

Summary of family interventions recommended and reviewed in NICE guidelines

Updated Jan 2011

AFT (2009).
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Update: January 2011.

The political status of Public Health has led to delays in the development and reviews of some NICE guidelines until they have been addressed by the House of Lords or government departments. Public Health England will focus on early interventions that are cost effective, as mentioned in the NICE newsletter in December 2010: *We have recently received advice from the Department of Health about our future programme of work. It has been confirmed that NICE will continue to develop authoritative, independent public health advice which contributes to the promotion of health and the prevention of ill-health.* These will cover a wide range of topics, and the most relevant for AFT at present are linked to changing behaviours and preventing obesity. The use of ‘systemic’ analyses can be found on p29-30 for Public Health..

Many Clinical Guideline topics are being considered for updating, in addition to the development of new topics. Full reviews take place when new evidence can expand the recommendations or change what has been recommended. An example of the effectiveness of new evidence can be seen in the **Evidence Base** where reviews by the Health Development Agency (HDA) before 2005 found no effective evidence family interventions for substance misuse. But the new guidelines on **Alcohol Dependence and Harmful Alcohol Use** found not only sound evidence for Behavioural Couples Therapy, but this was also the most cost effective psychological treatment for adults. The systemic / family therapies recommended in Antisocial Personality Disorder for young people are all recommended for their effectiveness for Alcohol Dependence and will probably be recommended in Conduct Disorders.

The involvement of SCIE with NICE led to queries about the ethics of random controlled trials (RCTs) for **Looked After Children**, which will be interesting to monitor.

Clinical Guidelines

Six new and developing guidelines include systemic / couple / family therapy in the reviews. Couple therapies are recommended in 2 of these guidelines, and Improving Access to Psychological Therapies (IAPT) has an important role in Common Mental Health Disorders. The following have been developed in the last few months, or will have consultations soon:

Alcohol Dependence and Harmful Alcohol Use (to be published in Jan 2011)

Common mental health problems: case identification and care pathways (consultation done)

Conduct Disorders in Children and Young People (consultation Jan- Feb 2011)

Psychosis with substance misuse (consultation done)

Schizophrenia for up to 18 year olds (Scope in progress)

Self Harm – long term treatment (consultation to start in May)

Public Health

Looked After Children focuses on the commissioning of different services (preferably ‘dedicated’) to provide early interventions and continuity of care and treatment. The following guidelines in development relevant to AFT have been suspended while decisions are being made at other levels:

Social & Emotional Wellbeing of Vulnerable Pre-School Children: Home-Based Intervention

Preventing Obesity

Preventing Domestic Violence

Quality Standards Consultations:

Quality Standards summarise the recommendations that have high quality and cost effectiveness. ‘Quality’ will address clinical effectiveness, patient safety and patient experience, and should involve the NHS and social care professionals to provide prevention as well as treatment.

Introduction

This document provides a summary of the NICE Guidelines that recommend working with families in different ways. Recommendations for family / couple therapy in Clinical Guidelines (CG) are in Section A, with an evidence base that meets NICE guidelines, including on the cost effectiveness of treatments. These treatments will usually be required within NHS mental health services. There is considerable evidence on the effectiveness of family and systemic therapy, which can be accessed on the AFT website¹, including studies on its cost effectiveness, but many do not fit with the criteria for NICE Clinical Guidelines.

Section B covers the Clinical Guidelines which recommend the inclusion of families, or family members, partners or carers in ways that fit with systemic therapeutic approaches without using terms like ‘family therapy’. This is often because the evidence does not fit with NICE criteria, whilst there is recognition of the impact of many diagnoses on close relationships, and the value of working with partners or families. Section C has Clinical Guidelines that do not regard relationship issues as significant, despite the value of systemic couple and family therapy for issues that are linked to the diagnosis.

One Technology Appraisal, in Section D, covers parent training and education and includes a recommendation for family therapy for those who need more than parent training, and was developed by SCIE and NICE. Public Health (PH) Guidelines often use systemic approaches in the organisational approaches to problems or in preventative services. Those that cover recommendations for work with families, including family therapy are in Section E.

Recommendations for research on families or family treatments appear at the end of the guideline summary. Section F covers recent pilot research projects that are based on such recommendations.

By drawing the recommendations together, AFT can consider the implications for services, family therapy posts and for NHS commissioners to demonstrate their application of NICE Guidelines. Some costs are based on the idea that posts are usually Band 7, although others acknowledge that qualified family therapists should be on Band 8a. Some research projects required family therapy qualifications, while others used mental health professionals with specific training in the specific therapy/ intervention. Each guideline will have a costing report, which will provide information based on the evidence that was used for the recommendations. The most detailed costings are provided on family therapy / interventions recommended for preventing Antisocial Behaviour Disorders, but with the Depression (Adult – update) no costings are provided because of the variety of psychological therapies available across the country, especially since the start of IAPTs. Some recent guidelines refer to ‘Think child, think parent, think family’ (SCIE, 2009) for recommendations on parental mental health. One Clinical Guideline was developed by SCIE and NICE (Dementia). Further work is needed to summarise theories and practice in recommended treatments based on research projects rather than conventional UK practice.

¹ Stratton, P.(2005), Report on the Evidence base for systemic therapy (www.aft.org.uk).
Stratton, P. (2010, in press): Report on the Evidence Base for Family Therapy (www.aft.org.uk).
Information Sheet: Research (www.aft.org.uk).
AFT (2009): Family Therapy in the UK (www.aft.org.uk).
AFT (2009): Current Practice, Future Possibilities (www.aft.org.uk).

NICE Clinical guidelines review relevant research in the FULL guidelines, and include personal stories from those with a diagnosis and their carers. NICE Clinical guidelines usually specify that evidence should be from random controlled trials (RCT) in order to be eligible to recommend a treatment. The key references mentioned in this summary come from FULL Guidelines and those in italics are based on practice and research in the UK.

Recommendations may include behavioural, cognitive behavioural, psychoanalytic and systemic principles, with couples or families, usually using terms like ‘therapy’ ‘counselling’ or ‘intervention’. Some recommendations are very specific, such as the four types of family therapies in the preventative interventions for Antisocial Behaviour Disorder, while others, like for Schizophrenia, recognise how more than one model is often used in ‘family interventions’ and acknowledge the value of including families in treatment. In order to meet the requirements for NICE Research Recommendations, there is a need for more research projects need to be developed, which has led to significant funding being available.

Some Clinical Guidelines for physical health problems recommend work with families by psychological services or palliative teams to create change and support patients and families.

Some Public Health Guidelines focus more on the need for services to collaborate in preventative actions or early interventions (e.g. in schools, voluntary agencies or entry to a health service). They may not be clinical, such as those that seek to limit access to alcohol by young people. Those that address and recommend clinical interventions may require an evidence base, but do not place the same emphasis on RCTs or diagnoses. The role of family therapy is recognised for vulnerable families and when more intensive treatments are needed.

It is easy to assume that these guidelines cover the whole of the UK, but NICE Guidelines usually only cover England and Wales. If Northern Ireland or Scotland are included, it is mentioned in the summary. Scotland develops guidelines through SIGN, and there are differences in topics covered to date as well as in the recommendations.

Titles indicate whether they cover all age groups, focus on children or adults, or different combinations, as well as the level of NHS or other services that are covered. Given the significance of recommendations in NICE Guidelines, these are identified first, with the recommendations. Information from FULL Guidelines provides details that have led to the recommendations, as well as reviews that did not lead to recommendations.

However, there will always be some people and situations for which clinical guideline recommendations are not readily applicable. This guideline does not, therefore, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual, in consultation with the person with GAD or their carer.

In using guidelines, it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness. In addition, of particular relevance in mental health, evidence-based treatments are often delivered within the context of an overall treatment programme including a range of activities, the purpose of which may be to help engage the person and to provide an appropriate context for the delivery of specific interventions

Access to all the guidelines covered in this document is through the NICE website:
www.nice.org.uk

A. NICE Clinical Guidelines recommend Family Therapy / Interventions

CLINICAL GUIDELINE	
Mental health & behavioural conditions (MH & BC)	Terms used for recommendations for specific Types of family therapy / interventions
Alcohol dependence & Harmful alcohol use (to be published Feb 2011)	CYP: Brief Strategic Family Therapy Functional Family Therapy Multisystemic Therapy Multidimensional Family Therapy Adults: Behavioural Couples Therapy /couples therapy
Antisocial Behaviour disorder 2009	Preventative interventions for CYP: Brief Strategic Family therapy (BSFT) Functional Family Therapy (FFT) Multisystemic therapy (MST) Multidimensional treatment for foster care (MTFC)
Bipolar Disorder 2006	Structured formal family interventions
Depression in Children and Young People 2005	Shorter-term family therapy (Systemic Behavioural Family Therapy) Systemic family therapy
Depression in adults - update 2009	Couple Therapy (<i>normally CBT</i>)
Depression in Chronic Health Problems 2009	Couple-focused therapies Family intervention (systemic, cognitive behavioural or psychoanalytic principles)
Drug Misuse Psychosocial interventions 2007	Behavioural Couples Therapy Behavioural Family Interventions Social-Systems interventions
Eating Disorders 2004	Family Interventions Eating Disorder focused Family therapy Combined individual and family work
Post Traumatic Stress Disorder 2005	Family therapy
Schizophrenia (update) 2009	Family intervention Single family intervention Multi-family group intervention
Endocrine, nutritional & metabolic conditions	
Diabetes Type 1 2004	Family Systems therapy Behavioural Family Systems Therapy /+ Group
In Development (MH & BC)	
Common mental health problems: case identification and care pathways	Will cover IAPTs which include systemic practice. Couple therapies
Conduct Disorders in Children and Young People	
Psychosis with substance misuse	Family interventions Social Systems Interventions Behavioural Couples therapy
Schizophrenia for up to 18 year olds	Family therapy
Self Harm – long term treatment	Family therapy

CYP – children and young people

Mental Health and Behavioural Condition Topics

Ten MH & BC NICE Clinical Guidelines recommend specific types of family therapy / intervention on mental health and behavioural conditions as does one from Endocrine, nutritional and metabolic conditions. Five MH and BC guidelines in development indicate that they will review the evidence on research projects to make recommendations for family therapy / interventions because of the recognition of the value of family / couple therapy in current practice.

Recommendations from NICE guidelines are given first, followed by information FULL guidelines which provide references for the evidence used.

ALCOHOL DEPENDENCE AND HARMFUL ALCOHOL USE **(FULL to be published Feb 2011) covers England, Wales + Northern Ireland**

Of the three guidelines on alcohol problems this is the one that addresses psychological treatments and the impact of alcohol problems on relationships, as well as the way that dependence may be passed on; how families can provide support and have a role in changing dependence on alcohol. It recommends that the impact on children of parents with alcohol problems should be addressed therapeutically (provided there are not serious safeguarding issues). The others address physical health issues (CG) and prevention (PH). The Full Guidelines refer to these interventions as 'systemic'. The cost effectiveness evidence for systemic interventions for young people is found in the Antisocial Behavioural Disorder guideline. The NICE guideline has not been developed yet.

For adults

1.3.5.2; 1.3.5.3.: Behavioural couple therapy for harmful drinking and mild dependence for those with a partner and there is a willingness to participate in treatment.

1.3.6.4: Behavioural couples therapy is part of psychological interventions: 12 x 60 min sessions

1.3.7.2: Behavioural couples therapy for moderate and severe alcohol dependence after successful withdrawal (details -1.3.6.)

FULL guidelines provide the evidence that couples therapy is the most effective intervention when long term follow up is assessed. It should be offered as a standalone intervention for mild alcohol dependence / harmful use, or along with a pharmacological intervention for moderate or severe dependence.

For children and young people,

1.3.9.7. Promoting abstinence needs 'multicomponent programmes including **multidimensional family therapy, brief strategic family therapy, functional family therapy/multisystemic family therapy. For those with co-morbid problems and/or limited social support**

1.3.9.9. Multidimensional family therapy (Liddle, 1992): 12-15 family-focused structured treatment sessions over 12 weeks. Family + individual sessions may be needed to address alcohol problems, educational and social behavioural, parental wellbeing + skills; and relationship with the wider social system.

1.3.9.10. Brief Strategic Family Therapy (Szapocznik, 1988), Fortnightly 'meetings over 3 months to engage and support family, connect with support in wider systems (eg educational), identify maladaptive family interactions; promote new and adaptive family interactions.

1.3.9.11. Functional family therapy (Alexander 1990), over 3 months by health/social care staff to improve family interactions, engaging and motivating the family in treatment, problem solving and behavioural change including parent training, extend need for change to broader networks, eg school.

1.3.9.12. Multisystemic therapy (Henggeler, 1992) 3-6 month by 'dedicated staff member with low caseload' to focus on problem solving within the family, and use resources in wider community.

Other interventions with families include 'family meetings', Social Network & Environment Based Therapies (*Copello*) **1.1.2.4** to be provided by staff, such as nurses.

Alexander, J. F., Waldron, H. B., Newberry, A., *et al.* (1990) The functional family therapy model. In *Family Therapy for Adolescent Drug Abuse* (eds A. S. Friedman & S. Granick), pp. 183-200. Lexington, MA: Lexington Books.

Fals-Stewart, W., Birchler, G.R. & Kelley, M.L. (2006) Learning sobriety together: A randomized clinical trial examining behavioral couple's therapy with alcoholic female patients. *Journal of Consulting and Clinical Psychology*, 74(3), 579-591.

- Fals-Stewart, W., Klosterman, K., Yates, B.T., *et al.* (2005) Brief relationship therapy for alcoholism: A randomized clinical trial examining clinical efficacy and cost-effectiveness. *Psychology of Addictive Behaviors*, 19(4), 363-371.
- Henggeler, S., Pickrel, S., & Brondino, M. (1999) Multisystemic treatment of substance-abusing and dependent delinquent: Outcomes, treatment fidelity and transportability. *Mental Health Services Research*, 1, 171-184.
- Henggeler, S., Clingempeel, W., Brondino, M., *et al.* (2002) 4-year follow up of multisystemic therapy with substance abusing and substance dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(7), 868-874.
- Lam, W.K.K., Fals-Stewart, W. & Kelley, M.L. (2009) Parent training with behavioral couples therapy for fathers' alcohol abuse: Effects on substance use, parental relationship, parenting and CPS involvement. *Child Maltreatment*, 14, 243-254.
- Liddle, H.A. A Multidimensional Model for Treating the Adolescent Drug Abuser. In *Empowering Families, Helping Adolescents: Family-Centered Treatment of Adolescents with Mental Health and Substance Abuse Problems*; Snyder, W., Ooms, T., Eds.; U.S. Government Printing Office: Washington, DC, 1992; 91-100.
- Liddle, H., Dakof, G., Parker, K., *et al.* (2001) Multidimensional family therapy for adolescent drug abuse: results of a randomised clinical trial. *American Journal of Drug and Alcohol Abuse*, 27,651-688.
- O'Farrell, T.J., Cutter, H.S.G., Choquette, K.A., *et al.* (1992) Behavioral marital therapy for male alcoholics: Marital and drinking adjustment during the two years after treatment. *Behavior Therapy*, 23, 529-549.
- Szapocznik, J., Perez-Vidal, A., Brickman, A. L. *et al.* (1988) Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology*, 56(4), 552-557.
- Szapocznik, J., Hervis, O., & Schwartz, S., (2003) Brief strategic family therapy for adolescent drug abuse (NIH Publication No. 03-4751). NIDA Therapy Manuals for Drug Addiction. Rockville, MD: National Institute on drug abuse
- Zweben, A., Pearlman, S. & Li, S. (1988) A comparison of brief advice and conjoint therapy in the treatment of alcohol abuse: The results of the marital systems study. *British Journal of Addiction*, 83, 899-916.

Clinical question: what are the cost effectiveness of different psychological treatments for children and young people?

ANTISOCIAL PERSONALITY DISORDER 2009.

Treatment, Management & Prevention

There are no specific treatments recommended for young people or adults with ASBD, although the importance of engagement and including wider systems is acknowledged. Psychotherapy is identified as *preventative interventions* for the children of vulnerable families where parents may have mental health problems, or misuse alcohol or drugs; were teenage mothers with a history of maltreatment; were in residential care or have recent or past history of being involved with criminal justice. The application of 4 types of systemic / family therapy is for 11-17 year olds with conduct problems (at risk of developing ASBD), because of the significance of the role of families in prevention. The FULL guidelines mention that family therapy training has become more 'competence-based', so that staff using FFT will have the necessary competencies. The costing report has substantial details of the cost effectiveness of the recommended preventative interventions.

1.2.7.5. Brief Strategic Family therapy

At least fortnightly sessions for 3 months.

1.2.8. 1 Those with drug related problems; to focus on engaging and supporting the family; identifying maladaptive interactions, and promoting new and more adaptive family interactions.

“Brief strategic family therapy: an intervention that is systemic in focus and is influenced by other approaches. The main elements include engaging and supporting the family, identifying maladaptive family interactions and seeking to promote new and more adaptive family interactions”

Szapocznik, J., Rio, A., Murray, E., *et al.* (1989) Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology*, 57, 571-578.

1.2.7.5. Functional family therapy

Sessions over 3 months, by health / social care professionals: behavioural in focus.

1.2.8.2. For those with a strong history of offending, to focus on improving interactions within the family: engaging and motivating the family in treatment (facilitating change, eg reframing); problem-solving and behaviour change through parent-training and communication training; facilitate change within wider contexts – family, schools, community

“Functional family therapy: a family-based intervention that is behavioural in focus. The main elements include engagement and motivation of the family in treatment, problem-solving and behaviour change through parent-training and communication-training, and seeking to generalise change from specific behaviours to positively influence interactions both within the family and with community agencies such as schools.”

Gordon, D.A., Graves, K. & Arbuthnot, J. (1995) The effect of functional family therapy for delinquents on adult criminal behavior. *Criminal Justice and Behavior*, 22, 60-73.

1.2.7.6. Multisystemic therapy

1.2.8.3. Sessions over 3 – 6 months - one professional visiting several times a week - for those with severe conduct problems and a history of offending – and at risk of being excluded from family / placed away from home: focus on problem-solving approaches with the family; involve and use resources of peer groups, schools and wider community,.

“Multisystemic therapy: using strategies from family therapy and behaviour therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people”.

Henggeler, S.W., Melton, G.B., & Smith, L.A. (1992) Family preservation using multisystemic therapy: an effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology*, 60, 953-961.

Henggeler, S.W., Melton, G.B., Brondino, M.J., et al. (1997) Multisystemic therapy with violent and chronic juvenile offenders and their families: the role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, 65, 821-833.

Henggeler, S.W., Schoenwald, S.K., Swenson, C.C., et al. (2006) Methodological critique and meta-analysis as Trojan horse. *Children and Youth Services Review*, 28, 447-457.

Henggeler, S.W., Halliday-Boykins, C.A., Cunningham, P.B. et al. (2006) Juvenile drug court: enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting and Clinical Psychology*, 74, 42-54.

Henggeler, S.W., Pickrel, S.G. & Brondino, M.J. (1999) Multisystemic treatment of substance-abusing and -dependent delinquents: outcomes, treatment fidelity, and transportability. *Mental Health Services Research*, 1, 171-184.

Research projects have been set up to assess the British application of Multi-systemic therapy.

1.2.7.7. Multidimensional Treatment for Foster care

1.2.8.4. Sessions over 6 months – team includes family therapy : For those with conduct problems at risk of being in long term care: Family therapy is for birth parents, to provide supportive environment for young person to return to after treatment.

“Multidimensional treatment foster care: using strategies from family therapy and behaviour therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people in foster care and other out-of-home placements. This includes group meetings and other support for the foster parents and family therapy with the child’s biological parents”

Chamberlain, P. & Reid, J.B. (1998) Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology*, 66, 624–633.

Chamberlain, P., Leve, L.D. & DeGarmo, D.S. (2007) Multidimensional foster care for girls in the juvenile justice system: 2 year follow up of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 75, 187–193.

Also: Parent Training programmes include Webster Stratton and Triple P

Social problem skills training: a specialist form of cognitive problem-solving training that aims to:

- modify and expand the child’s interpersonal appraisal processes through developing a more sophisticated understanding of beliefs and desires in others
- improve the child’s capacity to regulate his or her own emotional responses.

Research recommendation: 4.3. Effectiveness of multi-systemic therapy vs functional family therapy

BIPOLAR DISORDER 2006 The management of BD in Adults, Children & Adolescents in Primary and Secondary care

General recommendations address the need to include families because of the impact of bipolar disorder on relationships, the welfare of dependent children, etc, as well as on friends. For children and adolescents, wider contexts need to be considered as well (eg implications for school), which are more widely explored in the Full Guideline. Tier 3 CAMHS staff are expected to include 'psychotherapists' without specifically mentioning family therapists.

1.5. 5.3. Focused family intervention

For those in regular contact with families, over 6-9 months; it should cover psychoeducation, improve communications and problem solving

Rea, M.M., Tompson, M.C., Miklowitz, D.J., *et al.* (2003) Family-focused treatment versus individual treatment for bipolar disorder: results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 71, 482–492

Full: Structured Formal family Interventions

For adolescents: Therapy during depressive episodes, when adverse family atmosphere evokes emotional, hostile and critical comments – so treatment provides education to help reduce negative comments which leads to reducing depressive episodes.

Miklowitz, D.J., Simoneau, T.L., George, E.L., *et al.* (2000) Family-focused treatment of bipolar disorder: 1-year effects of a psychoeducational program in conjunction with pharmacotherapy. *Biological Psychiatry*, 48, 582–592.

Miklowitz, D.J., George, E.L., Richards, J.A., *et al.* (2003) A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry*, 60, 904–912.

Vaughn, C.E. & Leff, J.P. (1976) *The influence of family and social factors on the course of psychiatric illness. A comparison of schizophrenic and depressed neurotic patients.* *British Journal of Psychiatry*, 129, 125–137.

DEPRESSION IN CHILDREN AND YOUNG PEOPLE. 2005 Identification & management in primary, community & secondary care

Guidelines support psychological therapies rather than medication as ways of addressing the experiences of children and young people with depression, since many of these will be linked to life events and factors within their family life, eg parental depression, separation, or family discord. Psychological therapies (p65) include family therapy (which may include systemic, cognitive behavioural and psychoanalytic principles) and systemic family therapy. The use of Stepped Care approach means that formal psychotherapies are used in Steps 4 and 5, for moderate to severe depression. Family therapists mentioned in descriptions of CAMHS Tiers 2 and 3. More models were reviewed in the FULL guidelines.

1.6.1.2. & 1.6.3.2. Shorter-term family therapy

For children and young people with moderate – severe depression for at least 3 months – more evidence for 12-18 yrs than for younger children

1.6.3.2. Systemic family therapy At least 15 fortnightly sessions, if child / young person are unresponsive to treatment, then further psychological therapy and /or family therapy should be considered. Trowell's research was not completed at time guidelines were set up.

Trowell, Joffe, Campbell *et al* (2007): *Childhood depression: a place for psychotherapy: An outcome study comparing individual psychodynamic psychotherapy and family therapy* *European Child and Adolescent Psychiatry*.16.3. 157-167

Full: Systemic Behavioural Family Therapy (Brent et al 1997): SBFT has a systemic overall perspective about who to include, etc, and therapy has 2 phases – 1st phase uses Functional Family Therapy (including reframing), and 2nd phase looks more at problem-solving (from Robin and Foster model). In Brent’s study, all therapists had Masters level qualifications and about 8 yrs experience + 6 months training for using the model for the research trial.

Brent, Holderr & Kolko, (1997): A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive therapy. *Archives of General Psychiatry*. 54. 877-885

Brent, D.A., Kolko, D.J., Birmaher, B., *et al.* (1998) Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 906–914

Home-based multi-systemic therapy

Henggeler, S.W., Rowland, M.D., Randall, J., *et al.* (1999) Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: clinical outcomes. *Journal of American Academy of Child and Adolescent Psychiatry*, 38, 1331–1339.

Research recommendation: 4.1 RCT to assess efficacy and cost effectiveness of individual CBT, systemic family therapy and psychodynamic psychotherapy.

4.2.: RCT to assess medication vs psychological therapies.

DEPRESSION – ADULTS (UPDATE) 2009

The treatment and management of depression in adults.

NICE Guideline: For effective treatments, competent practitioners are needed for psychological and psychosocial treatments. ‘Regular high quality’ supervision is needed, and it is assumed that manuals are required, especially in order to audit and monitor practice.

For Step 3, or for those who have not responded to low level treatments, Behavioural Couples therapy (BCT) is recommended where relationship issues may contribute to depression or have a role in maintaining it, or where involving a partner has ‘potential therapeutic benefit’. The recommendation is that the model should ‘normally’ be BCT, but other models can be used.

The Full guidelines acknowledge that psychotherapies can be effective despite not having an evidence base that meets NICE standards (p141). The description of depression covers family and systemic issues: current relationship issues or problems from childhood experiences, the impact of depression on the family and close relationships, including on children of parents with depression. The treatment recommendations focus on the evidence based practice, and say there is a stronger evidence base for behavioural couple-focused therapy than for systemic couple therapy (Problems on the evidence for the Maudsley model were raised). There are recommendations to include family in assessments and to help monitor mood, as well as to consider the impact on families, especially for BME families.

P149. 6.3.1 Improving Access to Psychological Therapies (IAPT) – couple therapy is mentioned as one of the treatments for IAPT. (and systemic couple therapy is included in IAPT)

8.10.3.1. & 8.10.4.5. Couples therapy For people with partners, either because of relationship issues that are considered to maintain the depression, or because of the therapeutic value of including a partner; and is ‘usually based on behavioural principles’ 15 – 20 sessions

Key relevant models covered:

Jacobson, N. S., Fruzzetti, A., Dobson, K. S., *et al.* (1993). Marital therapy as a treatment for depression II: The effects of relationship quality and therapy on depressive relapse. *Journal of Consulting and Clinical Psychology*, 61, 516–519.

Jones, E. & Asen, E. (1999) *Systemic Couple Therapy and Depression*. London: Karnac
Leff, J., Vearnals, S., Brewin, C.R., et al. (2000) *The London Depression Intervention Trial. Randomised controlled trial of antidepressants vs. couple therapy in the treatment and maintenance of people with depression living with a partner: Clinical outcome and costs*. *British Journal of Psychiatry*, 177, 95–100. (The Maudsley model is excluded in the 2009 update because it did not fit with NICE research criteria).

Key evidence articles:

Christian, J.L., O’Leary, K.D. & Vivian, D. (1994) Depressive symptomatology in maritally discordant women and men: The role of individual and relationship variables. *Journal of Family Psychiatry*, 8, 32–42.

Cooklin, A (2006) *Children of Parents with Mental Illness*. In *Children in Family Contexts, Perspectives on Treatment (2nd edn)* (ed L. Combrinck-Graham). New York, New York: The Guilford Press.

Pilling, S. A. (2009) *Developing evidence-based guidance: implications for systematic interventions*. *Journal of Family Therapy*, 31, 194-205.

Wheeler, J.G., Christensen, A. & Jacobson, N.S. (2001) Couples distress. In *Clinical Handbook of Psychological Disorders* (ed D.H. Barlow), pp.609–630. New York, New York: Guilford Press.

Ramachandani, P. & Stein, A. (2003) *The impact of parental psychiatric disorder on children*. *British Medical Journal*, 327, 242–243.

Clinical Questions: 7. 4, 5: same as for Depression and Chronic Health problems - assess the outcome following comparison of different psychotherapies, including family interventions / couples therapy, solution focused therapy and systemic interventions. Several questions about what is helpful, eg group / individual therapies; characteristics of therapists, patient characteristics – and are psychological therapies harmful? Assess which therapies are most effective in preventing relapse.

DEPRESSION WITH A CHRONIC PHYSICAL HEALTH PROBLEM 2009

The treatment and management of depression in adults with chronic health problems

NICE Guideline: As depression is more common in people with physical health problems (20% have depression), various treatments need consideration. Families and carers are recommended to be included in the assessment and clinical practice with people with depression with a physical health problem, providing there is agreement.

1.5 Stepped Care for ‘persistent subthreshold depression, mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression’:

1.5.1.1 & 1.5.1.2: Behavioural couple therapy for people with a regular partner, where involving the partner is potentially beneficial, or where issues in the relationship need to be addressed because of their role in triggering or maintaining depression.

1.5.3.5. Behavioural Couple therapy should ‘normally be based on behavioural principles’; 15 – 20 sessions over 5 – 6 months.

The Guidance covers adults with so many chronic health conditions that there were few RCTs available. The people with chronic health problems often have little access to psychological therapies, apart from counselling in primary care or hospital. The evidence from Depression for CBT and couples therapy is recommended, because of the impact of depression on a partner – and the guidelines do acknowledge the impact of stress with chronic health problems on all close relationships, including on the children, partners and others offering support. They recommend a stepped care approach, so that couple therapy is for those with moderate to severe depression, involved with primary care and hospital settings for their health problems, and who have not responded to initial treatments.

FULL guideline: 7.4.1.10. & 7.4.1.11.& 7.4.1.18. Couple –focused therapy

Aims: To develop more supportive and less conflict in relationships; to understand the effects of interactions on each other.

& 8.5.2.33. – where drug treatments for depression are being stopped or reduced..

Martire, L., Schulz, R., Keefe, F., Rudy, T., & Starz, T. (2007). Couple-oriented education and support intervention: Effects on individuals with osteoarthritis and their spouses. *Rehabilitation Psychology, 52*, may 07-132.

Family interventions are mentioned in the psychological therapies but not recommended because of the absence of evidence base. Based on systemic, behavioural and psychoanalytic principles, they must include one of these: psychoeducational interventions; problem solving / crisis management; or intervention with the identified service user

Clinical Questions: B5 assess the outcome following comparison of different psychotherapies, including family interventions / couples therapy, solution focused therapy and systemic interventions. Several questions about what is helpful, eg group / individual therapies; characteristics of therapists, patient characteristics – and are psychological therapies harmful?

B6: assess which therapies are most effective in preventing relapse.

DRUG MISUSE –PSYCHOSOCIAL INTERVENTIONS 2007

Drug Misuse covers a range of psychological, social and medical problems as well as treatments, and many of the models of couple, family and network interventions come from the US, but there are examples of development in the UK (Copello and Velleman – or Yandoli, whose work is referred to in Drug Misuse – Opioid Detox).

1.4.4.1. & 1.4.5.1. Behavioural Couples therapy

For people in close contact with a non-drug-misusing partner – to focus on the person's drug misuse for at least 12 weekly sessions. To prevent relapse to opioid dependence Couples based interventions (including BCT) will involve supportive spouse / partner, with a behavioural contract. The aims are to improve their relationship through developing communication skills, acknowledging 'pleasing behaviour' and finding shared activities.

Fals-Stewart, W., Birchler, G. R. & O'Farrell, T. J. (1996) Behavioral couples therapy for male substance-abusing patients: effects on relationship adjustment and drug-using behaviour. *Journal of Consulting and Clinical Psychology, 64*, 959–972.

Fals-Stewart, W., O'Farrell, T. J. & Birchler, G. R. (1997) Behavioral couples therapy for male substance-abusing patients: a cost outcomes analysis. *Journal of Consulting and Clinical Psychology, 65*, 789–802.

Fals-Stewart, W., O'Farrell, T. J. & Birchler, G. R. (2001) Behavioral couples therapy for male methadone maintenance patients: effects on drug-using behavior and relationship adjustment. *Behavior Therapy, 32*, 391–411.

Fals-Stewart et al 2002

1.4.5.1. Family Interventions

Involving the family recognises the role of family interactions and relationships in both drug misuse and its treatment (including parents, children and siblings). Sessions will include whole family or subsections

Catalano, R. F., Gainey, R. R., Fleming, C. B., (1999) An experimental intervention with families of substance abusers: one-year follow-up of the focus on families project. *Addiction, 94*, 241–254

Copello, A. G., Velleman, R. D. & Templeton, L. J. (2005) Family interventions in the treatment of alcohol and drug problems. *Drug and Alcohol Review, 24*, 369–385

Social Systems Interventions Networks – usually for young people -include family members, close friends and significant people, eg teachers or probation officers to participate in treatment sessions.

Henggeler, S.W., Pickrel, S.G. & Brondino, M.J. (1999) Multisystemic treatment of substance-abusing and -dependent delinquents: outcomes, treatment fidelity, and transportability. *Mental Health Services Research, 1*, 171-184.

EATING DISORDERS 2004. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (review considered soon)

Covers the importance of involving family members in treatment, but does not necessarily use the term family therapy or family interventions, and sometimes uses the term ‘family work’. Need for having family therapist in teams mentioned in Guidelines.

1.2.2.1. & 1.2.2.13. Family interventions

Family interventions focused explicitly on eating disorders, using the Maudsley model – for children and young people with anorexia nervosa; involve siblings and other family members because of the impact on them. Address family and individual issues.

Describe Family Intervention as based on systemic, cognitive behavioural or psychoanalytical principles, which may include psycho-education, problem-solving and crisis management.

Lock, J. & Le Grange, D. (2001). Can family-based treatment of anorexia be manualised? Journal of Psychotherapy Practice Research, 10(4), 253–261. (Practice in US based on Maudsley model).

Eisler, I., Dare, C., Hodes, M., Russell, G., Dodge, E. & Le Grange, D. (2000). Family therapy for adolescent anorexia nervosa: The results of a controlled comparison of two family interventions. Journal of Child Psychology & Psychiatry & Allied Disciplines, 41, 727–736

1.2.2.6. Combined individual and family work – when more intensive treatment is considered because of deterioration, or when day care or inpatient treatment is needed.

Research recommendations: 4. Several questions about what makes treatment effective for anorexia nervosa and bulimia nervosa. Full Guideline recommends comparison between Family therapy and other psychological therapies for Bulimia Nervosa.

POST TRAUMATIC STRESS DISORDER (PTSD) 2005

The management of PTSD in adults and children in primary and secondary care

The value of including families in treatment comes across strongly, to support the person with PTSD and their families – especially if the trauma affects other family members. It also acknowledges that trauma within the family has implications for whom to involve – addressing sexual abuse has implications for who to involve, while when all the family are affected by some other trauma, there will be benefits for being seen together.

1.5.4. Treatment of the family should be ‘coordinated’ when trauma affects the whole family. Generally recommendations are to provide support to families as well as helping families to support person who has PTSD, particularly as families underestimate the impact of trauma in children.

1.9.5.6. Family Therapy

Should be included in psychological treatments, but to inform them there is no evidence

Ramchandani, P. & Jones, D. P. (2003) Treating psychological symptoms in sexually abused children: from research findings to service provision. British Journal of Psychiatry, 183, 484–490.

SCHIZOPHRENIA update 2009: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.

These guidelines integrate the cognitive and systemic approaches to working with families allowing for flexibility in the application of the work. Emphasis is placed on the need for longer term work, including the person with schizophrenia if possible and considering what suits the family. The value of including families who live close to the person with psychoses is recognised, since the evidence shows that it reduces relapse and hospital admissions.

1.3.4.13 Key guideline: Should include person with schizophrenia if possible, take between 3+ 12 months, with at least 10 sessions, use family's preference of single / group family sessions, address key relationships, psychoeducation, problem solving and crisis management.

1.3.4.2 & 1.3.4.4 & 1.4.3.2 & 1.4.3.3.& 1.4.6. Family interventions Guidelines acknowledge the importance of family support as well as the impact of psychoses on family. Interventions – FI from behavioural and systemic ideas, adapted to the needs of the family - can offer support, education, reduce stress, improve communication, address problems.

For those who have not responded adequately to treatment; to all families who live with or have close contact with person with schizophrenia

References come from UK, USA, Australia, China

UK:: *Barrowclough (1999); Leff (1982); Tarrier (1988); Vaughn (1992); Falloon (1981); Szukler (2003)*

1.3.4.13. Multi-family group intervention / single-family intervention

Leff (1989); McFarlane (1995a & 1995b); Montero (2001); Schooler (1997)

Research recommendations: 8.7.11.1 . For BME groups, will family interventions adapted for ethnic groups help with engagement, reduce distress in families and reduce relapse?

8.7.11.2. Research is needed to identify the competencies needed for Family Interventions

PHYSICAL HEALTH TOPICS

TYPE 1 DIABETES: 2004. (Topic -Endocrine, nutritional and metabolic conditions) **Diagnosis and management of Type 1 Diabetes in children, young people and adults**

Need for involving families is because of the complexity of issues and experiences for children and young people with Type 1 Diabetes. Involving the family can reduce the impact of stress and mental health disorders on diabetes.

1.4.7.4. & 1.4.7.5. Behavioural Family Systems therapy

To reduce diabetic-related conflict between family members; to address problems associated with depression, anxiety, behavioural / conduct disorders and family conflict.

Harris MA, Mertlich D. Piloting home-based behavioral family systems therapy for adolescents with poorly controlled diabetes. *Children's Health Care* 2003;32:65–79.

Chernoff RG, Ireys HT, De Vet KA, Kim YJ. A randomized, controlled trial of a community-based support program for families of children with chronic illness: pediatric outcomes. *Archives of Pediatrics and Adolescent Medicine* 2002;156:533–9.

Harris MA, Greco P, Wysocki T, White NH. Family therapy with adolescents with diabetes: a litmus test for clinically meaningful change. *Families, Systems and Health* 2001;19:159–68

Research recommendations: effectiveness of social and behavioural interventions for problems associated with type 1 Diabetes, including anxiety, Depression, eating disorders, conduct disorders, and those who have do not easily engage with treatment for Diabetes.

FULL Guideline: Type 1 Diabetes in Children and Young People.

P138: **6.7 Psychosocial Support. Recommendation A.** Families of children and young people with type 1 diabetes should be offered specific support strategies (such as behavioural family systems therapy) to reduce diabetes related conflict between family members.

GPP. Children and young people with type 1 diabetes and their families should be offered timely and ongoing access to mental health professionals because they may experience psychological disturbances (such as anxiety, depression, behavioural and conduct disorders and family conflict) that can impact on the management of diabetes and wellbeing.

A – best evidence, Level 1; GPP – Good Practice Point

P123. Research recommendation - adolescents: Further studies are needed to evaluate the effectiveness of behavioural and social interventions on anxiety and depression, eating disorders, behavioural and conduct disorders, and adherence to therapy in children and young people with type 1 diabetes, especially in adolescence, from diagnosis and in established diabetes.

647. Harris MA, Greco P, Wysocki T, White NH. Family therapy with adolescents with diabetes: a litmus test for clinically meaningful change. *Families, Systems and Health* 2001;19:159–68.

644. Wysocki T, Harris MA, Greco P, Bubb JA, Harvey LM, Taylor A. Randomized, controlled trial of behavior therapy for families of adolescents with insulin-dependent diabetes mellitus. *Journal of Pediatric Psychology* 2000;25:23–33.

645. Wysocki T, Greco P, Bubb J, White NH. Behavior therapy for families of adolescents with diabetes: maintenance of treatment effects. *Diabetes Care* 2001;24:441–6.

646. Anderson BJ, Brackett J, Ho J. An office-based intervention to maintain parent–adolescent teamwork in diabetes management. Impact on parent involvement, family conflict, and subsequent glycemic control. *Diabetes Care* 1999;22:713–21.

647. Harris MA, Greco P, Wysocki T, White NH. Family therapy with adolescents with diabetes: a litmus test for clinically meaningful change. *Families, Systems and Health* 2001;19:159–68.

648. Ireys HT, Chernoff R, DeVet KA, Kim Y. Maternal outcomes of a randomized controlled trial of a community-based support program for families of children with chronic illnesses. *Archives of Pediatrics and Adolescent Medicine* 2001;155:771–7.

649. Chernoff RG, Ireys HT, DeVet KA, Kim YJ. A randomized, controlled trial of a community-based support program for families of children with chronic illness: pediatric outcomes. *Archives of Pediatrics and Adolescent Medicine* 2002;156:533–9.

650. Harris MA, Mertlich D. Piloting home-based behavioral family systems therapy for adolescents with poorly controlled diabetes. *Children's Health Care* 2003;32:65–79.

Clinical Guidelines in Development

a) Draft NICE and FULL Guidelines

COMMON MENTAL HEALTH PROBLEMS: CASE IDENTIFICATION AND CARE PATHWAYS (Consultation > Dec 2010). England, Wales and Northern Ireland.

Draft FULL Guidelines focus on care pathways, and use recommendations for depression and anxiety, as well as for IAPTs. (Improving Access to Psychological Therapies). Family issues were discussed primarily for ethnic minorities and parental mental health.

NICE recommendations:

Recommendation 1.3.3. for persistent sub threshold depressive symptoms; mild-moderate common mental health disorders – with inadequate responses to initial interventions; or moderate-severe common mental health disorders: Behavioural Couple Therapy is included in the psychological interventions.

Bernal G. (2006) Intervention development and cultural adaptation research with diverse families. *Family Process*, 45, 143-151.

Bernal, G. & Domenech Rodriguez, M. M. (2009) Advances in Latino family research: cultural adaptations of evidence-based interventions. *Family Process*, 48, 169-178.

Ramachandani, P. & Stein, A. (2003) The impact of parental psychiatric disorder on children. *British Medical Journal*, 327, 242–243.

Rodriguez, M., Valentine, J.M., Son, J.B., et al. (2009) Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. *Trauma Violence Abuse*, 10, 358-374.

PSYCHOSIS WITH SUBSTANCE MISUSE (Consultation > Oct 2010)

NICE: Family interventions –treatments will be complex and different agencies will be involved, especially where for parents with young children.

Recommendations: 1.1.8 – recommendations for Family interventions linked to Schizophrenia (using adult treatment models)

1.4.19 Use recommendations from other guidelines, eg Bipolar Alcohol dependence, Drug misuse.

Research recommendations: 4.3 *The clinical and cost effectiveness of psychological /psychosocial interventions in reducing substance misuse in people with psychosis and coexisting substance misuse*

Are psychological/psychosocial interventions (such as motivational interventions) more clinically effective and cost-effective at reducing substance misuse in people with psychosis and coexisting substance misuse? In Full guideline, FT may be used in recommendations 7.3.2. p 204

FULL guideline: Where families /carers are involved or live with person with psychosis and substance misuse, then use family interventions, based on Schizophrenia guideline.

Couples therapy (Fals-Stewart *et al.*, 2005)

Social systems Interventions (Henggeler *et al.*, 1999).For children and young people, the importance of social networks is recognised.

b) SCOPES

CONDUCT DISORDERS IN CHILDREN AND YOUNG PEOPLE NICE+ SCIE (due to start consultation soon)

SELF HARM – The longer term management of self harm (Scope Nov 2009) From 8yrs + Psychological therapies to be reviewed will include problem solving therapy and family therapy and RCTs will assess family therapy.

SCHIZOPHRENIA for up to 18 years old (Scope > Jan 2011) England, Wales & Northern Ireland.

Family therapy mentioned several times as one of several psychological therapies in the Scope. The focus is on schizophrenia rather than psychoses. Problems with access to therapy resources are mentioned: *Provision of these therapies for adults and young people, especially for family therapy, is variable and largely poor despite their growing evidence base.*

B. Clinical NICE Guidelines that recommend the inclusion of family in treatment without specifying family therapy/ intervention.

Nine Clinical Guidelines for mental health and behavioural conditions and five for physical health conditions include recommendations for including families or partners in treatments or care without using terms like ‘family therapy’. The FULL Guidelines review available evidence, and recognise that a systemic approach would benefit, but there is not a sufficient evidence base within NICE criteria. One guideline in development is likely to fit this category.

Guidelines that recommend including families

Mental health topics	Treatments reviewed / mentioned in Full Guideline
ADHD 2008	Structural FT; Strategic FT; Brief solution focused therapy
Antenatal and Post Natal Mental Health 2007	
Antenatal Care 2008	
Borderline Personality Disorder 2009	Full: Home treatment teams
Dementia 2006	Family therapy
Drug Misuse – Opioid Detoxification 2007	Family intervention Social network interventions
OCD 2005	Marital / couple therapy Family-based behaviour therapy
Pregnancy and complex Social Factors	Family Therapy
Self Harm 2004	Home-based family therapy/interventions
Physical health	Treatments reviewed in Full Guideline
Chronic Fatigue Syndrome 2007	
Palliative Care for Adults with Cancer 2004	
Children and Young People with Cancer 2005	
Nocturnal Enuresis for CYP 2010	
Obesity 2006	
Guidelines in development	
Autism in children and adolescents	

ATTENTION DEFICIT HYPERACTIVITY DISORDER. 2008. Diagnosis & management of ADHD in children, young people and adults

Parent training / education: Focus on giving advice & education in the NICE Guidelines but reviews 3 forms of family therapy in FULL guideline: Structural family therapy; Strategic Family therapy; Brief Solution Focused therapy. Emphasis on including parents and family members in assessment is to consider the impact of ADHD, to consider the impact of life events, but the focus is on advice and parent training / education.

ANTENATAL AND POSTNATAL MENTAL HEALTH 2007: Clinical management and Service Guidance

The involvement and support of family members is acknowledged as crucial to support the relationships between the mother and her baby (and other children) when serious mental health problems occur during pregnancy and post natal. The emphasis is on responding rapidly to provide psychological treatments, but because of limited evidence, the types of therapies are not spelled out. With OCD the relationships between the mother with mental health problems, her baby and partner, are important to consider.

ANTENATAL CARE 2008: Routine Health care for healthy pregnant women

Impact of mental health on families and relationships – partner and baby
Full Guidelines have more details about need to consider close relationships for healthy pregnant women. Domestic violence is mentioned, with a focus on assessment in the Guideline.
The 2003 Guideline recommended research on interventions for domestic violence.

BORDERLINE PERSONALITY DISORDER 2009

Treatment & management (covers England, Wales + Northern Ireland)

The emphasis is on the need to engage people with BPD, with an assumption that the work will be seen individually, partly because of the relationship problems associated with BPD. Concerns that there is a risk that people with BPD may withdraw from services / treatment if family members are included – because of some of the family issues associated with BPD.
Because of the limited RCTs, specific psychological treatments are not mentioned, apart from DBT. Full Guidelines acknowledge value of support from families, and need to address relationship issues – and reviewed research studies in which psychoeducation increased the sense of burden in families. Lofflestaska (2003) studied psychoanalytic treatment with in patient care, and systemic family therapy for 1 years with outpatients

1.4.1.5. Home treatment teams

For young people requiring Tier 4 Treatment: when ‘parenting is distorted’ and family relationships undermine progress. There is an implication that this is family therapy, but it is not spelled out.
Jones, J. M., Pearson, G. T., & Dimpero, R. (1989) Long-term treatment of the hospitalized adolescent and his family: an integrated systems-theory approach. *Adolescent Psychiatry*, 16, 449-72. Hoffman, P. D., Fruzzetti, A. E., & Buteau, E. (2007) *Understanding and engaging families: An education, skills and support programme for relatives impacted by borderline personality disorder. Journal of Mental Health*, 16, 69-82.

DEMENTIA (2006) (SCIE and NICE)

Supporting people with dementia and their carers in health and social care

NICE Guidelines acknowledge the role of families / carers, in the assessment and treatments.

1.11.2.5. For carers who experience psychological distress they should be offered psychological therapy from a ‘specialist practitioner’ (including CBT), as individuals rather than as part of a couple / family relationship.

FULL Guideline: Most care for people with dementia is provided by family (including spouse), although they may not live close by. Reviews of systemic family therapy are included as relatively new interventions, as well as considerations for offering support or psychological treatments for the carers.

Benbow, S.M., Marriott, A., Morley, M., et al. (1993) Family therapy and dementia: review and clinical experience. International Journal of Geriatric Psychiatry, 8, 717–725.

Gilleard, C.J. (1996) Family therapy with older clients. In Handbook of the Clinical Psychology of Ageing (ed. R.T. Woods). Chichester: J. Wiley and Sons.

4. Research Recommendations:

4.3. For carers of people with dementia, is a psychological intervention cost effective when compared with usual care?

DRUG MISUSE - OPIOID DETOXIFICATION 2007

Guidelines focus on interactions, associated with drug misuse, to understand the impact of interactions on each other in drug misuse – aim to change relationships to be more supportive and reduce conflict.

Family Interventions

Both references mentioned in the Full Guideline rather than in NICE Guideline are from the UK, and Copello and Velleman are used in Drug Misuse – Psychosocial interventions.

Yandoli, D., Eisler, I., Robbins, C., et al. (2002) A comparative study of family therapy in the treatment of opiate users in a London drug clinic. Journal of Family Therapy, 24, 402-422

Copello, A.G., Velleman R.D.B. & Templeton, L.J. (2005): Family interventions in the treatment of drug and alcohol problems. Drug & Alcohol Review. 24.2.369-385.

Social Network Interventions

Not mentioned in the NICE Guidance. Recommends that network is brought together quickly after referral, and professionals invite the members to support person to stop using drugs

Galanter, M., Dermatis, H., Glickman, L., et al. (2004): Network therapy: decreased secondary opioid use during buprenorphine maintenance. Journal of Substance Abuse Treatment, 26, 313

OBSESSIVE COMPULSIVE DISORDER 2005 : Core interventions in the treatment of obsessive-compulsive disorder – dysmorphic disorder (review considered soon)

The reviews of the use of family therapies with OCD in the FULL Guideline include case examples rather than RCTs, and this enables the Guidelines to consider the value of involving family members through marital / couple therapy or different ways with children and adolescents. They do recommend that if family therapy is offered, they should be informed that there is no evidence to support the treatment, and the FULL guidelines cover more descriptions of what family therapy can offer, with an assumption that it will be offered by qualified staff.

Marital / couple therapy

For adults, where family have become involved in the OCD behaviours, to reduce their involvement, in sensitive and supportive manner

Recommend that families should be informed that there is not an evidence base for couple therapy

Hafner, R.J. (1982) Marital interaction in persisting obsessive-compulsive disorders.

Australian and New Zealand Journal of Psychiatry, 16, 171–178.

Keiley, M.K. (2002) Affect regulation and attachment focused treatment of a husband with obsessive-compulsive disorder and his wife. *Journal of Couple and Relationship Therapy*, 1, 25–44.

Stern, R.S. (1973) Contract therapy in obsessive-compulsive neurosis with marital discord. *British Journal of Psychiatry*, 123, 681–684.

Family-based behaviour therapy /Conjoint family therapy

For children and young people: Numerous recommendations to involve parents / carers because of the impact of the symptoms, and the need to involve families in treatment, which may be CBT

Barrett, P., Healy-Farrell, L., & March, J.S. (2004). Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: a controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 46–62.

Dalton, P. (1983) Family treatment of an obsessive-compulsive child: a case report.

Family Process, 22, 99–108.

O'Connor, J.J. (1983): Why can't I get hives: brief strategic therapy with an obsessional child. *Family Process*, 22, 201–209

Definitions include brief summaries of several models under the term 'Family Therapy': Systemic therapy; Strategic family therapy; Family-based behaviour therapy; Cognitive behavioural therapy; Narrative family therapy.

Research questions 4.1. RCT to compare CBT / medication with other psychological therapies for young people & young adults (12-25) with OCD & BDD

4.5: CBT for children & young people with OCD – to include families

Full: Clinical Question. 7: for people with OCD, does family therapy produce benefits/ harms when compared with other therapies?

PREGNANCY AND COMPLEX SOCIAL FACTORS (covers England, Wales plus Northern Ireland) Sept 2010.

Complex factors cover migrants, refugees and asylum seekers; teenagers; those who misuse substances, and women who are victims of domestic violence. Family therapy is mentioned in the FULL guideline as a treatment available in a voluntary service for some women who misuse substances. This is included in the document: *Descriptions of services for pregnant women with complex social factors* where family therapy is in part of the voluntary agency that the Manchester Specialist Midwifery Services has access to for pregnant women with substance misuse.

Research Recommendation: 1.3.1. & 1.3.2. What training would help staff to work better with women with complex social factors? And is family support effective in improving outcomes for women and babies?

P49. Clinical Question Q3. What additional consultations and/or support should be provided to women misusing substances, their partners and families in order to improve pregnancy outcomes? (Additional here means over and above that described in the NICE Antenatal care guideline).

P99 Clinical question : Q3. What additional consultations and/or support should be provided to young women aged under 20, their partners and families in order to improve pregnancy outcomes? (Additional here means over and above that described in the NICE Antenatal care guideline).

SELF HARM 2004: The short-term physical and psychological management and secondary prevention of self harm in primary and secondary care (update in progress - longer term treatment)

Brief home-based interventions/

Home-based Family therapy

Home-based Family Interventions

For children and young people: Guidelines recommend involving families, and to assess for child protection issues, although the Guidelines did not specify family therapy.

Harrington, R.; Kerfoot, M.; Dyer, E., McNiven, F.; GILL, J. M; Harrington, V.; Woodham, A.; Byford, S. Randomized Trial of a Home-Based Family Intervention for Children Who Have Deliberately Poisoned Themselves

Kerfoot, M. Harrington, R & Dyer, E. (1995) Brief home-based intervention with young suicide attempters and their families. Journal of Adolescence, 18(5), October, pp.557-568

Research recommendations: Although recommendations do not specify family interventions, they want to include family factors along with various other issues that need to be considered, including the characteristics of therapists. *(this has led to a major research project)*

Physical Health

CHRONIC FATIGUE SYNDROME 2007 (Topic - Central Nervous System):_Diagnosis and management of CFS / ME in adults and children

Family intervention

Brief contacts with partners / family members with aim of facilitating support and for providing education, especially for children – however, FI referred to communications on the phone ‘counselling’ or home visits by nurses – possibly 1 session – but some studies did demonstrate this reduced anxiety and stress in families

Buls P. The effects of home visits on anxiety levels of the client with a coronary artery bypass graft and of the family. *Home Healthc Nurse* 1995; 13(1):22-29.

Dracup K, Meleis A, Baker K, Edlefsen P. Family-focused cardiac rehabilitation. A role supplementation program for cardiac patients and spouses. *Nurs Clin North Am* 1984; 19(1):113-124

Research recommendations: very open question – how to help people to return to as normal life as possible, including ‘normal family life’

IMPROVING SUPPORTIVE AND PALLIATIVE CARE FOR ADULTS WITH CANCER 2004 The Manual <http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf>

Most cancer guidelines address the need to include families so that they may be there for the patient when decisions need to be made, as well as addressing the implications of living with seriously illness. This is one of the manuals covering several types of cancer where the guidelines use the term ‘systemic’ to describe the impact of cancer on the body, and the need for treatments to address this. The quality of life and psychosocial functioning can be improved when work is done with families, especially when there are high levels of stress and distress when the diagnosis is made, as well as at different stages of the cancer. The Manual covers supportive and palliative care, where teams will be involved with patients and their families – including social workers and psychologists who will provide the services needed, including those who need therapeutic work as a family during the illness, treatment or bereavement.

Key recommendation 9 ; commissioners and cancer service providers should ensure that there are psychological assessments and there is appropriate psychological support – some will need more specialist services than others.

12. Families and carers may benefit from looking after someone with cancer, but because of the stress involved, eg for special needs, they may need counselling or psychological treatments may be needed for the sexual partners, children and young people involved.

Psychological Support measures for the Manual of Cancer Service is being developed

Research recommendation 13.21; 13.23; 13.30. These recommendations are about assessing the benefits of working with families and carers – a longitudinal perspective, as well as the experiences of what palliative care is most helpful for both the patient and the families at different stages.

IMPROVING OUTCOMES IN CHILDREN AND YOUNG PEOPLE WITH CANCER **2005 Manual**

This guideline covers a range of treatments including palliative care, and the need to include families – siblings and grandparents are mentioned – comes across very strongly in the manual. The psychosocial treatments need to help families know how best to care the child / young person with cancer, as well as addressing their feelings and distress so that they can provide good support, including during the preparation for bereavement, as well as after death.

Psychological Support measures for the Manual of Cancer Service is being developed.

NOCTURNAL ENURESIS IN CHILDREN (Oct 2010)

Covers children and young people under 19 years of age. The impact of enuresis may be anger, or negativity or blame, when families need support. Families are to be included where appropriate, and various psychotherapies needed for those who do not respond to basic treatments. Some treatments will require ‘psychological expertise’, and although family therapies were not reviewed, research recommendations might be used to explore these.

4.2.9.2 Use ‘appropriate treatments’ for the circumstances and needs for children and families.

Research recommendations:

NICE: 4.3. p35 / FULL: 2.9.4. p.41. *What is the impact of bedwetting upon the psychological functioning and quality of life of children and their families? How do these change with treatment?*

FULL: 2.9.4: what is the impact of bedwetting on children, young people and family life p and how do these change with treatment

FULL: 2.9.5, p41: what is the most useful and effective psychological therapy?

FULL: 4.2: p79. *What is the family impact of children and young people aged under 19 who have bedwetting?*

OBESITY 2006 (Topic–Endocrine, nutritional and metabolic conditions) The prevention, Identification, assessment and management of overweight and obesity in adults and children.

Family programmes

Need to include family in both treatment and prevention, because of lifestyle issues, role of parents in providing food and exercise, and when other family members are obese.

Research recommendations: Whilst not specifying therapy, intensive interventions are needed, and families are acknowledged to be important in changing eating and exercise patterns.

Clinical Guidelines in development

AUTISM IN CHILDREN AND YOUNG PEOPLE (Full Guidance consult. 28/1 – 25/3/11

Some feedback from the consultation on the Scope is that working with families will be given more attention than in the draft scope.

C. CLINICAL GUIDELINES that do not include family issues, but they may benefit from Systemic Couple & Family Therapy

The guideline for anxiety (GAD) is updated and now includes references to relationship and families but there is very little evidence for psychological treatments. The other two are in different stages of development.

Topic	Any reference to family therapies
Generalized Anxiety Disorder & Panic Disorder	Counselling may include systemic approaches
Autistic Spectrum Conditions (adult) In development	

GENERALIZED ANXIETY DISORDER AND PANIC DISORDER (with or without agoraphobia) in ADULTS: management in primary, secondary and community care (partial update) – due for publication Jan 2011.

NICE: Although early interventions are recognised as being valuable, these are self help, computerised CBT and education. The impact of anxiety on relationships and families is now included for assessments in Step 4 for generalised anxiety disorder (GAD), and for panic attacks, although the literature does not address relationship issues with GAD or panic attacks.

4.4.5. Issues for families and carers of people with GAD did not emerge from the literature and common themes could not be identified in the personal accounts, which offer different perspectives of being a carer.

5.2.2: Yonkers et al (2000) found that family relationships were one factor that reduced the risk of remission, but other studies did not replicate these findings.

Yonkers, K.A., Dyck, I.R., Warshaw, M., *et al.* (2000) Factors predicting the clinical course of generalised anxiety disorder. *British Journal of Psychiatry*, 176, 544–549.

7.1.1. Acknowledged that counselling may include ‘psychodynamic, systemic and cognitive behavioural elements’ (Bower *et al* 2003)(details of this publication not available).

If the anxiety is linked to substance misuse then use recommendations for working with families in other guidelines.

FULL. Step 4 Recommendation: 4.5.6.3; 5.3.4.2; 5.3.4.3. Consider assessment and support for carers involved with someone with GAD.

Full: Clinical Question: 1. For people who have GAD and their carers, what are their experiences of having problems with GAD, of access to services and of treatment? (see chapter 4)

AUTISTIC SPECTRUM CONDITIONS: diagnosis and management of autistic spectrum conditions in adults. Scope Aug 2010.

Family issues not addressed, although these may be done in the draft Full Guideline..

D. TECHNOLOGY APPRAISAL (NICE & SCIE)

Only Technology Appraisal to include family relationships.

Parent-training/education programmes in the management of children with conduct disorders 2006/07 For children 12 yrs and younger

The Guidelines are about parent training / education, and the value of including families when children have conduct disorders, both through giving advice and support. Difficulties within families are covered, and the need to address relationship issues as well as to strengthen parenting roles. The term ‘systemic’ is not used, but it written in a way that acknowledges the importance of relationship contexts and interactions. Parent training / education is expected to take place in groups, but can be provided for individuals / parents where families who have complex needs or are difficult to engage in groups.

2.9 Family therapy Various psychological therapies should be considered for some children including family therapy, where the ‘Therapist’ meets whole family to explore interactions linked to conduct problems, and work with the issues that tend to sustain the conduct problems – but families may not have access because of limited resources – or they may not be easy to engage in treatment.

Research recommendations: RCTS looking at the British ways of using parent training, as well as questions about those who do not suit parent training – and a need to do non-RCT study to look at good practice in different available resources.

E. PUBLIC HEALTH

Public Health Guidelines cover networks and low level interventions within frontline services, some of which convey an understanding of systemic thinking. But some address the need for more intensive and specialist resources. Five guidelines recommend either family therapy or ways of involving families and three guidelines in development are likely to make similar recommendations. Some guidelines address the need for access to services within CAMHS, whilst others recognise the need for services for children and young people who may not meet CAMHS referral criteria.

Topic	Terms used in recommendation
Interventions to reduce substance misuse 2007	Family therapy Family-based programme of structured support
Promoting physical and emotional wellbeing in Looked After Children 2010	
Social & emotional wellbeing in primary education 2008	Parents need to be involved, eg parenting sessions Family issues to be addressed by CAMHS /services
Promoting young people's social and emotional wellbeing in secondary education 2009	Includes the need to work with parents and carers
Behaviour change 2007	Family-level interventions
Guidelines in development	Terms used in recommendation
Social and emotional wellbeing of vulnerable pre-school children: home-based interventions.	Home based family interventions
Preventing obesity – whole systems approach	Focus on systemic approach
Preventing Domestic Violence	

INTERVENTIONS TO REDUCE SUBSTANCE MISUSE AMONG YOUNG PEOPLE 2007. For under 25 yr olds

The vulnerability of children and young people is often associated with difficulties within the family, with issues like substance misuse, conduct problems and exclusions. Parent training is recommended for the parents of young children, although other family interventions are not mentioned, they may be recommended by CAMHS or other social care or voluntary agencies that become involved.

Recommendation 3: Covers vulnerable and disadvantaged young people: 11- 16yrs; at risk of substance misuse, and their parents / carers. The recommendations cover a wider professional network that have direct access to young people (teachers) as well as services catering for the vulnerable children, including the NHS.

Family –based programmes: These are structured support systems to cover 2 years, and include parent training, as well as offering motivational interviews aimed at parents; assessing family interaction; part of holistic approach for vulnerable children and families

Family therapy – where more intensive support is needed by families.

Research recommendations: what is the most effective and cost effective way of providing family based interventions (eg family therapy) for vulnerable and disadvantaged children. How do group based interventions compare with individual or no interventions?

PROMOTING THE PHYSICAL AND EMOTIONAL WELBEING OF LOOKED AFTER CHILDREN : SCIE + NICE (Oct 2010)

The documents on SCIE and NICE websites covers the need to commission different services to cover the complex needs of Looked After Children (LAC), as well as addressing the importance of services working together. The guidelines cover birth to 25 years, because of the vulnerability of those leaving care, and needing support or treatment from adult services. The expectation is that social workers need to work with foster families as well as birth families and although these fit with systemic approaches at different levels, details are not mentioned. The value of access to CAMHS services is stressed without specifying the problems and treatments needed, apart from reference to other NICE guidelines that are relevant for the different problems of the child or young person, and young adults.

The Costing Report recommends ‘dedicated services’ to address the various needs of the children and young people. Early interventions are recommended to promote emotional wellbeing as well as mental health problems, including conduct problems and those linked to physical health problems. Early interventions have a role because the costs of looking after CYP with emotional and mental health problems are 6 times greater than those without the problems. It also covers the training for those working with foster carers and their families. Services for 16-25 years need to address various mental health problems, including psychoses and self harm, substance misuse, complications of pregnancy and the risk of going to prison.

Reviews of the family and systemic interventions used for these guidelines can be found on the Centre for Excellence and Outcomes in Children’s Services (C4EO) website, as C4EO is a Consortium Partner of SCIE:

Dickson, K., Sutcliffe, K., Gough, D. & Statham, J. (2010): Improving the emotional and behavioural health of looked after children and young people.

Vulnerable (Looked After) Children: Final Summary & Recommendations Sept 2010

Research Recommendation: *Explore barriers to conducting controlled studies (for example, concerns about random allocation of looked-after children and young people) and making recommendations to reduce these obstacles. It should produce clear guidance about when it would be considered unethical, unnecessary, inappropriate, impossible or inadequate to randomly allocate participants.* Black 1996

Black N (1996) Why we need observational studies to evaluate the effectiveness of health care.

British Medical Journal 312: 1215–8

SOCIAL AND EMOTIONAL WELLBEING IN PRIMARY EDUCATION 2008

Whilst the stress associated with vulnerable families are key factors in this guideline, the emphasis is on getting staff within educational settings to be able to work with families and children when necessary and to provide practical support, eg help with childcare or transport.

Recommendation 3: For 4 – 11 year olds with early signs of emotional or social difficulties, and their parents / carers. Although family interventions / therapy are not specifically mentioned, parenting sessions and problem solving groups are recommended for some children, whether these are provided within the educational services or multi-agency involvement is required through referrals to CAMHS to address family issues.

Research recommendations: questions about how to work with vulnerable families to improve children’s emotional and social wellbeing

PROMOTING YOUNG PEOPLES'S SOCIAL AND EMOTIONAL WELLBEING IN SECONDARY EDUCATION. 2009

Recommendation 4: Working with parents and families to support learning (and this will include group based programmes from appropriately trained professionals) as well as providing support needed (eg parenting sessions) to promote social and emotional wellbeing for disadvantaged young people. The guidelines do not cover clinical interventions for mental illness.

Research Recommendations: Suggestions consider the types of approaches for things like bullying behaviours that may be organisation-wide, or work with parents.

BEHAVIOUR CHANGE AT POPULATION, COMMUNITY AND INDIVIDUAL LEVELS. 2007.

This guideline focuses on the organisational and systemic processes involved in changing health-related behaviours within the public sector. Community interventions will include family groups, or 'family-level interventions' – and interventions at one level may affect behaviours on individual or whole population levels. Many concepts used are systemic, alongside concepts such as 'planned behaviour'. It aims to develop ways to promote resilience and to evaluate different approaches to behavioural change, without addressing usual topics or methods.

Update: Behaviour Change is currently being reviewed: *The House of Lords Select Committee on Science and Technology has launched an inquiry into the use of behaviour change interventions as a means of achieving government policy goals.*

<http://www.parliament.uk/business/committees/committees-a-z/lords-select/science-and-technology-committee/inquiries/behaviour/>

PUBLIC HEALTH in development

3 guidelines have been suspended as the part of the new developments within Public Health England. These topics will be considered in conjunction with relevant developments in process.

SOCIAL AND EMOTIONAL WELLBEING OF VULNERABLE PRE-SCHOOL CHILDREN: HOME-BASED INTERVENTIONS.(Scope June 2010)

Vulnerable parents include those with mental health problems and who misuse substances, as well as those on low income, are unemployed, single parents, teenagers, or have poor parenting skills. Children at risk are those who had a low birth weight, a poor parent-child attachment, have poor cognitive, social and emotional skills and who have behavioural difficulties (but don't have a diagnosed mental disorder). This will not cover assessments or treatments for CAMHS services. The importance of involving families and supporting parents is expressed through 'home-based family interventions' for those needing intense treatments / interventions.

PREVENTING OBESITY – WHOLE SYSTEMS APPROACH (Scope Feb 2010)

Systemic training should have a role for staff providing early interventions.

PREVENTING DOMESTIC VIOLENCE (no Scope yet)

The PUBLIC HEALTH guidelines below do not refer to systemic couple / family therapy, although it may have a role for some people and those in close relationship.

PH19 Management of Long Term Sickness and incapacity for work: Guidance. 2009

Mentions counselling and CBT, and psychological treatment.

PH16 Mental Wellbeing and Older People 2009 – addresses Occupational Therapy and physical activity to improve mental health

PH22 Promoting Mental Wellbeing through Productive and Healthy Working Conditions: Guidance for Employers 2009: Stress will be something for employers to manage for various reasons, and only counselling and CBT are mentioned

F. Recent research projects from NICE consultations and Guidelines

Cabinet Office: Social Exclusion Action plan:

Multisystemic therapy:

£17.5m was invested (DH & DCSF) for the 10 pilot sites after 2 successful projects for young people with conduct disorders in Cambridgeshire and Brandon, North London, located across England: London Boroughs: Greenwich, Hackney; Merton and Royal Borough of Kingston; Plymouth, Reading, Peterborough, Barnsley, Leeds, Sheffield and Trafford. Team leader posts are for clinical psychologists/systemic psychotherapists.

Department of Children, Schools and Families

Multidimensional Treatment Foster Care in England (MTFCE)

13 teams under DCSF (adolescents) + 10 in network partnership.

Family therapy is provided for birth families, with a qualified family therapist (Band 8a) + professional with foundation level training (Band 7) – one component of the programme, to help young people return to live with their birth families.

National Team – based in 2 locations: North – Manchester; South Team- Maudsley
20 local authorities were using MTFC model in 2008 report, and some using it for younger children. Locations given as: Cheshire, Dorset, Dudley, Gateshead, Hammersmith & Fulham, Kent, North Yorkshire, , Northumberland, North Tyneside, Oxfordshire, Reading, Solihull, Southampton, South Gloucestershire, & Wandsworth. Glasgow

NHS – Health Technology Assessment Programme

SHIFT. Self Harm:

Major research project: to evaluate the effectiveness of family therapy for young people with problems and who self harm. By qualified family therapists in London, Yorkshire & Manchester.

G. EVIDENCE BASE – BY HDA AND ON SYSTEMS

There was a recent publication of articles in **NICE Alerts, Dec 2010** from the Health Development Agency that were written up to 8 years ago for the development of Public Health consultations, and these take systemic and strategic approaches which would benefit if managers understood more about the therapeutic use of these models.

A. Some reviewed the evidence for specific topics, while others covered the broader issues, such as ‘systems governance’ that needed to be considered for Public Health. Some used systemic perspectives for the difficulties in getting collaboration between the organisations that need to implement Public Health guidelines. Another reviews different research methods, eg from a social constructivist or feminist perspective.

http://www.nice.org.uk/aboutnice/howweare/aboutthehda/evidencebase/evidence_base.jsp

Family therapy was reviewed from Swedish evidence on the value of family therapy for the prevention of Obesity, but this was considered to be limited evidence for effectiveness (NHS CRD). Interestingly, no evidence on family interventions was found for Prevention and reduction of Alcohol Misuse (2005) or Drug Use prevention among Young People (2004). Family interventions were reviewed in the Irish review for Youth Suicide Prevention (2005), included Alan Carr’s articles, and although they did not find satisfactory evidence for home based family therapy, the recommendation for future research was: *Interventions to foster supportive family relationships, use of activities to promote self-esteem and reduce depression, interventions promoting coping skills, and social support initiatives and peer counselling should all be further evaluated.*

NHS CRD (Centre for Reviews and Dissemination) (2002). The prevention and treatment of childhood obesity. *Effective Health Care* 7 (6).

B. What is Known about Effective Approaches to Managing Strategic Systems Change and What Are the Implications for Mainstreaming Inequalities? Ewan Ferlie 2002.

This includes a review of systems perspectives, particularly because this broader perspective highlights the difficulties of connecting the relevant agencies: *An increasing number of writers are using a systems perspective in analysing complex change processes, perhaps drawing on the ‘soft systems’ perspective pioneered by Checkland (1981). The systems perspective suggests that localised change is difficult to effect, as the underlying properties of the system will cause regression. One implication may be that ‘radical shock’ or multiple interventions may be needed to unfreeze a system, although the long term effects of this may be unpredictable.*

The final statement was:

Literature Stream 5: it may be helpful to review the use of systems thinking as a change management tool, both within and outside health care, and assess the evidence as to impact.

C. SYSTEMS GOVERNANCE: Towards Effective Partnership Working CONTENTS 2002

This paper was for a seminar to use a whole systems approach to understand the failures in governance and to promote partnerships between relevant agencies.

D. Marks, David F. (2002) Perspectives on evidence-based practice 2002

This article included social constructionist / relativist approaches in the review of different research approaches that are not included in the random controlled model. Feminist perspectives are also considered in research.

2010: Health systems and health related behaviour change: a review of Primary and Secondary Evidence. NICE, World Health Organisation & Europe:

<http://www.nice.org.uk/media/0E6/62/SpecialReportHealthSystemsAndHealthRelatedBehaviourChange.pdf>

In 2010 NICE, working with the World Health Organisation, produced this special report on health systems and health related behaviour change. It presents a review and analysis of evidence from research literature, NICE public health guidance, and NICE public health stakeholder responses about features of health and public health systems that promote and support health related behaviour change.

Themes from this report that are relevant for AFT include the effectiveness of multi-component interventions; more intensive interventions; involving parents and carers for behaviour change in children; and family-based interventions for obesity prevention. There are many systemic concepts in the document, about the need for partnerships to be interactive, and the challenges for services to coordinate in order to create change.

Research Question 3.2 & 4.2 : *What are the characteristics of health systems and services – at national, regional and local level – that promote and support health-related behaviour change?*

Landau J, Mittal M, Wieling E (2008) Linking human systems: strengthening individuals, families and communities in the wake of mass trauma. *Journal of Marital and Family Therapy* 34 (2): 193–209

Appendix 5 addresses Stakeholder Responses (p228) in response to Behaviour Change: *XXX welcomes the document's acknowledgement of the urgent need to develop training and national training standards for those involved in helping to change people's behaviour.*

Much effective intervention that supports individuals and families in change can be provided by those not formally accredited as family therapists or systemic psychotherapists. This work will achieve the necessary standards if practitioners have access to current best practice of family work through working with, and (where appropriate) being guided and supervised by, properly trained family therapists.(quote from AFT response to Behaviour Change consultation)

H. QUALITY STANDARDS

DEMENTIA QUALITY STANDARD June 2010.

Carers should be assessed and offered psychological therapy if appropriate, although recommendations aim at individuals, who may become part of groups.

In development: DEPRESSION

To be developed with potential relevance for AFT:

- Antenatal Care
- Bipolar Disorder in Adults
- Bipolar Disorder in Children and Adults
- Diabetes in Children (Type 1 and Type 2)
- Drug Use Disorders (over 16_
- Postnatal Care
- Schizophrenia

General References:

www.nice.org.uk –for access to all completed guidelines and those in development

www.scie.org.uk for Think child, think parent, think Family.

www.sign.ac.uk Scottish Intercollegiate Guidelines Network

www.aft.org.uk Report on the evidence base for systemic family therapy.

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