.

Report on the evidence base of systemic family therapy

Prepared by Professor Peter Stratton, Leeds Family Therapy and Research Centre, and Academic and Research Development Officer, Association for Family Therapy. This report can also be viewed on the AFT website: www.aft.org.uk
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Overview

As this review demonstrates, Systemic Family Therapy provides effective help for people with an extraordinarily wide range of difficulties. The range covers childhood conditions such as conduct and mood disorders, eating disorders, and drug misuse; and in adults, couple difficulties and severe psychiatric conditions such as schizophrenia. Throughout the life span, it is shown to be effective in treatment and management of depression and chronic physical illness, and the problems that can arise as families change their constitution or their way of life.

While the range is remarkable, the effectiveness of Family Therapy is perhaps not so extraordinary. After all, the great majority of families cope with a range of difficulties. Families that include a child with serious mental health difficulties, for example, have been shown to come to therapy with substantial strengths and resilience (Allison et al, 2003). So we might expect that a determined effort by people trained and experienced in mobilising the resources of families that have reached an impasse would be effective.

A review of the existing evidence base finds substantial evidence for the efficacy and the effectiveness of family interventions. Where economic analyses have been carried out, family therapy is found to be no more costly, and sometimes significantly cheaper, than alternative treatments without loss of efficacy.

There is little evidence of differences in outcome from different kinds of family intervention. This consistency seems primarily due to the fact that well-trained practitioners draw on a wide variety of Family Therapy approaches, according to the needs of each case.

There is evidence that Family Therapy has a number of benefits beyond its effectiveness with referred conditions, including greater acceptability to clients and families, continued improvement after discharge, and improving compliance with medication when medical and Family Therapy treatments are combined.

In the light of such a strong evidence base for the effectiveness of Family Therapy, we conclude that trained family therapists need to be employed not just provide Family Therapy services but also:

- to support training of future family therapists through supervision;
- to provide training and support for professionals applying specific family interventions such as Expressed Emotion and Brief Solution Focused approaches;
- to provide supervision and, where appropriate, training of other professionals working with families;
- to develop the research base of their practice by participating in networked research.

Introduction

The evidence base of family therapy has been generated in two rather different forms – that provided by controlled outcome trials, and the wider evidence base beyond such formal reviews

Controlled outcome trials compare family therapy with other (or no) treatment for *clearly diagnosed conditions*. These studies are likely to fit the requirements of formal reviews, and have been extensively summarised in meta-analyses. For a number of reasons such research is not directly applicable to everyday practice in the NHS. Family therapy provision within the NHS and social services usually has the following characteristics:

- Most clients seen for family therapy, and their families, do not have a single clearly defined mental health problem.
- Family therapists work collaboratively with other colleagues and family therapy is often combined with other treatments.
- It is carried out by professionals with a range of training in family therapy techniques that can vary from little or no formal training through to completion of an accredited course and registration with UKCP as a systemic practitioner.
- Diagnoses are seen as useful information but therapy is not restricted to a specific condition.

This report therefore considers a wider range of evidence than that generated by controlled trials in specialist units, and we sometimes have to extrapolate from these trials in order to draw conclusions about the effectiveness of Family Therapy in practice.

A clear general conclusion from the evidence is that Family Therapy is effective in a very wide range of areas. In certain conditions the evidence is strongest for Family Therapy combined with other appropriate treatments, whether these be medication, individual, social or educational.

Decisions about the implications for provision that can be drawn from the existing evidence base need to be made in relation to current forms and availability of Family Therapy. Family Therapy should be offered by qualified and accredited practitioners. Yet far more family work is needed than can be provided by the available numbers of qualified and accredited Family Therapists for the foreseeable future.

While other disciplines have studied the family, or have forms of psychotherapy that can be used within a family setting, it is family therapists who have the most extensive experience of working in detail with family difficulties. This experience should be made available to a wider group of professionals. Evidence-based practice (EBP) approaches can be used to specify effective approaches to working with families and other relationship groups within the full range of physical and psychosocial difficulties seen within the NHS and Social Services. Through training, supervision, support and consultation, Family Therapists in designated posts will be able to make these approaches available to all who offer family interventions at different levels.

Much effective work with people in their families can be provided by those not formally accredited as Family Therapists or Systemic Psychotherapists. But this work is only likely to achieve the necessary standards if other professionals have access to current best practice of family work through working with, and where appropriate, being guided and supervised by, properly trained Family Therapists.

Fully trained systemic family therapists (registered with UKCP as Systemic Psychotherapists) will also be able to offer consultation in productive ways of working within public services, for example with multidisciplinary teams and through effective collaboration with managers, many of whom will already be using a systems approach to organisational functioning.

Family therapists and others trained in systemic family therapy are already helping families and other groups mobilise their resources to tackle difficulties, respecting families' particular needs and insights and encouraging family members to find constructive ways to help each other. The challenge now is to spread this work and training throughout health, education and social care services.

Overviews and meta-analyses of efficacy and effectiveness

The most general approach to evaluating the evidence of the effectiveness of Family Therapy is through meta-analyses.

Extensive early analyses by Hazelrigg et al (1987) and Shadish et al (1993) reviewed research that reflected the weak methodology of many studies of that time. Thus Hazelrigg et al. (1987) found only 20 of 281 studies that met their criteria. They concluded that Family Therapy does have a positive effect post treatment, particularly for behavioural measures (mean effect size Cohen's *d*= 0.50 Vs no treatment controls and *d*=0.65 Vs alternative treatment controls), but was only slightly more effective than alternative therapies. Shadish et al (1993) included only trials with random assignment and distressed participants. Over a 25-year period (1963-1988), 163 studies met these criteria of which only 71 were of Family Therapy. This study also found a positive effect for Family Therapy (*d* = 0.51) but with no difference between immediate post-treatment and follow-up scores.

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There was some suggestion that family therapies might do less well than individual therapies for children and adolescents.

A further limitation in our reliance on earlier studies is that the forms of therapy being researched would now be regarded as only of historical importance in this rapidly developing field. Even the most recent research in the Shadish et al (1993) analysis would have been planned in the early 1980s, with the earliest dating from around 1960, yet they classified the 71 Family Therapy studies into 22 different theoretical models and still had 7 studies left over that they were unable to classify.

Over the past decade the technology of meta-analysis has become more rigorous and increasing numbers have been published. Shadish & Baldwin (2003) identified 140 meta-analyses in psychotherapy. Probably the best overview comes from this publication, in which the authors undertook a meta-analysis of 20 meta-analyses of couple and family therapy. It is thus a meta-meta-analysis. They conclude that 'marriage and family therapy is now an empirically supported therapy in the plain English sense of the phrase - it clearly works, both in general and for a variety of specific problems.'

More specifically, they conclude:
- Marriage and family interventions are clearly efficacious compared to no treatment.
- Those interventions are at least as efficacious as other modalities such as individual therapy, and may be more effective in at least some cases.
- There is little evidence for differential efficacy among the various approaches within marriage and family interventions, particularly if mediating and moderating variables are controlled.

What kinds of family therapy?

While Shadish & Baldwin (2003) provide a general and positive answer to the question of whether systemic family therapy is effective, their third conclusion is particularly relevant to any attempt to summarise the evidence base.

Family Therapy started from a common basis in systems thinking but has developed in many directions during its 50-year history. The variety of approaches within current Family Therapy presents a potential difficulty for an overview. For example, in the Shadish et al (1993) review it is not possible in most cases to determine the particular approach used during therapy.

While differences between models are enthusiastically championed by theorists and practitioners, the research findings offer a practical solution to the dilemma of combining findings from these different approaches. Almost all reviews that have compared outcomes from different Family Therapy approaches have concluded that there are minimal differences in outcome. An explanation comes not from the disputed idea that all psychotherapy works (when it does) because of factors unrelated to the form of therapy itself (Sexton, Ridley, & Kleiner, 2004). Rather, it seems that in practice, different models of Family Therapy share substantial common ground.

Pote et al (2003) report on the construction of a Manual of Systemic Family Therapy that was based on the work of one clinic (Leeds Family Therapy & Research Centre) but checked for consistency with five other major training institutes in the UK. The analysis of the rationales and intentions identified by the practitioners show that they draw on techniques from a full range of current models of Family Therapy. Current models of family therapy pay explicit attention to issues of culture, ethnicity, gender, discrimination and wider physical and societal contexts.

Henggeler & Sheidow (2003), in reviewing three effective but apparently very different treatments for adolescent conduct disorder and delinquency (Functional Family Therapy, Multisystemic

Therapy, and Oregon Treatment Foster Care), conclude that 'they share several commonalities in their conceptualization, delivery, and procedures'.

Weissman & Sanderson (2002) state that: 'The efficacy of the various family interventions (behavioural, supportive, & systems) appear to be equivalent (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Indeed, the only direct comparison of two evidence-based family interventions found that supportive family therapy and behavioural family therapy were not significantly different. These findings are not surprising considering the family intervention strategies across the three theoretical orientations share many common essential treatment components (Baucom et al., 1998).'

Pinsof et al. (1995, 1996) reviewed the outcome literature for a variety of presenting difficulties. They concluded that Family Therapy works, and for some presenting difficulties is more efficacious than individual interventions (e.g. marital distress, and anorexia in young adolescents), but that there is as yet no data to support the differential efficacy of different Family Therapy models. Family Therapy may be more cost effective than residential and inpatient treatments, but may not be sufficient in itself to address some severe disorders and problems (e.g. Schizophrenia, adolescents' conduct difficulties). More recent research in these areas is reviewed below.

MCFarlane (2003) reviewing the effectiveness of multiple family/ psychoeducation for people with schizophrenia calls the title a misnomer because the treatment actually had more aspects of family intervention. Macdonald, (1997) claimed that systemic psychotherapy often incorporates a Brief Therapy approach making it a cost-effective modality.

In conclusion, while we are beginning to see research reports that distinguish between different approaches to therapy, these tend to be based on specialist clinics and the use of manuals to ensure that particular procedures are followed. In the outcome studies for which meta-analyses are available, and in the everyday practice of trained family therapists, it is likely that therapists draw on a wide range of techniques to meet the needs of the therapeutic situation.

Within the field the value of such an approach is being recognised by calls for explicit integration of approaches (e.g. Rivett & Street, 2003; Vetere & Dallos, 2003). In clinical practice the integration goes wider with incorporation of psychodynamic and cognitive-behavioural methods within systemic psychotherapy. But for our current purposes in reviewing the evidence, it makes sense to group the different forms together under the general heading of "Family Therapy" except where outcomes are clearly linked to just one specific model of family intervention.

Reviews of the effectiveness of Family Therapy for specified conditions.

There have been several recent, careful reviews that assess the range of evidence available in relation to specific conditions. The reviews consistently identify certain conditions of children, adolescents and adults as effectively treated by Family Therapy. As these reviews are readily available, in this section we simply list the conditions for which Family Therapy is indicated as a treatment, with additional information where this is likely to be useful.

Family therapy with children and adolescents

Cottrell and Boston (2002) conclude that family interventions are effective for the following:
- Conduct disorders
- Substance misuse
- Eating disorders
- And as a second-line treatment for depression and chronic illness.

From an extensive review Carr (2000a) concluded that there is good evidence in the following areas:

- Childhood physical abuse and neglect;
- Conduct problems in childhood and adolescence, including oppositional behaviour
- Difficulties and problems with attention and overactivity;
- Drug-related problems;
- Emotional disorders including anxiety, depression and grief following bereavement;
- Psychosomatic problems

Asen (2002), from a more selective review, also concludes that there is strong evidence for using Family Therapy with conduct problems of children and eating problems in adolescence. Further detail is provided by Eisler, leGrange, & Asen (2002) who conclude that Family Therapy is an effective treatment for anorexia nervosa in adolescence. The majority of adolescents suffering from anorexia nervosa, even when severely ill, can be managed on an outpatient basis providing the family has an active role in treatment. They felt that family interventions are best viewed as treatments that mobilise family resources rather than treat family dysfunction (for which there is little empirical evidence). They also argue that brief, intensive multiple family interventions provide an important alternative to engaging families in treatment and are viewed very positively by families.

Family therapy with adults

The review by Asen (2002) had more focus on work with adults. He concluded that the evidence supported Family Therapy with:

- Psychotic disorders
- Mood disorders
- Drug and alcohol misuse
- Anorexia (adult as well as adolescent) and bulimia
- Distress in couple relationships.

In his second review, concentrating on therapy with adults, Carr (2000b) found good support for Family Therapy in the following range:

- Chronic pain management
- Management of neurologically impaired adults
- Treatment of psychosexual difficulties
- Marital conflict and distress
- Adult alcohol misuse
- Anxiety disorders
- Agoraphobia with panic disorder
- Obsessive-compulsive disorder
- Major depression and bipolar disorder

Sprenkle (2002) reported effectiveness of Family Therapy with:

- Severe mental illness
- Alcohol and substance misuse
- Relationship dysfunction
- Chronic physical illness.

A sample of specific recent research studies and reviews

Reviews and meta-analyses are a convenient source of critical assessments of the evidence literature. They can be supplemented by more specific and more recent reports which have a more precise focus and which exemplify current approaches to Family Therapy.

Useful guidance for the UK can be obtained from Department of Health reviews. The National Institute of Clinical Excellence (NICE) reports focus on rigorous research. A selection of NICE recommendations are summarised by Eisler (2005):

- Family interventions should be available to the families of people with schizophrenia who are living with or in close contact with the service user (NICE, 2002).
- Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa (NICE, 2004a).
- Couple-focused therapy should be considered for patients with depression who have a regular partner (NICE, 2004b).

Child and Adolescent Studies

Woolfenden, Williams, & Peat (2002) conclude that family and parenting interventions reduce subsequent arrests and length of time in institutions for youths with conduct disorder and delinquency.

Wilson & Fairburn (1998) in reviewing treatments for eating disorders, conclude that Family Therapy is one of the most effective treatments. A major series of studies (Dare et al, 1995; Eisler, LeGrange & Asen 2002) shows that Family Therapy is effective in the treatment of adolescent eating disorders. Krautter & Lock (2004) found that manualised Family Therapy was acceptable to families where an adolescent presented with anorexia

An exemplary research project

One of the most comprehensive research programmes has been carried out by Howard Liddle and Associates. This series of studies is worth considering in some detail because it shows the range of information that can be provided by properly funded and rigorous research. The studies are especially impressive because the therapy was provided for a difficult group of clients (adolescents, mostly living in poverty, and in disrupted family constellations) with problems that are difficult to treat (drug misuse and a high level of co-morbidity). The authors have developed a comprehensive treatment drawing on a wide range of achievements in Family Therapy, called Multi-Dimensional Family Therapy (MDFT). Their fully documented claims include:

- MDFT has demonstrated better results than several other state-of-the-art treatments, including family group therapy, peer group treatment, individual cognitive-behavioural therapy (CBT), and comprehensive residential treatment.
- In addition to successfully treating adolescents who are heavy drug users, MDFT has worked effectively as a community-based prevention model and has successfully treated younger adolescents initiating drug use.
- Substance use is significantly reduced in MDFT to a greater extent than all comparison treatments investigated (between 41% and 66% reduction from intake to discharge).
- Treatment gains are enhanced in MDFT *after treatment discharge;* MDFT clients continue to decrease substance use after discharge up to 12-month follow-up, while teens in individual CBT and residential treatment increase drug use following treatment.
- Psychiatric symptoms show greater reductions during treatment in MDFT (range of 35% to 80% within treatment reduction) than comparison treatments – MDFT clients also continue to improve following discharge while teens in CBT show relapse of emotional and behavioural problems after treatment.

- School functioning improves more dramatically in MDFT than comparison treatments -- MDFT clients return to school and receive passing grades at higher rates (43% in MDFT vs. 17% in family group therapy and 7% in peer group therapy).
- Family functioning improves to a greater extent in MDFT than family group therapy or peer group therapy using observational measures and these improvements are maintained up to 12-month follow-up.

Treatment Engagement and Retention

- MDFT clients stay in treatment longer than clients in outpatient and residential comparison treatments. 95% of clients in intensive outpatient MDFT stayed in treatment for 90 days as compared to 59% in residential.

Cost Savings of Multidimensional Family Therapy

- Average weekly costs of treatment are significantly less for MDFT ($164) than community-based outpatient treatment ($365) (French et al. 2003).
- An intensive version of MDFT designed as an alternative to residential delivers better outcomes at 1/3 the cost (average weekly costs of $384 vs. $1,138)

Sample references for this research programme are grouped here:

French, M. T., Roebuck, M. C., Dennis, M., Godley, S., Liddle, H. A., & Tims, F. (2003). Outpatient marijuana treatment for adolescents: Economic evaluation of a multisite field experiment. *Evaluation Review, 27,* 421-459.

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Liddle, H. A., Rowe, C. L., Dakof, G. A., Ungaro, R. A., & Henderson, C. (2004). Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized controlled trial comparing multidimensional family therapy and peer group treatment. *Journal of Psychoactive Drugs*.

Schmidt, S. E., Liddle, H. A., & Dakof, G. A. (1996). Changes in parenting practices and adolescent drug abuse during multidimensional family therapy. *Journal of Family Psychology, 10,* 12-27.

Adult Studies

Kelley & Fals-Stewart (2002) found couples therapy more effective than individual-based therapy for men entering treatment for alcohol or drug abuse. The effect was not only stronger for the client but had greater positive effect on discord within adult couple relationships and the psychosocial adjustment of the couples' children.

Byrne Carr &Clark (2004) reviewed panic disorder with agoraphobia. Couples work was effective, especially if the relationship was good.

The London depression trial (Leff et al, 2000) found that manualised Family Therapy had higher compliance than CBT or medication, and was more effective and of comparable cost to medication. Those receiving Family Therapy had better compliance with medication as well as a reduced probability of relapse.

Weissman (2002), in reviewing evidence-based psychological treatments, concludes that: 'Overall, when compared to treatment as usual, behavioural, supportive, and systems based

family intervention strategies were efficacious in reducing relapse rates in patients with schizophrenia (e.g., Falloon, Boyd, & McGill, 1984; Leff et al., 1985; Schooler et al., 1997).'

Burbach and Stanbridge (1998) report on a highly regarded family intervention in psychosis service, integrating systemic and family management approaches that had high levels of acceptance (Stanbridge et al, 2003).

Hazel, McDonell, & Short (2004) conclude that multiple family group treatment reduced distress for caregivers of people with schizophrenia, but did not increase caregivers' resources compared with usual care.

A study of adult opiate users found more favourable outcomes for those receiving Family Therapy, compared with two individually based interventions, particularly for those living with a partner (Yandoli et al., 2002).

Doyle et al (2003) compared residential with community-based Family Therapy programmes. Both had very positive results. The residential group were more likely to be total abstainers with bouts of heavy drinking. Those treated in the community had many more (43%) who were moderate drinkers but with far fewer bouts of heavy drinking.

Family therapy combined with other treatments

Epstein et al (1988) combined family interventions with drug treatments and showed a more positive effect in terms of family functioning and symptom resolution than drug therapy alone.

Pilling et al. (2002) states that Family Therapy, in particular single family therapy, had clear preventative effects on the outcomes of psychotic relapse and readmission, in addition to benefits in medication compliance. In this study CBT was associated with lower drop-out rates.

Family Therapy can also be a source of necessary collaboration between services. Reder, McClure, & Jolley (2000) cite the example of a single mother with depression who has a 7-year-old child with profound sleep disturbance. How likely would it be that the management of both would be fully integrated without a family-based treatment?

Conclusions from the evidence

There is strong empirical support for using some form of Family Therapy with a wide range of conditions.

Researchers differ in their choice of conditions to review and there has been no co-ordination in the research effort. Some conditions have received significant research funding, and there are carefully conducted and well-resourced research studies available. In many other areas, research is patchy or has never been commissioned. There is, therefore, an arbitrariness about the research base that makes it necessary to extrapolate from those areas that have been well-researched.

Family Therapy is of proven effectiveness wherever it has been properly researched, and the conditions of proven effectiveness cover a wide range of difficulties (e.g. distress in couple relationships, drug dependence and psychosis). It is a treatment with a well-developed theoretical base, forged through decades of practice in highly varied settings.

Future research directions

The available research into efficacy is generally positive, but the research base is limited. There is therefore a strong justification for including Family Therapy in future comparison outcome trials, and for conducting more coherent and rigorous outcome research on Family Therapy.

Efficacy trials are, however, only the start of the story because efficacy does not necessarily amount to the kind of therapeutic change implied by the term 'effectiveness', and the fact that a treatment produces cost-effective improvements under specialist conditions does not guarantee effectiveness in everyday practice (Chorpita, 2003). Although effectiveness usually achieves lower scores than measures of efficacy, controlled trials may underestimate the value of a therapy. As Fonagy et al (2004) state "Outcome measures should cover more domains than that of symptomatology: a treatment may be more effective in the long run if it has a beneficial impact across other domains of functioning, even if the effect on symptoms is no greater".

Therapy conducted in controlled conditions by specialists who are often the originators of the particular approach needs to be followed by trials in more realistic field conditions. Are the methods still effective when transported to less specialist locations with no input from the originators? There is a woeful shortage of data on the progression from efficacy through effectiveness to transportability and one can only speculate about the factors that might be relevant in maintaining the results shown by research.

Strategies for making decisions from evidence

The evidence base of any area of psychotherapy is a complex mixture of research that appropriately draws on all five levels of evidence identified by the DoH (1999):

- Type I evidence (at least one good systematic review and randomised controlled trial (RCT) for a range of problems),
- Type II evidence (at least one good RCT),
- Type III evidence (at least one non-randomised intervention study),
- Type IV evidence (at least one well-designed observational study),
- Type V evidence (expert opinion, particularly of service carers and users).

Because much of the research by Family Therapists needs to use rigorous qualitative methods, these studies must be evaluated according to the relevant criteria. Lincoln & Guba (1985) formulate these as *credibility, transferability, dependability* and *confirmability*. Qualitative criteria are further discussed by Robson (2002).

The range of what needs to be considered is indicated by the document "Psychological Therapies Working in Partnership" (NHS Executive, 2000) which advocates that choice of treatment be informed by psychological formulation, clinical judgement, research indications, user preferences and cost efficiency rather than diagnosis or presenting symptoms alone. Sackett's (1996) conclusions about evidence-based medicine include: 'The practice of EBM means integrating individual clinical expertise with the best available external clinical evidence from systematic research.'

We would propose four types of sources that should converge in deciding when Family Therapy is the treatment of choice:

<u>Source 1: Evidence</u>

- Evidence that it works best for this condition.
- Evidence it works for similar conditions, and no contrary evidence for this condition.

- Evidence that family treatment is synergistic with other treatments that will be used.

Source 2: Nature of the condition

The condition is understood in terms such that Family Therapy is most appropriate. E.g. dependence on the family for sustaining treatment; known to be exacerbated by certain forms of family functioning that are likely to be present; is largely defined in terms of family relationships; arises from family life stage.

Further reasons are provided in '*Treatment Choice in Psychological Therapies and Counselling'* (DoH, 2001) and relate to the decision whether to refer out of primary care (to either a community mental health team [CMHT] or psychotherapy service). Criteria include: history of severe trauma, where previous attempts to treat at primary care level have been unsuccessful, or where the appropriate service is not available in primary care. This is likely to include patients with complex social/family problems, severe depression, anxiety or social dysfunction, and co-morbidity.

The report also states that: "Patient preference or demand for a secondary service should also be taken into account", leading to:

Source 3:Acceptability

Examples can be taken from the DoH website: Patient choice. Giving patients more choice about how, when and where they receive treatment is a cornerstone of the Government's health strategy.

This strategy paper draws out and develops the main themes that emerged from the "Choice, Responsiveness and Equity" consultation, which closed on 11 November 2003. It broadly sets out how the Government aims to make NHS services more responsive to patients, by offering more choice across the spectrum of healthcare. Its main aim is to improve patient and user experience and build new partnerships between those who use health and social care and those who work in them.

The section of this report reviewing evidence pointed to findings of greater acceptability to clients of family-based therapy. Cottrell and Boston (2002) conclude that there is evidence that systemic therapies may reduce drop-put and increase consumer satisfaction with therapies.

Source 4: Family Therapy can be delivered

In any particular situation Family Therapy can only be considered if it can realistically be delivered. As already discussed, the availability of trained family therapists is crucial but once this resource is available it becomes practical, and ethical, to also have family interventions provided by other professionals whose practice can be planned, supervised and kept up-to-date by the registered family therapist(s). The model here follows well-established approaches of cascading expertise. It is not the only route to providing clients with this essential resource, but for many services it is likely to be the most practical.

Conclusion: why Family Therapy is an essential provision.

While this review attempts a balanced assessment of evidence it has been written by researchers and practitioners from a position that systemic family therapy is an important part of the provision

for people who are coping with mental health and other problems. However, that conviction itself has developed from the range of accepted sources described in the previous sections.

There is strong evidence of both efficacy and effectiveness in a range of specific conditions. Family Therapy is used for an extremely wide range of problems, many without a clear (DSM-type) diagnostic definition, so there is no prospect that there will be evidence for every application of the approach to treatment. However, if we take the conditions that have been researched as representative, then we can deduce the range of problems for which it would be appropriate to expect Family Therapy to be effective.

In summary, reasons to ensure and expand provision of Family Therapy include:

- It has proven effectiveness for those conditions for which it has been properly researched.
- There is very substantial supportive evidence for its effectiveness from diverse research and clinical experience.
- Trained family therapists draw on a good range of approaches with clear theoretical rationales. Current models of family therapy pay explicit attention to issues of culture, ethnicity, gender, discrimination and wider physical and societal contexts.
- Responsive and effective therapy for families in the UK needs to develop through practice in the UK, rather than relying on methods developed by practitioners in the USA and elsewhere.
- Properly trained family therapists have transferable skills in relation to team working, consultation, organisation etc.
- Family therapists can support other professionals in their work with families.

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