

Introducing Evidence-Based Family Assessment and Therapy in Child and Youth Mental Health Services: Applying Systemic Principles to Maintain, Sustain and Build Capacity

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The purpose of this article is to overview the context of the mental health service in which we work, and family therapy's status prior to and after the impact of changes wrought by the introduction of the *National Mental Health Policy*. We then explore some key issues that we think contribute to the persistence of the occlusion of family therapy in child psychiatric services; and the strategies that we developed and are continuing to develop to support change. Finally, we describe the use of a family assessment instrument that we believe is central to our change strategy.

Key words: mental health, policy, family therapy

Family therapy has had a very chequered career across the two decades that we have been associated with Child and Youth Mental Health Services in the Royal Children's Hospital and Health Service District (CYMHS, RCH and HSD) of Brisbane, Queensland. Even prior to the widespread changes introduced to public mental health services by the implementation of the *National Mental Health Policy* (Australian Health Ministers, 1992) the provision of family therapy as an intervention of choice tended to be sporadic.

Reflecting on our experiences of working in the public sector it seemed that the provision of family therapy intervention and training activities to develop clinicians' knowledge and skill in family therapy was dependent on the presence of a worker who was both interested and dedicated to this field. It seemed that every few years someone was telling us about how they were introducing family therapy to the service. However, these efforts were not sustained — when the worker left

so too did the interest and skill in family therapy intervention.

The following quote from Glenn Lerner's (2004, p. 18) review of the evidence base for family therapy suggests that this is not an unusual experience:

Yet while family therapy continues to invite interest and application, particularly in child and adolescent therapy (Cotterell and Boston, 2002), it is not high on the preferred treatment list for mental health services ...

When one of the authors, Ingrid Wagner, returned to the CYMHS, RCH and HSD in 2001, family therapy had again disappeared from the range of treatment interventions offered by the service. In the intervening years between the latter part of the 1990s and 2001, there had been substantial changes made to the delivery of mental health services in the public sector due to the introduction of the national policy, which had



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and continues to have a substantial impact on the provision of therapeutic services. We begin by considering the impact of these changes from the broad perspective of service provision and also from our experience in the frontline of service delivery. We then examine the problem of persistence in systemic practices' failure to thrive in public sector service provision, before describing our strategy for change. Finally, we describe the use of the Beavers Family Assessment System (Beavers and Hampson, 1990) as an instrument to support change.

The Context of Service: Setting the Scene

In Australia, the responsibility for mental health service provision is shared between state, territory and Commonwealth governments, NGOs and the private sector. The Australian Constitution does not assign a specific role for the Commonwealth in regard to health aside from powers of quarantine for the prevention of disease. However, the Commonwealth plays a lead role in the implementation of the *National Mental Health Policy* (AHM, 1992) through its fiscal dominance over the States and Territories (cf. Magarry, 1999). It influences the direction of reform via the agreements for the transfer of monies to finance service delivery.

Hence, although there is consistency in the broad agenda for reform, there is also great variation in the structure and delivery of services across Australia. These variations are not only between the states and territories but also within, as the responsibility for the implementation of service reforms are decentralized and devolve down to area, region, district and local level service provision. Therefore, we first consider the issues that impinge on the context of service provision arising from the broad reform agenda before describing the impact at the particular location of frontline service delivery within our district. In so doing, we recognise that our experience of the impact of change will share both similarities and differences with others who work in other localities.

The Context of Service: The Paradigm of Population Health

In the first plan (AHM, 1992b) for the implementation of the National Mental Health Policy (AHM, 1992) the focus was on structural change to the mental health services, and in the second (AHM, 1998) and third (AHM, 2003) on population health, with its emphasis on promotion, prevention and early intervention. In the paradigm of population health large-scale studies provide estimates of prevalence and incidence of disease and dis-

order, independent risk factors are identified and their relative contribution to the risk of the disorder is quantified. It is through such studies that groups who are to receive priority in service are identified, and strategies of prevention and intervention are informed. Patterns of health and disease are explained by epidemiology as a complex web of interconnected risk and protective factors, and consequently, the effectiveness of interventions and preventive strategies rest on the ability to identify and predict the results of breaking selected strands of the web.

McMahon's (1960) 'web of causation model', through which the notion of multicausal aetiology is expressed, omits discussion of the origins as opposed to the interactions of the multiple causes. Thus the model of disease causation is unstated, with no explanation as to why certain components are selected, and others left out, (Susser, 1991). Krieger (1994) contends that the selection of 'strands' to break, closest to the specified outcome, in the chain of causation of health issues, inevitably translates to the direct biologic causes of disease in individuals and/or to 'lifestyles' and other risk factors. These factors allegedly can be addressed at the individual level through education or medical intervention. The selective weighting of these factors, despite the claim of multicausal aetiology being inclusive and nonhierarchical, indicates the 'web' model is based on the theoretical rationale of bio-medical individualism.

The Context of Service: The Paradigmatic Clash

The implementation of the National Mental Health Policy (AHM, 1992) through the successive plans (AHM 1992, 1998, 2003) has spawned a plethora of action plans and strategy papers for various focal areas that are beyond the scope of this paper to review. However, if the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Commonwealth Department of Health and Aged Care, 2000) is taken as an exemplar, the influence of the web of causation can be unequivocally identified at a cursory glance.

The strategic framework and plan divides the population into priority age groups across the lifespan, and for each group there is a rationale for action that includes a list of risk and protective factors, as well as a summary of the evidence base for action. For example, the action plan for the priority age group of children 5 to 11 years (CDHAC, 2000) describes a range of outcomes for the promotion of mental health and the prevention and reduction of mental health problems and mental disorders among parents and children.

These include positive parenting skills and optimal family functioning, reduced marital conflict and reduced child abuse and neglect. Throughout this developmental period, the risk factors for poor mental health outcomes are identified as increasingly derived from the social and physical environments that provide education and socialisation experiences, as well as ongoing family factors.

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The evidence base for action describes effective interventions as those that promote structures to support the family and the school community in developing social, emotional and problem-solving life skills for children. In addition, programs that identify and manage children showing the early signs of mental health problems are noted to be effective. The interventions cited include clinical approaches for conduct problems and anxiety disorders; universal, selective and indicated positive parenting programs; and mental health promoting schools. While the policy statements acknowledge the importance of considering a broad causal net, the classical disease model is still tacitly assumed in how services are designed and delivered.

The model also serves as the guide for diagnosis and treatment. This is particularly important in child and youth mental health because it means that the initial assessment of the presenting problem is formulated on an individual basis. This has always been a challenge for therapists who engage in systemic thinking; however, in the current framework of mental health services there is an additional permutation of biomedical individualism as ‘familial problems’ become conceptualised as risk factors in the causal pathway to individual disorder. Paradoxically, the paradigm of population health, as its

tenets drip down to the frontline of service provision, creates a peculiar problem for systemic interventions as it promotes an approach to treatment that construes families as constituted of atomised entities and only contingently connected to each other.

Our experience of the influence of service development, underpinned by the paradigm of population health, is that systemic understanding is lost amid the increasing demands for clinicians to identify and refer children and young people, who are within priority groups, to programs designed to address their needs. These programs are rarely inclusive of all family members, but target the individual child/young person, or a subsystem of the family — the children, the siblings, the parents or a parent–child dyad.

How a problem is defined, and how an intervention is designed is contingent upon the underlying paradigm, and will necessarily lead to different solutions. Thus, while many worthy programs have been developed which target ‘family factors’, they are not necessarily family-level interventions or informed by systemic theory. Indeed, a parallel argument has been raised by eminent epidemiologists such as Rose (1985) and Syme (1994) who considered that the substitution of traditional epidemiologic research categories of the environmental source of infection — airborne, waterborne, food-borne and vector-borne — with disease/disorder classifications has subsumed the practice of epidemiology into that of clinical medicine in large groups.

The Context of Service: The Conundrum of Citizenship

The issues for systemic practice arising from the paradigm of population health are further complicated for the child and youth mental health sector by the peculiar status of children and youth in regard to citizenship. The adoption of UN Convention of the Rights of the Child in 1989 was seen to signify a new relationship between children, the state and the international community (Kulynych, 2001). However, the UN document reflects the ambiguity of the meaning of childhood and the political status of children. Although granting a wide range of rights including legal, social and civil rights, which might appear to form the basis for the entry of children into the body politic, the convention explicitly excluded the rights of political participation. It was considered that the very status of a child means in principle that the child has no political rights.

The lack of a political voice means that the particular needs of children and young people are often neglected or marginalised. Within the mental health

sector this is reflected by the fact that mental health policies primarily pertain to adults. Shatkin and Belfer (2004) analysed the mental health policies of 35 countries, inclusive of Australia, and found that there was a global absence of child and youth mental health policy to guide service development and programming. They considered that there was ample evidence from studies of the burden of disease associated with the mental disorders of children and youth to demonstrate the life long societal cost associated with these disorders. However, unlike the impact of such studies in the adult sector, it has not resulted in substantial policy development to initiate and sustain programming. A consequence of this may be the adoption of inappropriate strategies, derived from adult experiences, into service models for this sector.

The ambiguity of citizenship status of children and youth is also of salience in how consumer rights influence service provision in the child and youth sector. The National Mental Health Policy (AHM, 1992) endorsed the Mental Health Statement of Rights and Responsibilities (AHM, 1991), and the national policy primarily has a consumer rights focus. As such, it does not place an emphasis on the rights of carers and advocates, although recognising the importance of their role. The potential for conflicts of the rights and responsibilities of consumers and carers is particularly evident in case of children and youth.

In this respect, parents/guardians/carers of a child or adolescent have the responsibility to obtain professional assistance if they have reason to believe the child may have a mental health problem or mental disorder. The refusal of family members to participate in the treatment process is not considered as grounds for refusing treatment to a child or adolescent. Indeed, children and adolescents have the right to be treated as an autonomous individual by service providers when seeking assistance for a mental health problem or disorder. This right of autonomy also gives children and adolescents, as consumers, the right to refuse treatment unless subject to mental health legislation.

It is unclear in a situation where the family seeks help in meeting their responsibilities to the child or adolescent, and the child or adolescent exercises their right to refuse treatment, which should prevail. Although parents/carers have a right to help with their own difficulties generated by the process of caring for a person with a mental health problem or mental disorder, it is unclear where the responsibility for meeting this right lies, as neither the statement nor the policy refers to the provision of service for parents/carers in respect to this right. Similar to the paradigm of popu-

lation health, the consumer rights focus also contributes to the atomisation of the family, as rights refer to the individual. There is, in effect, no obligation for child and youth mental health services to provide treatments that are inclusive of family members other than the identified patient.

Across Australia, this institutionalised failure to recognise the central role of the family is reflected in the national collection of data, which is promoted as serving the dual purpose of providing information on both the progress of the implementation of the policy, and of funding needs. The national Outcome measures, for example, do not include a measure of family functioning. In our particular district, the database that tracks clinicians' service activities, records service provisions where the client is present or not present, and lists activities such as assessment, counseling, psycho-education and carer support. However, if the client is not present, it is counted as an indirect service activity and there is no service activity category, other than carer support, which captures the provision of family intervention.

Finally, these issues may also impact on the capacity of child and youth mental health services to effectively provide family level interventions, with respect to the available funding. For example, in Queensland, the funding of adult mental health services is based on estimates of the general population, but for child and youth services the funding is based on estimates of the population of children and youth. However, the majority of children and young people are not seen in isolation from their caregivers, indeed our observation of service provision within our clinics is that children and young people are most commonly treated in parallel with their parents — primarily the mother receiving parent management training. Hence, many of the cases involve more than one clinician. As such this funding arrangement may constitute a substantive underestimate of the level of service provision required for effective treatment outcomes, and may prove to be even more so if family therapy was widely considered as a treatment of choice.

The View from the Frontline

The changes emanating from the introduction of the National Mental Health Policy (AHM, 1992) have created a very different work environment in which there are dilemmas for therapeutic work. The widespread impact of the national plans on therapeutic work was indicated in the evaluation of the first National Mental Health Plan (AHM, 1992b), which made reference to clinicians' perceptions that specialisation was no longer valued by the mental health services (National

Mental Health Strategy Evaluation Steering Committee, 1997). The Second National Mental Health Plan (AHM, 1998) addressed the need for specialisation within the mental health services. However, within the population health framework it is understood as developing strategies to meet the needs of high-risk population groups such as homeless young people, and children of parents with mental health problems. The focus of service development has been on programs targeted at specified population groups and the upskilling of clinicians to identify, refer and case manage children and young people falling within these groups.

In our experience, as senior supervisors within this service, clinician concerns about specialisation are in relation to competencies in clinical skills for specific therapeutic interventions such as family therapy, play therapy or cognitive behavioral therapy. Programs that require clinicians to attain competencies in assessment rather than treatment skills do not address the development of these skills. Further, the programs that are intended to expand the treatment capabilities of clinicians are either designed as modularised interventions to be delivered by clinicians with minimal training; or, as part of the evidence-base movement, underpinned by cognitive-behavioural theories (c.f. Sanders, 1999) that are primarily compatible with the biomedical paradigm. Regardless of the type of program, the quest for the upskilling of clinicians has promoted a culture of simplification where interpersonal/relational skills are subservient to the program content. Similar to the atomisation of the family, the paradigm of population health can also be seen as atomising the therapeutic relationship.

The tension between biomedical individualism and systemic approaches has always been present in formal health settings. However, the sweeping changes to the health system have escalated this tension. For family therapy and its place in child and youth mental health services, it can be summed up as *the more things change the more they remain the same*. That is, '... a wider social system enmeshed in a problem in a persistent and repetitive way, despite desire and effort to alter the situation', and as Watzlawick et al. (1974, p. 2) point out two questions equally arise:

- How does this undesirable situation persist?
- What is required to change it?

The View from the Frontline: The Problem of Persistence

We began this article with the observation that even prior to the changes wrought by the introduction of the

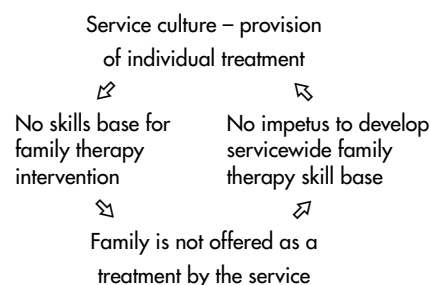


FIGURE 1

Circular sequence of skill deficit.

national policy; family therapy had failed to find a place as an intervention of choice within our service. We then explored the broad changes to the service context to consider implications for systemic practice. In this section we consider the problem of persistence and the valence of the current changes to our service context. We believe that this understanding is essential to inform change strategies because the overarching policy, which determines the direction of public sector services, creates the day-to-day work context which shapes how clinicians think about their work (Wagner, 2004).

Our understanding of the persistence of the occlusion of family therapy in child psychiatric services is that there are two intertwined issues. First, family therapy is understood to be a complex intervention that requires clinicians to develop sophisticated relational skills for which there are no formulaic guidelines. Our experience as supervisors is that clinicians generally feel more comfortable working with individuals; and very inexperienced clinicians often prefer cognitive-behavioural programs because of the perceived safety of structured interventions. Hence, to enable clinicians to develop family therapy skills, there needs to be a pool of experienced workers who are able to offer support through training, mentoring, co-working and supervision.

Second, we consider that the tacit assumption of the medical model that underpins service provision creates a strong culture that is biased toward the provision of individual treatment. This leads to the problem that the existing workforce has no skill base other than individual treatment. This then creates a circular sequence (Figure 1) — as there is no skill base to draw upon to do family therapy, no family therapy is undertaken, so no-one develops the skills. In our current service context, there are multiple feedback loops that sustain this circular sequence embedded in everyday practice.

Persistence: Framing Clinical Practice

In practical terms, at the local level of our service, the work roles in mental health have become more generic. Rather than discipline specific most tasks are shared. Assessment and treatment planning processes have become standardised, allied health and nursing disciplines now perform initial diagnostic interviews and diagnostic formulations, and categorise presenting problems with reference to the ICD-10-AM Mental Health Manual (National Centre for Classification in Health, 2002). Prior to the national policy, formal diagnosis of children and young people was less common, and not the direct responsibility of the allied health and nursing clinicians.

Under the implementation of the national policy the diagnosis of children and young people attending clinics is a requirement for national data collection. It is also understood as a demonstration that the services are being implemented in accordance with the intention of the policy, to ensure that those with the most severe mental disorders receive priority in treatment. Additionally, funding of services is tied to the collection of this data, and as funding is of particular concern for the administration of the service, the data collection is also used for the surveillance of clinicians to ensure their compliance. Further, because the ability of clinicians to formulate and diagnose according to the classification system, and enter the information into the data collection system, is a priority for public sector services, these tasks form part of the core skills of the workforce and, therefore, an area of competence that is assessed in work performance and development processes.

The emphasis on core clinical skills for clinicians in the mental health workforce being formulation and diagnosis is also related to the rise of evidence-based practice. A major focus of the implementation of the national policy has been both the expectation that clinicians provide the most effective evidence based treatments, and the support of research to expand the evidence base. As evidence-based treatments are derived from research into the efficacy of interventions for specified diagnostic categories clinicians must, of necessity, be able to competently diagnose the presenting problems of their clients in order to determine which, if any, of the evidence based treatments are the treatment of choice for intervention.

Persistence: Framing Treatments of Choice

Despite the ongoing debate it engenders, the national policy has given the evidence-based practice move-

ment a conspicuous presence throughout the mental health sector. Tanenbaum (2005) has categorised the controversies that surround evidence-based practice as those associated with defining the evidence, that is, the question of the inappropriate privileging of some treatments over others; the application of research evidence, that is, can or should practice consist of the faithful application of research evidence; and finally, what is meant by 'effective' and who decides this? Currently, in Australia the issues are not as acute as for the United States where managed behavioral health care organisations have used efficacy research to limit the types of interventions and their duration.

Within our service the impact of the evidence based practice movement is both overt and subtle. First, there are the primarily low-level coercive strategies aimed at clinicians, such as the provision of web-based resources including databases and toolkits to assist them to review research literature and strategies to encourage clinicians to participate in evidence-based practice such as informal research support groups, competitive grants, and other professional development activities.

Second, there are the activities that are incorporated into day-to-day practice. Our district, like many others, has a range of projects that have been developed in response to the national plans' identified population priority groups. Some of these projects run in parallel to the clinical services, and clinicians receive training to identify and refer children and young people to the project's programs. Other projects require clinicians to attend cyclical training days at six-month intervals to increase and maintain skills to identify and treat children and young people in priority groups, with the intent of expanding the clinician's capacity to treat marginalised population groups. Finally, there are the projects that require all clinicians to identify and refer children and young people for the program, and in addition train selected clinicians to implement the programs in accordance with a manualised treatment program. All of these projects trains clinicians to recognise and refer or treat children and young people based on their specific characteristics, whether behaviour, diagnosis, signs and symptoms or family factor.

Third, the clinicians are required to fill out the national Outcome measures for every client at their first interview and at regular intervals until they are discharged from the service. As previously noted, these measures do not include family functioning and, as such, change or the effect of treatment is considered at the level of the individual. Currently, as for the service

activity data, a clinician's compliance in completing the Outcome measures is monitored and there is a standard expectation of work performance. The Outcome measures are also incorporated into case reviews to track the effectiveness of the interventions provided by clinicians. Clinicians are encouraged to review the Outcome measures with their client and the parent/carer to discuss the progress of the treatment. Since the outcome measures pertain only to the individual child or young person, 'progress' is understood as improvements in the individual child's emotional or behavioural symptoms due to the intervention.

Persistence in Practice

These features of the work environment, together with the administrative aspects of the referral and treatment processes, such as ensuring that young people are aware of and have consented to referral to the service, and have participated in treatment planning and signed their treatment plan, serve to underline that the individual is the focus of intervention. They form multiple feedback loops in the day-to-day context of work, which both train and constrain clinicians to think within the biomedical model.

Our experience at the clinic level has been that many of the clinicians that we supervised seemed to think there was some kind of prohibition on treating families. At the frontline of service the construction of the family as constituted of atomised entities became embodied in what clinicians understood as 'core business'. Core business was seen as treating the child or young person who was the identified patient, whereas treating the family equated to treating adults, which was not core business. In practice, family interviews generally meant interviewing the mother for collateral information, and family work often referred to training parents, again primarily mothers, to undertake behavioral management strategies. Interviews inclusive of all family members were not generally undertaken.

At the policy level, due to the acknowledgement of considering a broad causal net, there is actually no restriction on the inclusion of families or family based treatments. The Future Directions Policy for Child and Youth Mental Health Services (Queensland Health, 1996), which guides service provision in Queensland, refers to services for children, young people and their families throughout the policy statement. The following quotes from the section on Service Delivery Approach demonstrate the potential to be inclusive of systemic approaches and family therapy intervention.

Professionals working in specialist children [sic] and youth mental health services need to possess a knowledge of childhood and adolescent development and temperament, disorders in children and youth, the course of these disorders, disorders in parents, resilience and protective factors, and *patterns of interactions within families*. (QH, 1996, p. 6, emphasis added)

Since the social context of young people has a powerful influence on the onset, expression and remission of psychiatric disorder, *working with families*, schools and communities is a central part of treatment approaches. (QH, 1996, p. 6, emphasis added)

Nevertheless, there has been a widespread perception that family level intervention is not supported by public mental health services. This perception appeared to be underpinned by two interlinking assumptions. First, the dominance of evidence-based treatments by cognitive behavioral therapies was often cited as the reason why family therapy was not supported in public services. There was little awareness of the growing body of evidence that demonstrates that family therapy is an effective intervention or is as effective as other commonly used therapeutic interventions (c.f. Lerner, 2004). Second, there was an assumption that our service managers would not support the inclusion of family therapy as a treatment of choice within the clinics. At times it appeared that clinicians had confused the constraints placed upon managers for personal preference, or rigid epistemology, that biases service provision in favor of the biomedical model. We found this assumption of the lack of managerial support for family intervention surprising, given that two of the authors, as the Principal (Ingrid Wagner) and Senior (Glenn Munt) of the Social Work Discipline, represent their discipline within the management structure.

Our experience has been that our management group was both receptive and supportive of service innovations to increase family intervention. However, what is required for management groups to support such innovation is the capacity to interpret service planning guidelines and articulate family intervention in terms that allow its incorporation into the business plan. This in turn supports management in the process of demonstrating the service's compliance with requirements that are ultimately imposed by funding agreements. Further, our understanding is that whichever treatment interventions are favoured, the range of conditions that are addressed by the evidence base is quite narrow. There is not a large body of evidence in mental health about what works for whom and under what conditions. Cognitive behavioral therapies are not the only interventions practiced in the service and family therapy is not alone with respect to the limitations of its evidence base.

Change: The Beginning of Beginning

In trying to change the service culture, we are embarrassed to admit that our first attempt could be classified as 'more of the same'. Some funding became available through a Queensland Health initiative, which allowed us to pay external experts to assist in developing the clinical skills of the allied health workers. In collaboration with the other Discipline Principals for Psychology and Speech Pathology, we employed people with expertise in family therapy to provide training and supervision for the allied health clinicians. After 18 months of training workshops and small group supervision no one was doing family therapy, and no one felt they had the skills to do family therapy.

Clearly this was a strategy that was ineffective for the promotion of a change in a service culture. Similar to the impact of those who entered the service with perceived expertise and left with their expertise, outside experts are just that — outsiders with expertise that is not seen to be transferable to others. When they are gone so is the expertise. The expertise did not become embedded into the service, and family therapy remained peripheral to what was understood as the core business of the service.

In 2003, the other Discipline Principals wanted to diversify into other areas, and the Discipline Principal of Social Work (Ingrid Wagner) took the opportunity to maintain the social work group's focus on family therapy. The two key problems of how to change the culture to include families in the clinicians' understanding of core business, and how to develop a skill base in family intervention remained. The challenges were:

- How to get the social work group to take up family therapy
- How to embed it into the service
- How to build skill

The process of thinking through how to address these challenges brought an awareness of the issues of the service context and the recognition of the need to develop multiple feedback loops to both develop and sustain the practice of family therapy. This understanding underlined the need to develop strategies that promoted change both at the frontline and the administrative level of service to enable systemic practice to become assimilated into day-to-day practice. It also led to a realisation that sustainability required a vision of the future beyond ourselves as the current professional leaders to the future generation of service seniors. It was imperative to develop strategies that not only inspired interest in family therapy intervention,

but also provided opportunities to support the retention of systemic therapists within the service.

Change: Group Investment in the Practice of Family Therapy

The development of group investment in the practice of family therapy was essential to enable the building of a skill base within the service. We understood that the training required to effectively build a skill base was beyond our capacity within the service and would be best achieved through training in a formal postgraduate course in family therapy. At present, for allied health workers in Queensland, there is no inducement for attaining postgraduate qualifications as salary levels are not tied to education beyond the qualifications that give admission to professional associations, nor are there additional supplements to salary for postgraduate qualifications. Moreover, encouraging group investment in systemic practice was necessary, as the Discipline Principal's role is to enhance the professional development of their discipline group through leadership and suasion, rather than through directives to participate in initiatives.

To develop group investment, first, the social work group was asked to form working parties to undertake two tasks. The first was to write a statement of social work practice in child and youth mental health. The second was to search and review the literature on family assessment and family therapy. The end goal of these tasks was to integrate family assessment and therapy into the social work discipline's practice statement. Further, by engaging the group in an accepted process for the promotion of evidence-based practice, it allowed family therapy to be clearly recognised as within the range of interventions offered by the service.

Change: The Rising Generation

A statement of practice and recognition of family therapy as an intervention of choice, are necessary but not of themselves sufficient for group investment to become embodied in practice. There must also be an effective strategy to enable practice, which addresses both development and sustainability of change. To develop this strategy the professional opportunities available to clinicians in the service to advance their career were reviewed (see Table 1), with the intent of determining how to use family therapy as the vehicle for career advancement. The mapping of a career pathway through the development of knowledge and skill in family therapy allowed workers to weigh the costs of

TABLE 1

Available Resources for the Encouragement of Professional Development

Resource	Purpose
The Allied Health Supervision Fund	Recurrent funding for professional development through clinical supervision
Study and Research Assistance Scheme	Gives limited support to Queensland Health employees to pursue post-graduate education related to their job
Clinical Progression	Acknowledges clinicians who have highly developed knowledge and skills by progression to a higher salary level (PO3)
Allied Health Conditional Clinical Advancement Scheme	Acknowledges advanced clinicians (PO3) who have continued to develop knowledge and skills, and have demonstrated leadership in their field by progression to higher salary levels (PO4, PO5 and PO6)

postgraduate education against the potential opportunities for career advancement within the service.

From this standpoint, a small group of interested workers agreed to undertake a postgraduate certificate in family therapy, with the limited support from Queensland Health's *Study and Research Assistance Scheme*. To both recognize their contribution and assist them in their career advancement, a recognized role of 'family therapy mentor' was created within the service. In this role, these social workers were expected to contribute a family systems perspective to case review discussions; and, initially with the support of the senior supervisors (Ingrid Wagner and Glenn Munt), undertake family assessments and family therapy interventions. As they attained higher levels of competence, the mentors were to offer to co-work with other clinicians, from all disciplines, at their clinic. This role gave systemic practice a voice and presence in the day-to-day work of the clinics.

In return, the family therapy mentors received access to small group supervision with an accredited family therapist (Peta Briner) external to the service, which was enabled by the Allied Health Supervision Fund. This initiative served several purposes; first, it allowed a link between the formal study and the service context, as the external supervisor (Peta Briner) was also a course coordinator at the university. Second, it allowed the clinicians to accumulate supervision time that was recognised by professional associations. Finally, as clinicians value external supervision, the offer of access to

this resource for those who took up post-graduate study in family therapy acted as a further inducement.

This strategy also positioned the clinicians who participated to apply for *clinical progression*, as their role of family therapy mentor allowed the demonstration of advanced knowledge and skills. Their continuing skill development and expansion of their role, also positions them to apply for *clinical advancement* through opportunities to demonstrate their leadership by offering training, and conducting research, and writing journal articles from access to the data that we routinely collect on our family therapy cases.

Change: Embedding Systemic Practice in the System

The engagement of the clinicians was only half the equation. To embed family assessment and therapy into the wider service it had to be accepted by other disciplines, supported by management; and, to be sustainable, the process of assessment had to be a good fit with how the service currently conducts its business. The outcome of the literature review was central to embedding family assessment and therapy into the service. From this we identified five family assessment systems, three of which met the evidence-base criteria of having been tested for reliability and validity. These were the:

- Beavers Family Assessment System
- McMaster Clinical Rating Scale
- Circumplex Model Clinical Rating Scale

After comparing these instruments we adopted the Beavers Family Assessment System (Beavers & Hampson, 1990), because it provided an insider and outsider view of the family through an Observer Scoring Task and a Family Self Report Inventory. In comparison to the McMaster Clinical Rating Scale (Miller et al., 2000) and Circumplex Clinical Rating Scale (Olson & Killorin, 1988) there was an economy of time in conducting the assessment, which is extremely important in a busy clinical setting. Finally, in comparison to the other scales it was very easy to access.

The use of the Beavers System provided a useful tool to underpin attempts to change the service culture because it is:

- supported by evidence, which was very important for acceptance of its clinical use by other disciplines, and also for management to support its use
- it was useful for clinicians as the assessment gives direction to treatment planning and intervention

- it was a good fit with current practice because it is standardised and is able to be implemented as a consistent process across the clinic sites
- the use of the assessment system enabled a shared understanding and common language of assessment which supported clinical team discussions
- the use of standardised instruments and the video-taping of the families undertaking a standard task, also allowed us to collect both qualitative and quantitative data, which not only gave us the potential to undertake research activities but also provided very useful training material.

These features of the assessment tool offered the potential to assist in the process of embedding family therapy into the service. This was not only because an evidence-based and standardised assessment procedure mirrored the current practice within the clinics, albeit to a different end, but also because it created circularity within the system which supported the ongoing development and sustainability of family therapy. An important aspect of formalised family assessment systems is that the reliability and validity relies on the training and experience of the assessors. Thus, to effectively provide the assessment the workers must undertake training in family therapy. These process issues also allowed Ingrid Wagner to present a service case to the management group to support family therapy within the District Business Plan under areas of staff recruitment and retention, and improvement of services to the child and family.

In this respect, the social work group's activities created a platform for the further development of family therapy intervention within the service. However, the question remains as to the success of our attempt to initiate a cultural shift in the service. At this point we are in an early phase of the process and cannot give a definitive answer. Our prediction is that it will take at least five years to establish this cultural shift. We can, however, describe what we have achieved since we implemented this strategy.

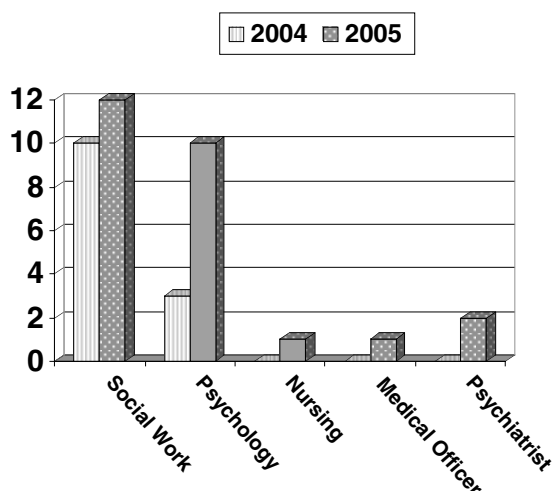
The Signposts of Change

Mentor group. In 2004, of the group of 12 clinical social workers, three agreed to enroll in postgraduate study. By the end of 2005, these workers had successfully completed their family therapy training, and two more of the social work group had enrolled in the course. At the start of this year (2006) two of the first group had left the service for higher paid positions, and another of the social work group enrolled in the

course. Unfortunately developing expertise is a two-edged sword. While there is potential for recognition it is difficult for allied health staff within the public sector to get adequate compensation for the effort and cost of postgraduate education. Currently, there are four social workers in the family therapy mentor group, as well as the two senior workers (Ingrid Wagner and Glenn Munt) who actively support family therapy across the three community clinics. Two of the mentors are currently preparing to apply for *clinical progression*. One of our mentors has recently been appointed to a senior position within the service.

Group investment in family therapy. In our roles as senior supervisors, we (Ingrid Wagner and Glenn Munt) continue to actively promote family assessment and therapy as part of the knowledge and skill of our discipline. All of our community clinic social workers undertake training in the Beavers Family Assessment System (Beavers & Hampson, 1990) and we encourage our supervisees to include family assessment and therapy in their annual professional development plans. In 2005 the interest and investment in family therapy was indicated when Queensland Health offered the opportunity for clinicians to apply for Evidence-Based Review Grants, and six social workers submitted applications for a range of family assessment and family therapy topics. This year, from the mentor group, two abstracts were submitted in response to the call for papers for the Australian Family Therapy Conference.

Embedding family therapy in the wider service system. At the managerial level of the service, the support for family assessment and therapy has been shown by a number of actions. In 2004, by a consensus process, the senior management group of the CYMHS, RCH and HSD placed the development of evidence-based family assessment in the top five priorities within the service's business plan. This process was influenced both by Ingrid Wagner's advocacy for family assessment and therapy and by line managers' direct experience of the family therapy mentors contributions to practice at the clinics. Through this action family assessment was incorporated into the Royal Children's Hospital and Health Services District's Business Plan 2004–2007. A whole of service awareness of the Beavers Family Assessment System (Beavers & Hampson, 1990) was supported by the Education Subcommittee's decision to include a module on this assessment in the service's mandatory training program, which all clinicians undertake every two years.

**FIGURE 2**

Referral source for family intervention.

In 2005 the senior management group endorsed the modification of the service's policy for *consent to videotape for clinical purposes* to incorporate consumer consent to use their case material for research and training activities. This was to accommodate the social work discipline group's objectives to develop training material and to participate in research activities. To support the coordination of service across the three clinics, the senior management group also endorsed the development of a service-wide policy for *referral for family assessment and family therapy intervention*.

In respect to the acceptance of family interventions by other disciplines within the service, family assessment and family therapy is currently being undertaken in all three of the CYMHS, RCH and HSD community clinics. To manage the increasing number of referrals and cases we are currently initiating a fortnightly case review of family intervention across the clinics. When we initiated this process in 2004, our referrals for family intervention came predominantly from the social work group (see Figure 2). However, across 2005 both the number of referrals and the discipline groups that have requested family intervention have increased. Similarly, in 2004 we supervised and co-worked exclusively with social workers; we now provide supervision of, and co-work with, psychologists, nurses and psychiatrists across the service. We believe that this growing demand across the disciplines represents the initiation of a shift in the service culture.

Conclusion

Historically, the provision of family therapy intervention within the CYMHS, RCH and HSD has been

dependent on the presence of clinicians with expertise and interest in the field. However, it had failed to become embedded in the service as part of core business. We have applied our understanding of systemic principles to address a problem of persistence and to establish the conditions for sustained change. We addressed the question of how this undesirable situation persists and identified circular causality in the service context, which was perpetuated by the meta-framework of policy.

Although the implementation of the National Mental Health Policy (AHM, 1992) has increased the challenges for systemic therapists, it has also created opportunities for change. Paradoxically, this meta-framework also contained the tools for change, which we have assiduously applied with both rigor and imagination. We have attempted to garner these opportunities in the service of building a structure to enable family therapy to become embedded in our service, and we have attempted to engage with the evidence-based movement to promote and develop family therapy. We have established feedback loops across and between levels of service and between our service and the tertiary sector.

We are yet to discover whether our change process is of the first or second order. However, in the permutations of our strategy for change, we have seen the evolution of unexpected but not unwelcome changes. While we remain open to these surprises, we also remain aware of the need to keep in focus our original purpose, which was to embed systemic intervention in a context that primarily supports biomedical individualism. To honour our own discipline, and engender a cultural shift we have chosen systemic family therapy as both the vehicle and destination of change.

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