SUMMARY OF COUPLE AND FAMILY INTERVENTIONS
RECOMMENDED AND REVIEWED
IN NICE GUIDELINES

Updated March 2012

Contents
Update – March 2012 ........................................................................................................................................ 4
INTRODUCTION .................................................................................................................................................... 4
A - Clinical Guidelines recommending family and couple therapies ................................................................. 7
  CG115 ALCOHOL DEPENDENCE AND HARMFUL ALCOHOL USE (Feb 2011) ............................................. 7
  CG77 ANTISOCIAL PERSONALITY DISORDER (2009) .................................................................................... 8
  CG38 BIPOLAR DISORDER (2006) The management of BD in Adults, Children and Young People. 10
  CG28 DEPRESSION IN CHILDREN AND YOUNG PEOPLE ........................................................................... 11
  CG90 DEPRESSION – ADULTS (UPDATE) 2009 .............................................................................................. 12
  CG91 DEPRESSION WITH A CHRONIC PHYSICAL HEALTH PROBLEM 2009 ............................................... 12
  CG51 DRUG MISUSE – PSYCHOSOCIAL INTERVENTIONS 2007 ................................................................... 13
  CG9 EATING DISORDERS 2004 ......................................................................................................................... 14
  CG26 POST TRAUMATIC STRESS DISORDER (PTSD) (2005) ...................................................................... 14
  CG120 PSYCHOSIS WITH CO-EXISTING SUBSTANCE MISUSE (Mar 2011) .................................................... 15
  CG82 SCHIZOPHRENIA (now Psychosis and Schizophrenia) update 2009: ..................................................... 16
CLINICAL GUIDELINES IN DEVELOPMENT ...................................................................................................... 16
  CLINICAL GUIDELINES WHICH RECOMMEND INCLUDING FAMILIES AND CARERS. without recommending couple/family therapy ......................................................................................... 17
  CG72 ATTENTION DEFICIT HYPERACTIVITY DISORDER. 2008. ................................................................. 17
  CG45 ANTENATAL AND POSTNATAL MENTAL HEALTH 2007 .................................................................... 18
  CH62 ANTENATAL CARE 2008: ........................................................................................................................ 18
  CG78 BORDERLINE PERSONALITY DISORDER 2009 ................................................................................... 18
  CG42 DEMENTIA (2006) (SCIE and NICE) .......................................................................................................... 19
  CG52 DRUG MISUSE - OPIOID DETOXIFICATION 2007 ................................................................................. 19
  CG 113 GENERALIZED ANXIETY DISORDER AND PANIC DISORDER ....................................................... 19
  CG31 OBSESSIVE COMPULSIVE DISORDER 2005 : ....................................................................................... 20
CG110  PREGNANCY AND COMPLEX SOCIAL FACTORS ................................................................. 20
CG16  SELF HARM 2004: ............................................................................................................. 20
CG 133. SELF HARM – Longer Term Management Nov 2011 ...................................................... 21
CG136. SERVICE USERS EXPERIENCE IN ADULT MENTAL HEALTH (2011) ......................... 21
CG89  WHEN TO SUSPECT CHILD MALTREATMENT (2009) ..................................................... 22
MH & BC CLINICAL GUIDELINES IN DEVELOPMENT ................................................................ 22
PHYSICAL HEALTH CLINICAL GUIDELINES ............................................................................. 22
CG15 TYPE 1 DIABETES: 2004. ................................................................................................... 23
CG53  CHRONIC FATIGUE SYNDROME 2007 .............................................................................. 24
CSGST: IMPROVING SUPPORTIVE AND PALLIATIVE CARE FOR ADULTS WITH CANCER 2004 ...... 24
CG76 MEDICINE ADHERENCE: ................................................................................................. 25
CG111 NOCTURNAL ENURESIS IN CHILDREN (Oct 2010)........................................................... 25
CG43  OBESITY 2006 ................................................................................................................... 25
CG37 POSTNATAL CARE: ROUTINE POST NATAL CARE OF WOMEN & THEIR BABIES 2006 review: 2012. ................................................................. 26
TECHNOLOGY APPRAISAL (TA) .................................................................................................. 26
PUBLIC HEALTH GUIDELINES: recommend family/couple therapies or involve families ............. 27
PH6  BEHAVIOUR CHANGE AT POPULATION, COMMUNITY AND INDIVIDUAL LEVELS. 2007 ..... 27
PH4  INTERVENTIONS TO REDUCE SUBSTANCE MISUSE AMONG YOUNG PEOPLE 2007 .......... 28
PH28  PROMOTING THE PHYSICAL AND EMOTIONAL WELLBEING OF LOOKED AFTER CHILDREN : SCIE + NICE (Oct 2010) ................................................................. 28
PH12  SOCIAL AND EMOTIONAL WELLBEING IN PRIMARY EDUCATION 2008 ..................... 29
PH20  PROMOTING YOUNG PEOPLES’S SOCIAL AND EMOTIONAL WELLBEING IN SECONDARY EDUCATION. 2009 ........................................................................ 29
IN DEVELOPMENT .................................................................................................................... 29
APPENDIX 1: QUALITY STANDARDS ......................................................................................... 30
APPENDIX 2: REFERENCES INCLUDED IN FULL GUIDELINES, REVIEWS AND UPDATES .......... 31
A  MENTAL HEALTH AND BEHAVIOURAL CONDITIONS ....................................................... 31
CG115 ALCOHOL DEPENDENCE AND HARMFUL ALCOHOL USE (Feb 2011) ......................... 31
CG45. ANTENATAL AND POST NATAL MENTAL HEALTH .................................................... 32
CG77  ANTISOCIAL PERSONALITY DISORDER 2009. ................................................................. 32
CG 72  ATTENTION DEFICIT HYPERACTIVITY DISORDER (2008) ............................................ 33
CG38  BIPOLAR DISORDER 2006 ............................................................................................... 33
CG78  BORDERLINE PERSONALITY DISORDER (2009) ............................................................ 34
CG123 COMMON MENTAL HEALTH DISORDERS (2011) ........................................................... 34
**Update – March 2012**

The focus of this update has been to adjust the summary for the new AFT website, and there have been no significant recommendations for family or couple therapy since December.

References are now in Appendix 2, and it is therefore possible to see which topics are most likely to review family and couple therapies, although these may not be quoted in the FULL guidelines. The strongest British evidence is in the recent review for Eating Disorders, which did not lead to a change in recommendations although current research projects are likely to lead to more recommendations for family therapy.

The most common model reviewed across different topics is multi-systemic therapy, because of the range of topics addressed by Henggeler, as can be seen in Appendix 5. Multisystemic therapy is recommended for Alcohol Dependence and preventing Antisocial Personality Disorder.

The publication of Service Users Experience in Adult Mental Health does raise the need to consider what the service user would like. Hopefully the current review of the guidelines manual will review the focus on random controlled trials for evidence.

**INTRODUCTION**

This document provides a summary of the NICE guidelines, and identifies NICE Pathways, Quality Standards and Costing Reports that recommend the value of involving families and/or systemic family and couple therapies / interventions. Potentially relevant recommendations for research are at the end of each topic. Access to the evidence reviewed for NICE, SCIE and Cochraneon [https://www.evidence.nhs.uk/](https://www.evidence.nhs.uk/). More details of the information here can be found on the NICE website [www.nice.org.uk](http://www.nice.org.uk), including access comments from AFT and the responses from NICE in consultations and reviews.

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. References reviewed in guidelines and in updates are now in Appendix 2. There is considerable evidence on the effectiveness of family and systemic therapy, which can be accessed on the AFT website (details below) including studies on its cost effectiveness, but many do not fit with the random controlled trials or topics required by NICE.

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.

Physical Health Guidelines are in Section C, as some topics review studies on family therapy, and families / carers do need to be involved for some treatments, as well as to address the stress in the service user or the families involved.

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.

Appendix 1: Quality Standards are intended for commissioning, but they tend to provide more generalised recommendations for psychotherapies.

Appendix 2 has the references that have been used in the FULL Guidelines and the reviews to consider updating the Guidelines.

Appendix 3 includes the few Costing Reports. 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/ clinical psychologists 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.

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. Public Health is becoming increasingly important and often convey systemic approaches to the need for collaboration between services as well as including families when preventing, reducing problems as well as providing interventions. This also means greater collaboration between social and health services. 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 only expect primary health care services to be involved. Those that address and recommend clinical interventions may require an evidence base, but have not placed 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.

Statement about the limits of RCTs repeated in many guidelines: 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 - Clinical Guidelines recommending family and couple therapies

1) Mental Health and Behavioural Condition Topics (MH & BC):
   - CG115 Alcohol Dependence & Harmful Alcohol Use (Feb 2011)
   - CG77 Antisocial Behaviour Disorder (2009)
   - CG38 Bipolar Disorder (2006)
   - CG123 Common mental health Disorders (May 2011)
   - CG28 Depression in Children and Young People (2005)
   - CG90 Depression in Adults (update 2009)
   - CG91 Depression with a Chronic Health Problem (update 2009)
   - CG51 Drug Misuse – Psychosocial Interventions (2007)
   - CG26 Post-Traumatic Stress Disorder (2005)
   - CG120 Psychosis with coexisting Substance Misuse (Mar 2011)
   - CG82 Psychosis and Schizophrenia in Adults (partial update 2012)
   - CG15 Diabetes Type 1 (2004)- see Section C – Physical Health Guidelines

2) Relevant Guidelines in Development
   - Conduct Disorders for Children and Young People
   - Psychosis and Schizophrenia in Children and young People

1) Mental Health and Behavioural Condition (MH & BC)Topics

Twelve MH & BC NICE Clinical Guidelines recommend specific types of family therapy / intervention on mental health and behavioural conditions as does one physical health guideline. Two 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 for NICE Guidelines are given first, followed by the reviews of family interventions in the FULL Guidelines. If these recommendations are currently included in NICE Pathways, Quality Standards or Costing Reposts, it will be indicated. References can be found on Appendix 2

CG115 ALCOHOL DEPENDENCE AND HARMFUL ALCOHOL USE (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 other Alcohol guidelines address physical health issues (CG) and prevention (PH). NICE Pathways incorporates these guidelines in Reducing Substance Misuse with Vulnerable Children and Young Peoplewww.pathways.nice.org.uk. The Costing Report Reducing Substance Misuse with Vulnerable Children and Young People makes strong recommendations for family-based interventions
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. Quality Standards include recommendations for behavioural couples therapy and family and systemic therapy, as in this recommendation.

**NICE for adults**: 1.3.3.2; 1.3.3.3; 1.3.3.7; 1.3.6.2 -- Recommendations for Behavioural couples therapy at various stages, from those with mild alcohol problems, moderate and severe, and for harmful drinkers who do not respond to other treatments.

**NICE for 10 – 15 year olds**: 1.3.7.8: Referral to CAMHS, and Delivering Psychological and psychosocial interventions: 1.3.7.10: Multidimensional Family Therapy; 1.3.7.11: Brief strategic Family Therapy; 1.3.7.12: Functional Family Therapy; 1.3.7.13: Multisystemic therapy. Other interventions with families include ‘family meetings’, Social Network & Environment Based Therapies (Copello) 1.3.3.1. to be provided by staff, such as nurses.

**FULL For adults**
Recommendations for BEHAVIOURAL COUPLES therapy cover harmful drinking and mild dependence to through to sever problems: 6.23.1.13; 6.23.1.14 and 6.23.1.18.

7.15.1.2: 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 pharmalogical intervention for moderate or severe dependence.

**FULL For children and young people**, 6.23.1.7 Promoting abstinence needs ‘multicomponent programmes including multidimensional family therapy, brief strategic family therapy, functional family therapy and multisystemic family therapy. For those with co-morbid problems and/or limited social support:

6.23.1.8. 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.

6.23.1.9. 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.

6.23.1.10. 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.

6.23.1.11. Multi-systemic 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

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

**Research recommendations**: 4.1 Is contingency management effective in reducing alcohol consumption in people who misuse alcohol compared with standard care?

**CG77 ANTISOCIAL PERSONALITY DISORDER (2009)**
Treatment, Management and Prevention.
UPDATE (NOV 2011): No need for change yet. The update included reviews of early interventions for young people to prevent ADHD. Multi-systemic research projects in the UK are in progress, and recent evidence did not indicate that changes were required (see Appendix 2). Stakeholders also commented on the limited number of services that were using the guidelines or had access to these interventions, and that commissioners need to include funding for the parenting interventions.

Costing report includes specific references.

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 et al (1989)

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 et al (1995)

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.

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

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 & Reid (1998), Chamberlain, Leve & De Garmo (2007).

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


Update. July 2011: To be reviewed in 2012 because of the need to address ‘Interventions and lifestyle advice (pharmacy and issues like weight)’. Recent studies on family interventions were included (Appendix 2), but it is not clear whether these are will require changes to the current recommendations, or support current recommendations.

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, Thompson, Miklowitz et al (2003).

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.


The focus is for better access to services for Common Mental Health Disorders: anxiety and depression, using a Stepped Care Approach across primary and secondary services, with recommendations of links between services so that those who do not respond enough can easily
access the next steps of care. Common Mental Health Disorders include anxiety (general anxieties disorders, panic disorder, OCD) and depression, and although it is not specified, it seems to address only adults, and there are links with IAPT (Improving Access to Psychological Therapies). There is an acknowledgement of the need to work with families from diverse ethnic and cultural backgrounds (some references from Family Process), and to consider needs of pregnant women.

**NICE Recommendation:** 1.4.3.1 Behavioural Couples Therapy for those who have not responded to low level interventions and with persistent subthreshold symptoms or mild to moderate depression. This is based on the NICE Guideline for Depression. If people chose not to have behavioural couples therapy, they can be offered counselling or short term psychotherapy.

**Definition: Behavioural couples therapy:** a psychological intervention that aims to help people understand the effects of their interactions on each other as factors in the development and maintenance of symptoms and problems, and to change the nature of the interactions so that the person’s mental health problems improve (usually 15 to 20 sessions over 5 to 6 months).

**FULL Guidelines. 4.3.1. ADAPTING MODELS OF SERVICE DELIVERY AND THERAPEUTIC INTERVENTIONS:** The introduction refers to the need to consider different ways to alter that nature of a psychotherapeutic intervention when there are ethical or cultural issues to consider, and some comments are drawn from the articles by Bernal and Rodriguez (2009).

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**CG28 DEPRESSION IN CHILDREN AND YOUNG PEOPLE.**

2005 Identification & management in primary, community & secondary care

**NICE Pathways includes shorter term family therapy and Systemic Family Therapy**

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):

**Full: Systemic Behavioural Family Therapy** 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); Brent, D.A., Kolko, D.J., Birmaher, B., et al. (1998)

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.

**CG90 DEPRESSION – ADULTS (UPDATE) 2009**

Review in 2011 found no new evidence to change recommendations.

The Quality Standard and NICE Pathways include Behavioural Couples therapy

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

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.

**CG91 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 – couple-oriented intervention for osteoarthritis, Martire, L., Schulz, R., Keefe, F., Rudy, T., & Starz, T. (2007).

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.

CG51 DRUG MISUSE –PSYCHOSOCIAL INTERVENTIONS 2007

Update: March 2011. Because of the current research on the role of family / systemic therapy, this will be reviewed in July 2013, following the publication of the evidence. Other topics are also being reviewed. There are concerns about the lack of access to family interventions at the present time, and issues were raised about the impact of IAPT procedures. The 12 Step Approach is recognised as a systemic approach.

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). To be reviewed when current research is completed.

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


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).

CG9 EATING DISORDERS 2004.

Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders.

Update August 2011: Although the review acknowledged 14 good evidence based studies of systemic/family therapy with eating disorders, including 2 by Ivan Eisler et al, these do not challenge the current recommendations (Appendix 2). Research that will lead to new recommendations are currently in progress, so it will be reviewed later when issues like binge eating disorder will be addressed, as well as the use of language for psychological therapies (eg to recommend systemic / family therapy, which is not specifically recommended but many services recognise their value, and so employ a family therapist.

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.


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.

CG26 POST TRAUMATIC STRESS DISORDER (PTSD) (2005)

2011 Review: considered the role of early interventions and including families for children and young people, there was only one study and that was considered insufficient (Berkowitz et al 2011). Recommended Good Practice (RGP) was: 1.5.4.: When a family is affected by a
traumatic event, more than one family member may suffer from PTSD. If this is the case, healthcare professionals should ensure that the treatment of all family members is effectively coordinated.

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).

CG120 PSYCHOSIS WITH CO-EXISTING SUBSTANCE MISUSE (Mar 2011)

Family interventions are important for both psychoses and substance misuse, as recommended in relevant NICE guidelines.

NICE: Family interventions –treatments will be complex and different agencies will be involved, especially 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: family interventions.
1.8.6. Offer family interventions for young people

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 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. (4.8.1.8). Table 20 includes relevant psychological treatments in related guidelines (Bipolar, Alcohol Dependence, Drug Misuse, Schizophrenia) and identifies family interventions and couples therapy (Fals-Stewart et al., 2005, Fals-Stewart et al 2004).

9.5.2. Tier 3 CAMHS services: family therapy to all families to support parents/foster families. Social systems Interventions (Henggeler et al., 1999). For children and young people, the importance of social networks is recognised. Meriden mentioned but although they did not make recommendations on Meriden models.

CG82 SCHIZOPHRENIA (now Psychosis and Schizophrenia) update 2009:

Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.

Update July 2011: To be reviewed to consider ‘service level interventions (early interventions and ways to reduce admissions to hospital) and cognitive remediation’. The articles to be reviewed included 6 about family issues, including Bressi et al (2008) on Systemic family therapy in schizophrenia, and Carra (2010) on Multiple group family treatment, although these probably support current recommendations for family interventions (Appendix 2).

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); Szmukler (2003)


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

CLINICAL GUIDELINES IN DEVELOPMENT

CONDUCT DISORDERS IN CHILDREN AND YOUNG PEOPLE NICE+ SCIE (Full consultation – Jan-Feb 2012)

Most children and young people referred to CAMHS have a Conduct Disorder, and comments about the recommended psychological interventions are ‘Three themes are common to these interventions: a strong focus on working with parents and families, recognition of the importance of the wider social system in enabling effective interventions, and a focus on preventing or reducing the escalation of existing problems’. There is recognition of issues like parental mental health problems, and guidelines that will have an influence include the recommendations for preventing Antisocial Behaviour Disorder. Because of the variation in services across the country, it may be difficult to access multi-systemic approaches, while parenting programmes are most common. The full consultation will
review psychosocial interventions, including parenting and family interventions, social care (eg for looked after children), and multi-modal interventions.


Family interventions, including family therapy will be considered among a range of psychotherapies, and it is acknowledged that although there will be recommendations for various psychotherapies, this does not mean that there will be access to them all across the country. It will be important to consider the relevance of Early Interventions Services (15-35 years) for young people, given the evidence for intensive treatments, including family interventions).

**CLINICAL GUIDELINES WHICH RECOMMEND INCLUDING FAMILIES AND CARERS. without recommending couple/family therapy**

Twelve Clinical Guidelines for MH and BC and seven physical health guidelines include recommendations for including families, parents or partners in treatment or for supporting service users and carers, and despite some evidence, for systemic family and couple therapies, these do not meet NICE criteria. The Service User Experience is influenced by Darzi’s recommendations to consider what treatments the service users would prefer. Two guidelines are in development that should meet these criteria, so it will be interesting to see how this may influence subsequent guidelines. Articles reviewed in the FULL guidelines are in Appendix 2.

CG72 Attention Deficit Hyperactivity Disorder (ADHD) (2008)
CG45 Antenatal and Post Natal Mental Health 2007
CG62 Antenatal Care (2008)
CG78 Borderline Personality Disorder (2009)
CG42 Dementia (2006)
CG52 Drug Misuse – Opioid Detoxification (2007)
CG113 Generalised Anxiety Disorder and Panic Disorder (2011)
CG31 Obsessive Compulsive Disorder (OCD) (2005)
CG110 Pregnancy and Complex Social Factors (2010)
CG16 Self Harm – Short Term Management (2004)
CG133 Self Harm – Longer Term management (2011)
CG136 Service user experience in Adult Mental Health (2011)

Guidelines in Development
Autism in Children and adolescent Management
Social Anxiety Disorder

Guideline that does not address psychotherapeutic treatments
CG89 When to suspect Child Maltreatment (2009).

**CG72 ATTENTION DEFICIT HYPERACTIVITY DISORDER. 2008.**

Diagnosis & management of ADHD in children, young people and adults
Update: Nov 2011 – no review needed yet. Review considered various models parental training (including one from Family Process, Appendix 2).

**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.

**CG45 ANTENATAL AND POSTNATAL MENTAL HEALTH 2007:**
Clinical management and Service Guidance

Update: July 2011. Consultation needed to consider issues that have relevance for systemic approaches, such as interventions for subthreshold depression and/or anxiety, the management of traumatic birth, and substance misuse during pregnancy. The studies reviewed included the need to consider the mother’s relationships with other children, and substance misuse (Lam et al 2007, Appendix 2). Is to be updated.

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 postnatal. 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.

**CH62 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.

**CG78 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.
CG42 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.


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

CG52 DRUG MISUSE - OPIOID DETOXIFICATION 2007

Update 2011: see information for Drug Misuse: Psychosocial Interventions – research on systemic /family therapy is in progress, and after it is published it will influence the revised recommendations. Need for interventions during pregnancy and postnatal care also considered.

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. To be reviewed when current research projects have been completed, including whole systems approaches and family therapy.

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.


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.


CG 113 GENERALIZED ANXIETY DISORDER AND PANIC DISORDER
(with or without agoraphobia) in ADULTS: management in primary, secondary and community care (partial update) 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).

7.1.1. Acknowledged that counselling may include ‘psychodynamic, systemic and cognitivebehavioural 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)

CG31 OBSESSIVE COMPULSIVE DISORDER 2005:
Core interventions in the treatment of obsessive-compulsive disorder – dysmorphic disorder

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); Keiley, M.K. (2002); Stern, R.S. (1973)

Family-based behaviour therapy /Conjoint family therapy
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?

CG110 PREGNANCY AND COMPLEX SOCIAL FACTORS

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).

CG16 SELF HARM 2004:
The short-term physical and psychological management and secondary prevention of self harm in primary and secondary care

Following this guideline, they expected Longer Term Management to cover long term treatments, and family interventions..

Brief home-based interventions/
Home-based Family therapy
Home-based Family Interventions

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)

CG 133. SELF HARM – Longer Term Management Nov 2011

Unfortunately there is no current evidence for recommendations for family / couple therapy, although in the FULL guidelines interventions for young people ‘is usually family-centred’ (p25), and there is recognition of the value of family support. References reviewed are in Appendix 2, including insight-oriented therapy by Liberman & Eckman (1981).

The role of relationships is recognised, including relationships with the psychotherapist. The importance of including whoever is important is recognised, not just family members.

Research Recommendations: Some address psychological therapies, and one includes problem – solving elements.

CG136. SERVICE USERS EXPERIENCE IN ADULT MENTAL HEALTH (2011)

Although evidence has an important role in this guidance, these included the views of service users. There are recommendations to the involvement of families and carers, and references to the fact that this could be quite complex so that staff need training to do this, although there is no mention of ‘family therapy’. The only reference to therapy in the NICE guideline is for parents:
1.1.18 Ensure that service users who are parents with caring responsibilities receive support to access the full range of mental health and social care services, including:
• information about childcare to enable them to attend appointments, groups and therapy sessions.

In the FULL guideline, there were references to the poor access to family interventions or support (and to all psychotherapies), or that professionals often do not suggest including families or other psychotherapies. 38% said they did not get enough support for their caring responsibilities (p83). A quarter of service users felt that professionals did not offer families and carers enough support (Drug misuse guideline [NCCMH, 2008]) (p84). The Community Mental Health Survey (national Centre for Social Research 2010) also found that 20% service users felt that mental health services did not involve a close relative or friend. The Meriden Family Programme website was one resource.

Although it does use details from No Health Without Mental Health: a Cross-Government Mental Health Outcomes Strategy for People of All Ages. Department of Health 2011, which recognises the significance of families and carers, it acknowledges the significance of this approach.

CG89 WHEN TO SUSPECT CHILD MALTREATMENT (2009)
This covers the process of assessing maltreatment rather than treatments. Family issues are covered in this.

MH & BC CLINICAL GUIDELINES IN DEVELOPMENT

MANAGEMENT OF AUTISM SPECTRUM DISORDERS IN CHILDREN AND YOUNG PEOPLE
Update: Scope Consultation Sept 2011.
The effect of autism on families will be considered, and the consultation is addressing the low levels of evidence for the many psychotherapeutic approaches that are currently used, although these differ across the country.

SOCIAL ANXIETY DISORDER (Scope June 2011)
There is an acknowledgement of the impact on social relationships and functioning from social anxiety, and how it may not be identified. The guidelines will look at the value of various psychotherapies and the importance of access to these through IAPT as well as other services. Family and parenting issues will be addressed in clinical treatments, such as FRIENDS,‘ a family-based group CBT intervention involving cognitive reconstructing for parents and assistance in building social support’.

PHYSICAL HEALTH CLINICAL GUIDELINES

The role of families is recognised in different ways by some physical health guidelines, and the evidence for Behavioural Family Systems Therapy led to a recommendation for Type 1 Diabetes. Many physical health topics focus on medication rather than the psychological issues, but seven topics address these issues in different ways, not only for children and young people. Some topics acknowledge the need for both mental and physical health treatments, such as C91 Depression in Chronic Health Problems. Others may also have strong links with Public Health, such as obesity.

Recommends Family Systems Therapy
CG15  Type 1 Diabetes
Recommends involvement of families
CG53  Chronic Fatigue Syndrome (2007)
      Improving Outcomes in Children and young People with Cancer (2005)
CSGST Improving Supportive and Palliative care for Adults with Cancer (2004)
CG76  Medicines Adherences (2009)
CG111 Nocturnal enuresis in Children (2010)
CG43  Obesity (2006)
CG37  Post Natal Care

RECOMMENDS BEHAVIOURAL FAMILY SYSTEMS THERAPY

(Endocrine, nutritional and metabolic condition)
Diagnosis and management of Type 1 Diabetes in children, young people and adults

Update August 2011. To be reviewed to consider various issues including ‘psychological and social issues (eating disorders, cognitive disorders and psychosocial support)’ for children and young people; and the ‘management of social situations for adults (eating disorders and psychological problems). (reference in Appendix 2)

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.

Research recommendations: effectiveness of social and behavioural interventions for problems associated with type 1 Diabets, 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 on-going 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.

RECOMMEND INCLUDING FAMILIES.

CG53 CHRONIC FATIGUE SYNDROME 2007 
(Central Nervous System): Diagnosis and management of CFS / ME in adults and children

Update Mar 2011: No new evidence to change recommendations.

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. (1995); Dracup K, Meleis A, Baker K, Edlefsen P. (1984).

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

CSGST: IMPROVING SUPPORTIVE AND PALLIATIVE CARE FOR ADULTS WITH CANCER 2004


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. The recommend 4 Levels, with psychotherapists being involved in Levels 3 and 4, although family relationships should be addressed from level 2. Level 4 deals with severe interpersonal difficulties, and the needs determine which form of therapy, counselling or social care should be offered.

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.

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.

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.

**CG76 MEDICINE ADHERENCE:**

Involving patients in decisions about prescribed medicines and supporting adherence.

National Collaborating Centre for Primary Care (2009)

The FULL Guideline included evidence for family and couple therapies, but that was not regarded as suitable for the NICE Guideline. The recommendations are that ‘any interventions’ should address individual needs rather than having specific recommendations.

**NICE: 1.1.18.** Encourage and support patients, families and carers to keep an up-to-date list of all medicines the patient is taking.

**FULL**

Various RCTs found that family or couple therapy helped people to remain on prescribed medication. Family Therapy was used by Miklovitz, (2003) and Razali (2000) reported that culturally modified family therapy was better than behavioural family therapy, while Remien (2005) reported the value of couple therapy. The significance of family interventions when treating schizophrenia was also acknowledged (Strang et al 1981 and Xiong et al 1994).

Research Recommendations:

4.1. Developing effective interventions to support adherence to appropriate prescriptions.

**CG111 NOCTURNAL ENURESIS IN CHILDREN (Oct 2010)**

Endocrine, nutritional and metabolic conditions

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. p41.** 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 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?

**CG43 OBESITY 2006**

The prevention, Identification, assessment and management of overweight and obesity in adults and children.

Update: Dec 2011. Reviews of family therapy with children with obesity were not found to have appropriate evidence, although there is some on-going research on ‘family-based behavioural
Some family interventions will be reviewed in the new Public Health guidelines in development.

**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.

**CG37 POSTNATAL CARE: ROUTINE POST NATAL CARE OF WOMEN & THEIR BABIES 2006 review: 2012.**

The value of including families when babies are born and helping parents recognise they are now a family. Mental health issues are also considered, in mothers and in fathers, although the focus in on helping the mother with her new baby.

**Review 2012**
Whilst no need to change recommendations, articles in the review include ways to address family and community issues. In Sweden, medical staff have introduced a ‘family centred post natal model’, and so involving fathers has become crucial (Hildingsson et al 2009). A qualitative study on the value of psychotherapeutic interventions addressing interpersonal issues for post natal depression by marital and family therapists was included (Knudson-Martin C and Silverstein R., (2009).

**TECHNOLOGY APPRAISAL (TA)**

**Only one TA includes family relationships**

**TA102 PARENT-TRAINING / EDUCATION PROGRAMMES IN THE MANAGEMENT OF CHILDREN WITH CONDUCT DISORDERS 2006/07 For children 12 yrs and younger (NICE & SCIE)**

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. Professionals need appropriate training and supervision so parents can help their children.

**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.
PUBLIC HEALTH GUIDELINES: recommend family/couple therapies or involve families

New Public Health guidelines address many systemic issues about getting services to collaborate and involve families and communities. Recent documents review and recommend a systemic approach, and there are documents about using this approach, such as Health Systems and Health Related Behaviour Change: A critical review of primary and secondary evidence (2010). A few address the therapeutic interventions, including for parenting and families, many of which will be for preventing and reducing problems as well as social care. The services involved are likely to be primary health care, social care and voluntary agencies.

Published Guidelines that address family issues relevant to therapeutic interventions

- PH6  Behaviour change at Population, community and individual levels (2007)
- PH4  Interventions to reduce Substance Misuse among Young People (2007)
- PH28  Looked After Children and Young People (2010)
- PH12  Social and Emotional Wellbeing in Primary Education (2008)

In Development

- Preventing and Reducing Domestic Violence between Intimate Partners
- Social and Emotional Wellbeing – Early Years
- Personal, social and health education on sex and relationships and alcohol education
- Obesity – Working with Local Communities
- Overweight and Obese Adults – Lifestyle weight management
- Overweight and Obese Children – Lifestyle weight management.

May be relevant, but do not include psychotherapeutic interventions

- PH19  Management of Long Term Sickness and Incapacity for Work (2009)
  The review (2012) may consider whether to address the impact of relationship issues at work and outside work.
- PH16  Mental Wellbeing and Older People (2009) (addresses OT and physical activities
- PH22  Promoting Mental Wellbeing through productive and Healthy Working Conditions (2009)


Update: Review of Behaviour Change at Individual level currently in process. It is quite clear that this review will not address family issues although some topics will be relevant for families and family interventions.

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.

Behaviour Change review: 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

PH4 INTERVENTIONS TO REDUCE SUBSTANCE MISUSE AMONG YOUNG PEOPLE 2007. For under 25 yr olds

Update: no review required yet.
The vulnerability of children and young people if 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: 11-16 yrs; 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 – when 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?

PH28 PROMOTING THE PHYSICAL AND EMOTIONAL WELLBEING OF LOOKED AFTER CHILDREN : SCIE + NICE (Oct 2010)


The documents on SCIEand 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. Multi-systemic therapy (Henggeler and Borduin 1995)is reviewed as one of the key interventions by c4eo.

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 are 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). 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)

PH12 SOCIAL AND EMOTIONAL WELLBEING IN PRIMARY EDUCATION 2008

2011 Review recommended that all primary schools adopt a whole school approach to promote social and emotional wellbeing – at a strategic level. No change in guideline.

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

PH20 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

IN DEVELOPMENT

SOCIAL AND EMOTIONAL WELLBEING – EARLY YEARS Scope 2010

Previously this topic was divided into two (eg home-based intervention and early education), and these have now been combined, and will be influenced by the report Supporting Families in the
Foundation Years (DfE, DH July 2011), which provides the policy context for such guidelines. Working with families is recognised as powerful.

PREVENTING AND REDUCING DOMESTIC VIOLENCE BETWEEN INTIMATE PARTNERS. Scope, Jan 2012.

This will use a whole systems approach, and address the children of the intimate partners involved with domestic violence. The focus will be on NHS and social services, and it has been written in a different style to previous Scopes.

*Question 1:* What types of intervention or approach are effective and cost effective in preventing domestic violence from ever occurring? This will accept qualitative as well as quantitative evidence.

This issue – what type of intervention and cost effective? – is used to address 3 more questions about how to prevent or reduce domestic violence, and another question addresses partnership issues. The importance of working with children will be because of the long term impact of witnessing or living with domestic violence.

APPENDIX 1: QUALITY STANDARDS

Quality Standards are very much in development, and: *They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.*

They are also a response to government policies and intended to address health and social care professionals, patients and carers, service providers and commissioners. Of the 15 produced to date (March 2012), 3 have relevance for AFT.

ALCOHOL DEPENDENCE

http://www.nice.org.uk/guidance/qualitystandards/alcoholdependence/home.jsp

Refers to Behavioural Couples Therapy for adults willing to have treatment with their partner. Specialist Interventions for children and young people starts with: ‘*Children and young people accessing specialist services for alcohol use are offered individual cognitive behavioural therapy, or if they have significant comorbidities or limited social support, a multicomponent programme of care including family or systems therapy*.’ Family and systems therapy is referred to repeatedly, as it needs to be recognised by service providers, professionals, commissioners, and to the children and their carers. The family and systems therapies include multidimensional family therapy, brief strategic family therapy, functional family therapy and multisystemic therapy.

DEPRESSION—ADULTS

http://www.nice.org.uk/guidance/qualitystandards/depressioninadults/moderatechronic.jsp

For those with severe or residual depression, an appropriate psychological therapy should be offered 7. Behavioural Couples therapy for moderate depression with physical health problems, rather than for those who just have moderate depression.

END OF LIFE CARE FOR ADULTS

http://www.nice.org.uk/guidance/qualitystandards/endoflifecare/home.jsp

Some sections refer to ‘Holistic support’ - physical and psychological; social, practical and emotional, and for families and carers.
APPENDIX 2: REFERENCES INCLUDED IN FULL GUIDELINES, REVIEWS AND UPDATES.

References may be found in the FULL guidelines, although not all guidelines provide details. When a topic is due for review, recent evidence is provided, although this may not be used in the updated guidelines if it does not meet the criteria for the update. Whilst most authors are quoted in one topic, Henggeler’s articles, which address multi-systemic therapy, can be found in across 6 topics: Alcohol Dependence, Antisocial Personality Disorder, Depression for Children and Young People, Drug Misuse – psychosocial intervention, Looked After Children and Psychosis with Co-Existing Substance Misuse. Fals-Stewart is quoted in 3 topics: Alcohol Dependence, Drug Misuse – Psychosocial Intervention and Psychosis and Substance misuse.

A. Mental Health and Behavioural Conditions
B. Physical Health
C. Public Health
D. NICE Pathway

A  MENTAL HEALTH AND BEHAVIOURAL CONDITIONS.

CG115 ALCOHOL DEPENDENCE AND HARMFUL ALCOHOL USE (Feb 2011)

FULL GUIDELINE References:


CG45. ANTENATAL AND POST NATAL MENTAL HEALTH
Reviewed in 2011


CG77 ANTISOCIAL PERSONALITY DISORDER 2009.
Treatment, Management & Prevention

FULL GUIDELINE REFERENCES

Brief Strategic Family Therapy

Functional Family Therapy

Multisystemic Therapy


**Multidimensional Treatment for Foster Care**

**ARTICLES USED IN 2011 REVIEW**

**Costing Report:**

**CG 72 ATTENTION DEFICIT HYPERACTIVITY DISORDER (2008)**

**2011 Review**

**CG38 BIPOLAR DISORDER 2006**
**FULL Guideline**


**Evidence to be considered in 2012 review:**


**CG78 BORDERLINE PERSONALITY DISORDER (2009)**


**CG123 COMMON MENTAL HEALTH DISORDERS (2011)**


**CG42 DEMENTIA**

Supporting people with dementia and their carers in health and social care (2006)

**FULL**


Reviewed slight update 2011 (some referred to again in review)


**CG28 DEPRESSION IN CHILDREN AND YOUNG PEOPLE (2005)**


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


**CG90 DEPRESSION – ADULTS (Updated 2009)**

**FULL GUIDELINE REFERENCE**


Key evidence articles:


CG91 DEPRESSION WITH A CHRONIC PHYSICAL HEALTH PROBLEM (2009)


CG52 DRUG MISUSE – OPIOID DETOXIFICATION (2007)


CG51 DRUG MISUSE – PSYCHOSOCIAL INTERVENTIONS 2007


Fals-Stewart et al 2002


CG9 EATING DISORDERS (2004)

FULL GUIDELINE REFERENCES


Considered in 2011 review - no new evidence to recommend changes yet


CG113 GENERALIZED ANXIETY DISORDER & PANIC DISORDER (2011)

Bower et al (2003): details of this study not in guideline

CG31 OBSESSIVE COMPULSIVE DISORDER (2005)

CG26 POST TRAUMATIC STRESS DISORDER (PTSD) (2005)
FULL GUIDELINE REFERENCES

2011 REVIEW

CG120 PSYCHOSIS WITH CO-EXISTING SUBSTANCE MISUSE (MAR 2011)
FULL GUIDELINE REFERENCES

CG 16 SELF HARM (2004)
The Short-term physical and psychological management and secondary prevention of self harm in primary and secondary care

CG133 SELF HARM: Longer term management (Nov 2011)
FULL GUIDELINE

CG82 SCHIZOPHRENIA UPDATE (2009)
FULL GUIDELINE
UK references without details other than author::
Barrowclough (1999);
Leff (1982);
Tarrier (1988);
Vaughn (1992);
Falloon (1981);
Szmukler (2003)

Articled included in the Review in 2011

CG 136. SERVICE USERS EXPERIENCE IN ADULT MENTAL HEALTH (2011)


Meriden Family Programme: www.meridenfamilyprogramme.com

B PHYSICAL HEALTH

CG91 DEPRESSION with a Chronic Physical Health problem 2009 – see above.

CG15 TYPE 1 DIABETES (2004)

FULL GUIDELINE

Articles reviewed in 2011

CG37 POSTNATAL CARE: ROUTINE POST NATAL CARE OF WOMEN AND THEIR BABIES.

Provided in Consultation Review, 2011
CG53 CHRONIC FATIGUE SYNDROME (2007)


CG76 MEDICINE ADHERENCE:

involving patients in decisions about prescribed medicines and supporting adherence National Collaborating Centre for primary care. 2009

(Miklowitz DJ, George EL, Richards JA, Simoneau TL, Saddath RL. A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. Arch Gen Psychiatry 2003; 60(9):904-912.


CG43 OBESITY

prevention, identification, assessment and management of overweight and obesity in adult and children 2006 – Reviewed in 2011


CG37 POSTNATAL CARE:

ROUTINE POST NATAL CARE OF WOMEN AND THEIR BABIES.
Provided in Consultation Review, 2011

C  PUBLIC HEALTH
HEALTH SYSTEMS AND HEALTH RELATED BEHAVIOUR CHANGE: A CRITICAL REVIEW OF PRIMARY AND SECONDARY EVIDENCE (2010)

PH28 LOOKED AFTER CHILDREN (2010)
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
Hennigeler and Borduin (1995)

SOCIAL AND EMOTIONAL WELLBEING – EARLY YEARS – DEVELOPING

D  NICE PATHWAYS
PREVENTING AND REDUCING SUBSTANCE MISUSE WITH VULNERABLE CHILDREN AND YOUNG PEOPLE
APPENDIX 3:
COSTING REPORTS

Recent recommendations emphasize the cost effectiveness of psychological interventions, and recommend increasing these resources because it will reduce the numbers who develop more severe problems. Five Costing Reports specify couple or family therapies in Clinical Guidelines and one for Public Health. For some reason there is no Costing Report for Eating Disorders. These are accessible on the topic website [www.nice.org.uk](http://www.nice.org.uk).

**STRONGEST SUPPORT FOR SYSTEMIC THERAPIES**

**CG77  Antisocial Personality Disorder. 2009.**
Have details of the cost effectiveness of functional family therapy, brief strategic family therapy and multidimensional therapy, as preventions of antisocial personality disorder. These come after parent training, which will address parent-child relationship issues. Most of the document covers these issues rather than treatments for adults because of the valuable savings.

3.3.1. *Family therapy is predominantly based around trying to help family members find constructive ways to help one another. It can take place in a family home, or more commonly in a hospital or clinic. The therapists may be psychologists, psychiatrists, social workers, nurses or simply people who have been trained in the use of one or more types of family therapy.*
Reference: Layard R, Clark D, Knapp M et al. (2007).

**CG38  Bipolar Disorder 2009**
Family therapy is one of 3 recommended psychotherapies, and the assumption is that these will be provided by Band 8a Clinical Psychologists.

**CG28  Depression in Children and Young People 2005.**
Investment in psychological therapies is important because of the problems in access to psychotherapies, eg. waiting times and lack of trained staff. Short term family therapy is mentioned in the main document and systemic family therapeutic as an alternative treatment. Although it is recognized that staff will offering therapy will be at different levels, costing is based on Band 7 and Band 8a for supervision.

**CG51  Drug Misuse: Psychosocial Interventions + Opioid Detoxification. 2007**
Behavioural Couples Therapy and Couples Interventions are expected to be provided by Clinical Psychologists, and the costing for BCT is provided in detail. Although it may be difficult to access couple therapy, it should be offered in prisons. The costing report also addresses how many are likely to be offered BCT, and how many are suitable and how many will accept it, because of the benefits of this treatment.

**CG82  Schizophrenia 2009**
Family therapy recommended but costing not fully addressed because only 53% eligible people were found to have access to it over 12 month period in 2006. Costing not detailed because various staff members in secondary services will provide psychological therapies.

**PH4:  Interventions to reduce substance misuse among vulnerable young people 2007. Working with vulnerable and disadvantaged children and young people**
The cost impact of the recommendations addresses family-based programme of structured support. Family therapy is an intensive treatment, part of 2 year family-based programmes.

**SUPPORT FOR PSYCHOLOGICAL THERAPIES**
CG115 Alcohol Dependence and Harmful Alcohol Use 2011
Recommend more investment in psychological interventions because of the value of early interventions, and there is not sufficient access to recommended interventions. For mild and moderate alcohol misuse, the recommendations refer to ‘behavioural’ rather than behavioural couples therapy, and refer to social network and environmental based therapies rather than identifying systemic and family therapies. More services are required for more complex symptoms. The importance of the investment in these treatments is because these interventions reduce costing.

CG123 Common Mental Health Disorders 2011.
Recommends commissioning includes psychological therapies because of the value for reducing costs for CMHDs who often do not get identified, and better access to psychological therapies (including IAPT) means that more people are likely to come for treatment.
Costs:
Low intensity therapist: £57 per hour
High intensity therapist: £68 per hour
Clinical supervision: £72 per hour

CG42 Dementia (2006)
Focus on carers being offered psychotherapy, and although CBT is mentioned, it is acknowledged that other therapies will be offered, and the costs are based on a clinical psychologist.

CG31 Obsessive Compulsive Disorder (2005)
Costing report mentions that only 50% currently receive psychological therapies, and family therapy is one of the therapies offered. Families need to be involved with CBT and exposure and response prevention when working with children and young people.

APPENDIX 4

NICE PATHWAYS
Some pathways have excellent recommendations for systemic family interventions. They incorporate health and social care issues, as well as some clinical and public health guidelines. Many topics are linked at other topics, eg vulnerable children and substance misuse. http://pathways.nice.org.uk/

ALCOHOL USE DISORDERS
Excellent recommendations for AFT members, and is linked to other guidelines that include alcohol problems, including Reducing Substance misuse with Vulnerable Children and young People. Interventions for harmful drinking and mild alcohol dependence: Behavioural Couples Therapy.

REDUCING SUBSTANCE MISUSE WITH VULNERABLE CHILDREN AND YOUNG PEOPLE:
This includes several references to various systemic therapies, including in the Costing report. In the category of working with vulnerable and disadvantaged young people, the focus is on family-based interventions and ‘intensive interventions (such as family therapy) for those who need it’. References Dishion (2003, 2004); Joanning (1992); Liddle et al (2004)

And for promoting abstinence and preventing relapse for 10-17 year olds, this is mentioned: Offer multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy; see delivering psychosocial interventions for children and young people) for those with significant comorbidities and/or limited social support.
Adults with moderate or severe dependence and successful withdrawal are included: if there is a regular partner who would like to be involved – behavioural couples therapy.

DEPRESSION
Shorter term family therapy is recommended for children and young people, as well as needing to consider a ‘joint treatment alliance with the family’. For moderate or severe depression (including psychosis), after a review consider ‘alternative or perhaps additional psychological therapy for the parent or other family members’ and 15 fortnightly sessions of systemic family therapy.

For Adults: Various considerations should be considered when deciding which psychotherapy should be offered, based on backgrounds issues and the patient’s choice. Step 3: 15-20 sessions of Behavioural Couples Therapy over 5-6 months for both depression and depression with a physical health problem.

**DIABETES**

Need to offer psychological intervention or support for diabetes-related family conflict.

**SOCIAL AND EMOTIONAL WELLBEING FOR CHILDREN AND YOUNG PEOPLE.**

Refers to a whole schools approach, and covers primary and secondary schools. No specific treatment recommendations, but CAMHS may need to be involved with some children, and family interventions and parent training are important. There is an acknowledgement in the costing report of the need to employ staff for to provide the support services rooms may be rented outside of the school.

**WORKING WITH VULNERABLE AND DISADVANTAGED CHILDREN AND YOUNG PEOPLE –** linked to Reducing Substance Misuse with vulnerable children and young people

**APPENDIX 5**

**RECOMMENDED AND REVIEWED MODELS OF COUPLE AND FAMILY THERAPIES**

**Reviewed in FULL Guideline (F) or in recent reviews (RR)**

<table>
<thead>
<tr>
<th>FAMILY THERAPY MODEL</th>
<th>TOPIC – RECOMMENDED</th>
<th>REVIEWED IN FULL GUIDELINE /UPDATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural family interventions</td>
<td>CG91 Depression – chronic health</td>
<td>CG9 Eating Disorders (RR)</td>
</tr>
<tr>
<td>Family-based Behavioural therapy</td>
<td>CG51 Drug Misuse – Psychosocial</td>
<td>CG31 OCD (F)</td>
</tr>
<tr>
<td>Behavioural family systems therapy</td>
<td>CG15 Type 1 Diabetes</td>
<td></td>
</tr>
<tr>
<td>Brief Strategic Family Therapy</td>
<td>CG115 Alcohol Dependence</td>
<td>CG72 ADHD (F)</td>
</tr>
<tr>
<td>Brief Solution Focused Therapy</td>
<td>CG77 Antisocial PD</td>
<td>CG72 ADHD (F)</td>
</tr>
<tr>
<td>Family-based therapy/intervention</td>
<td></td>
<td>CG9 Eating disorder (RR)</td>
</tr>
<tr>
<td>Family Interventions (including systemic)</td>
<td>CG38 Bipolar Disorder</td>
<td>CG52 Drug Misuse – Opioid (F)</td>
</tr>
<tr>
<td>Family-centred interventions</td>
<td>CG28 Depression – C &amp; YP</td>
<td>CG15 Type 1 Diabetes (RR)</td>
</tr>
<tr>
<td>Single-family interventions</td>
<td>CG91 Depression- Chronic Health</td>
<td>CG38 Bipolar Disorder (F)</td>
</tr>
<tr>
<td>Focused family interventions</td>
<td>CG51 Drug Misuse – Psychosocial</td>
<td></td>
</tr>
<tr>
<td>Structured formal family intervention</td>
<td>CG 9 Eating Disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CG120 Psychoses + substance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CG82 Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Family Therapy / Systemic FT / Shorter term FT</td>
<td>CG28 Depression – C&amp;YP</td>
<td>CG38 Bipolar Disorder (RR)</td>
</tr>
<tr>
<td>Family Systems therapy/</td>
<td>CG9 Eating Disorders</td>
<td>CG42 Dementia (F)</td>
</tr>
<tr>
<td>Family psychotherapy/</td>
<td>CG26 PTSD</td>
<td>CG110 Pregnancy CSF (F)</td>
</tr>
<tr>
<td>Family-based therapy/</td>
<td>TA102 Parent training</td>
<td>CG82 Schizophrenia (RR)</td>
</tr>
<tr>
<td></td>
<td>PH4 Reduce substance misuse</td>
<td>CG16 Self Harm –short (F)</td>
</tr>
<tr>
<td></td>
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<td>CG76 Medical Adherence (F)</td>
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</tr>
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<td>Functional Family Therapy</td>
<td>CG115 Alcohol Dependence</td>
<td>CG77 Antisocial PD</td>
</tr>
<tr>
<td>Multidimensional FT</td>
<td>CG115 Alcohol Dependence</td>
<td>CG77 Antisocial PD</td>
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<td>Multisystemic therapy</td>
<td>CG115 Alcohol Dependence</td>
<td>CG77 Antisocial PD</td>
</tr>
<tr>
<td></td>
<td>CG28 Depression C &amp; YP (F)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PH28 Looked After Children (F)</td>
<td></td>
</tr>
<tr>
<td>Structural Family Therapy</td>
<td></td>
<td>CG72 ADHD (F)</td>
</tr>
<tr>
<td>COUPLE THERAPY RECOMMENDED</td>
<td>TOPIC – RECOMMENDED</td>
<td>REVIEWED IN FULL OR UPDATE</td>
</tr>
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<td>CG115 Alcohol Dependence</td>
<td>CG123 Common MH Disorders</td>
</tr>
<tr>
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<td>CG90 Depression – Adults</td>
<td>CG51 Drug Misuse PI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CG120 Psychosis + substance (F)</td>
</tr>
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<td>Couple Therapy/ Couple focused therapy</td>
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<td>CG90 Depression – Adults</td>
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<td></td>
<td>CG91 Depression + health</td>
<td></td>
</tr>
<tr>
<td>GROUPS + FAMILY</td>
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<td></td>
</tr>
<tr>
<td>Multi-family group intervention</td>
<td>CG82 Schizophrenia</td>
<td></td>
</tr>
</tbody>
</table>