adolescent mental health settings cautiously recommends a systemic family therapy approach, with the strongest evidence base indicating Multi Systemic Therapy and Functional Family Therapy; Multidimensional Family Therapy; Brief Strategic Family Therapy; and the Maudsley Model (for children and adolescents with Eating Disorders). It is unwise, however, to suggest that all family therapists working in child and adolescent mental health are trained in one particular family therapy technique. Indeed, Carr (2009) recognizes the effectiveness of a wide range of systemic family based interventions, drawn from cognitive behavioral, strategic and structural foundations, and suggests that the most successful interventions are those that are brief (less than 20 sessions) and offered by a range of professionals on an outpatient basis (p. 29). This sits comfortably alongside the recommendation made by a number of key informants/stakeholders in the family therapy field in New Zealand, that all professionals working in child and family services in New Zealand be trained in general family engagement and support techniques, to ensure that families feel well supported in accessing and engaging with services that provide care for their children and young people. Furthermore, findings drawn from interviews with key informants/stakeholders, reveal that access to training is only one cornerstone of developing the family therapy workforce in New Zealand - with access to exemplar programmes and quality placements, contextually relevant research, and quality supervision being the other three, and flexible, family focused service delivery frameworks which offer after-hours, weekend and in-home care being additional considerations.

Given the challenges described, our recommendations are that family therapy, and family therapists, practicing in New Zealand be provided with a number of opportunities to “become more visible” within child and adolescent mental health services. These opportunities could include:
A symposium for key stakeholders in family therapy to promote collaboration and learning opportunities

Working with child and adolescent service management to develop role descriptions and career pathways to develop specialist family therapy roles

Working with tertiary education providers to develop and promote family therapy courses at post graduate level supported by Skills Matter funding

Development of a national family therapy Association.

Development of a web-based national clearinghouse to ensure a centralised and coordinated approach to the dissemination of research, training, and leadership information.

Promotion of national training programmes in Family Therapy which recognise the unique cultural context in which family therapists working in New Zealand practice, ranging from short orientation courses to comprehensive training courses with a practicum component.

Promotion and provision of training in family engagement and family support strategies for all CAMH and AOD workers

Professional development of family therapy leaders including mentoring and supervision.

Further research of both appropriate indigenous models and applicability of “introduced” models to the New Zealand context.
REFERENCES


APPENDICES

Appendix A: Key Evidence Reviews – Family Therapy

Appendix B: Training Programs in Family Therapy in Australia and New Zealand (Adapted from Special Supplement to ANZJFT, 2008, Vol. 29, No. 3)
APPENDIX A: KEY EVIDENCE REVIEWS – FAMILY THERAPY

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<tr>
<td>1990</td>
<td>Markus, E., Lange, A., &amp; Pettigrew, T.F.</td>
<td>Meta-analysis</td>
<td>19 studies</td>
<td>FT is 76% more effective than alternative/minimal/no treatment. Effect increases during first year post-treatment but can diminish sharply 18 months post-treatment.</td>
</tr>
<tr>
<td>1995</td>
<td>Shadish, W., Ragsdale, K., Glaser, R.R., &amp; Montgomery, L.M.</td>
<td>Meta-analysis</td>
<td>163 RCTs</td>
<td>FT demonstrates moderate, statistically significant, and often clinically significant effects, although no model appears superior and nor is FT superior to individual therapy. Cost-effectiveness information is limited but appears supportive.</td>
</tr>
<tr>
<td>2006</td>
<td>Mental Health Division - Children’s Evidence Based Practices Expert Panel (Update)</td>
<td>Rankings of 67 programmes</td>
<td>67 standardized programmes</td>
<td>Level One Programmes (Best Support) – MST and FFT (Conduct Disorders); BSFT (Disruptive and oppositional disorders); FFT (High-conflict families); BSFT, MDFT, and MST (Substance use and Juvenile offending);</td>
</tr>
<tr>
<td>2000</td>
<td>Carr, A.</td>
<td>Review papers and meta-analyses</td>
<td></td>
<td>Demonstrated effectiveness of family-based treatment across a range of diagnoses in child and adolescent focused problems (child abuse and neglect; conduct problems; emotional problems; psychosomatic problems)</td>
</tr>
<tr>
<td>2002</td>
<td>Cottrell, D., &amp; Boston, P.</td>
<td>Practitioner review</td>
<td></td>
<td>Describes significant methodological issues in the evidence base. Determines systemic FT is an effective intervention for children and adolescents.</td>
</tr>
<tr>
<td>2005</td>
<td>Diamond, G., &amp; Josephson, A.</td>
<td>RCT’s (1995-2005)</td>
<td></td>
<td>FT proven effective for externalizing disorders, particularly conduct and substance abuse disorders, and in the reduction of co-morbid family and school behaviour problems associated with ADHD.</td>
</tr>
<tr>
<td>2009</td>
<td>Carr, A.</td>
<td></td>
<td></td>
<td>Update of demonstrated effectiveness of family-based treatment across a range of diagnoses in child and adolescent focused problems (child abuse and neglect; conduct problems; emotional problems; psychosomatic problems)</td>
</tr>
</tbody>
</table>
APPENDIX B: TRAINING PROGRAMS IN FAMILY THERAPY IN AUSTRALIA AND NEW ZEALAND (ADAPTED FROM SPECIAL SUPPLEMENT TO ANZJFT, 2008, VOL. 29, NO. 3)

<table>
<thead>
<tr>
<th>State/Country</th>
<th>Programme</th>
<th>Provider</th>
<th>Duration</th>
<th>Entrance Requirements</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>Master of Couple and Family Therapy</td>
<td>University of NSW, School Work Programs, in partnership with Relationships Australia (NSW)</td>
<td>2 years part-time.</td>
<td>Undergraduate degree. Training and 2 years experience in counselling, health and related areas.</td>
<td>Carmel Flaskas <a href="mailto:c.flaskas@unsw.edu.au">c.flaskas@unsw.edu.au</a></td>
</tr>
<tr>
<td>Queensland</td>
<td>Graduate Diploma of Mental Health (Family Therapy). From 2009-Master of Mental Health (Family Therapy)</td>
<td>The University of Queensland, School of Medicine</td>
<td>2-year part-time</td>
<td>Recognised health profession degree or equivalent, at least 2 years experience of clinical practice and current practice environment suitable for family therapy</td>
<td><a href="http://www.uq.edu.au">www.uq.edu.au</a></td>
</tr>
<tr>
<td>Tasmania</td>
<td>Graduate Diploma In Family Therapy (Clinical Practice) Tasmania</td>
<td>Gilead Downs Family Therapy Centre</td>
<td>2 year part-time course; 7 blocks per year (4 x 4 day blocks &amp; 3 x 2 day blocks — mainly weekends)</td>
<td>Degree in helping professions or equivalent experience</td>
<td>Harvey Miller <a href="mailto:gileaddowns@dcsi.net.au">gileaddowns@dcsi.net.au</a></td>
</tr>
<tr>
<td>Victoria</td>
<td>Diploma of Family Therapy</td>
<td>Alma Family Therapy Centre</td>
<td>Eight units, over 2 years. Each unit is 8 weeks and 32 hours duration.</td>
<td>Health professionals</td>
<td>Livia Jackson or Miriam Tisher <a href="mailto:alma@almafamilytherapy.com">alma@almafamilytherapy.com</a></td>
</tr>
<tr>
<td>Program Name</td>
<td>Institution</td>
<td>Duration/Study Mode</td>
<td>Requirements/Additional Notes</td>
<td>Coordinator/Contact Information</td>
<td></td>
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<td>----------------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| Graduate Certificate in Family Therapy                                     | The Bouverie Centre, Division of Allied Health, Faculty of Health Sciences, La Trobe University | 1 year, part-time 6 hours per week; two 13-week semesters | Undergraduate degree in any field but preferably in a counseling, health or welfare field or equivalent. Four-day Introductory Workshop in Family Therapy or equivalent.                                                        | Anne Welfare, Coordinator a.welfare@latrobe.edu.au  
www.latrobe.edu.au/bouverie                        |
| Graduate Certificate in Narrative Therapy                                 | The Bouverie Centre, Division of Allied Health, Faculty of Health Sciences, La Trobe University | 1 year, part-time 1 day per week; two 13-week semesters | Relevant Undergraduate & appropriate work experience.                                                                                                                                                                                       | Ron Findlay, Coordinator r.findlay@latrobe.edu.au  
www.latrobe.edu.au/bouverie                       |
| Graduate Certificate of Family Therapy in Psychiatry                     | The Bouverie Centre, Division of Allied Health, Faculty of Health Sciences, La Trobe University | 2 years, part-time, 3.5 hours per week; four 13-week semesters | Psychiatrists and Qualified Medical Practitioners                                                                                                                                                                                            | Colin Riess, Coordinator Email: c.riess@latrobe.edu.au  
www.latrobe.edu.au/bouverie                       |
| Graduate Certificate in Systemic Supervision, Consultation and Training   | The Bouverie Centre, Division of Allied Health, Faculty of Health Sciences, La Trobe University | 1 year, part-time, 6 hours per week; two 13-week semesters | Undergraduate degree in any field but preferably in a counseling, health or welfare field or equivalent. Preference will be given to applicants currently in work contexts that have direct involvement as supervisors. | Banu Moloney, Coordinator b.moloney@latrobe.edu.au  
www.latrobe.edu.au/bouverie                       |
| Master of Couple and Relationship Counselling (by full course work OR with minor) | The Bouverie Centre, Division of Allied Health, Faculty of Health Sciences, La Trobe University and Relationships | 2 years part time | Relevant Undergraduate degree & appropriate work experience.                                                                                                                                                                                | The Bouverie Centre r.elliott@latrobe.edu.au         |

A Report Of Effectiveness Research And Practice Perspectives To Inform Family Therapy Training and Workforce Development in New Zealand
The Werry Centre: September 2009

- 60 -
<table>
<thead>
<tr>
<th>Program</th>
<th>Institution</th>
<th>Duration</th>
<th>Requirements</th>
<th>Coordinator</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master of Clinical Family Therapy</td>
<td>The Bouverie Centre, Division of Allied Health, Faculty of Health Sciences, La Trobe University</td>
<td>2 years, 1 day per week; two 13-week semesters per year</td>
<td>Relevant Undergraduate degree, appropriate work experience and access to working with families. Four-day Introductory Workshop in Family Therapy or equivalent.</td>
<td>Robyn Elliott, Coordinator</td>
<td></td>
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<tr>
<td>Program</td>
<td>Institution</td>
<td>Duration</td>
<td>Requirements</td>
<td>Contact Information</td>
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<tr>
<td>Post Graduate Training in Applied Systems</td>
<td>Systems Co-Ordinators Pty. Ltd Upwey</td>
<td>4 hours per week.</td>
<td>Tertiary qualifications in relevant disciplines, working in a context which</td>
<td>For more information contact Claire Miran-Khan</td>
<td></td>
</tr>
<tr>
<td>Theory and Family Therapy</td>
<td></td>
<td></td>
<td>will utilise systemic techniques. Provision for unqualified/experienced</td>
<td>Ph: +61 3 9754 6913</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>practitioner-RPL.</td>
<td>Email: <a href="mailto:clairemirankhan@connexus.com.au">clairemirankhan@connexus.com.au</a></td>
<td></td>
</tr>
<tr>
<td>Graduate Diploma of Social Science (Family</td>
<td>Williams Road Family Therapy Centre &amp; Swinburne University of Technology</td>
<td>2 years part-time. Total</td>
<td>Undergraduate degree in health or social sciences at recognised Australian</td>
<td>Williams Road Family Therapy</td>
<td></td>
</tr>
<tr>
<td>Therapy), Melbourne</td>
<td></td>
<td>328 hours including 60</td>
<td>university, or equivalent qualifications; Training or experience in</td>
<td>Centre:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>hours of live supervision</td>
<td>counselling for a minimum of one year; Currently working with clients;</td>
<td><a href="mailto:info@williamsroad.vic.edu.au">info@williamsroad.vic.edu.au</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Suitability as determined by a selection interview and referee reports;</td>
<td><a href="http://www.williamsroad.vic.edu.au">www.williamsroad.vic.edu.au</a></td>
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<td></td>
<td></td>
<td></td>
<td>Successful completion of an Introductory 4-Day Family Therapy workshop</td>
<td>Williams Road Family Therapy</td>
<td></td>
</tr>
<tr>
<td>Graduate Diploma of Social Science (Family</td>
<td>Williams Road Family Therapy Centre &amp; Swinburne University of Technology</td>
<td>2 years part-time; Total</td>
<td>Undergraduate degree in health or social sciences at recognised Australian</td>
<td>Centre:</td>
<td></td>
</tr>
<tr>
<td>Therapy), Geelong</td>
<td>Campus: Swanston Center Barwon Health, Myers Road, Geelong Vic 3220</td>
<td>328 hours including 60</td>
<td>university, or equivalent qualifications; Training or experience in</td>
<td><a href="mailto:info@williamsroad.vic.edu.au">info@williamsroad.vic.edu.au</a></td>
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<tr>
<td></td>
<td></td>
<td>hours of live supervision</td>
<td>counselling for a minimum of one year; Currently working with clients;</td>
<td><a href="http://www.williamsroad.vic.edu.au">www.williamsroad.vic.edu.au</a></td>
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<td></td>
<td></td>
<td></td>
<td>Suitability as determined by a selection interview and referee reports;</td>
<td>Williams Road Family Therapy</td>
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<td>Successful completion of an Introductory 4-Day Family Therapy workshop</td>
<td>Centre:</td>
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<td><a href="mailto:info@williamsroad.vic.edu.au">info@williamsroad.vic.edu.au</a></td>
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<td><a href="http://www.williamsroad.vic.edu.au">www.williamsroad.vic.edu.au</a></td>
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<tr>
<td>Country</td>
<td>Course Name</td>
<td>Location</td>
<td>Program Details</td>
<td>Additional Information</td>
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<tr>
<td>WA</td>
<td>William Street Family Therapy Centre Family &amp; Relationship Therapy Training Course</td>
<td>William Street Family Therapy Centre, 544 William Street, Mt Lawley WA 6050</td>
<td>2 year course: Stage 1 - Introduction to Family Therapy (40 wks at 5hrs/wk). Stage 2 - Advanced Training (40 wks at 5hrs/wk)</td>
<td>Completion of basic training in the helping professions</td>
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<td>Aldo Gurgone</td>
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<td></td>
<td><a href="mailto:rgc@iexpress.net.au">rgc@iexpress.net.au</a></td>
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<td><a href="http://www.relateandgrow.net.au">www.relateandgrow.net.au</a></td>
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<tr>
<td></td>
<td>Post-Graduate Course in Systemic Family Therapy</td>
<td>Systemic Consultation Centre, Subiaco, Perth</td>
<td>1 to 3 year course: Foundation and Advanced levels. 5 hours per week for 40 weeks per year. 200 hours per year for years 1 and 2. 50 hours for year 3.</td>
<td>Graduate qualifications in Social Work, Medicine, Psychology, Counseling, Nursing and other health professions</td>
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<td></td>
<td>Roxanne Garven,</td>
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<td><a href="mailto:rgarven@iinet.net.au">rgarven@iinet.net.au</a></td>
<td></td>
</tr>
<tr>
<td>NZ</td>
<td>Family Therapy 123</td>
<td>Solutions Un-Limited, courses offered in both New Zealand and Australia</td>
<td>1 five day course; participants also receive a 3 DVD training programme for self-study</td>
<td>Appropriate work experience and/or training in mental health or counseling</td>
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<td></td>
<td></td>
<td></td>
<td>Frances Steinberg</td>
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<td></td>
<td></td>
<td><a href="mailto:solun@xtra.co.nz">solun@xtra.co.nz</a></td>
<td></td>
</tr>
<tr>
<td>NZ</td>
<td>Counselling and Family Therapy Diploma Programme</td>
<td>Human Development and Training Institute of New Zealand</td>
<td>4 stage programme which each stage being 40 weeks. Total hours for programme = 1902 hours.</td>
<td>Character references and evidence of previous tertiary level education.</td>
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<td>HD&amp;T office</td>
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<td><a href="mailto:info@hadandinstitute.co.nz">info@hadandinstitute.co.nz</a></td>
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