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Editorial

Family Interventions for Schizophrenia: Why Are They Still Not Routinely Offered?

Richard Gray [1,*], Martin Jones [2], Jacqueline Sin [3], Irene Ngune [4] and Daniel Bressington [5]

[1] School of Nursing and Midwifery, La Trobe University, Bundoora, VIC 3086, Australia
[2] School of Nursing and Midwifery, Edith Cowan University, Bunbury, WA 6230, Australia; martin.jones@ecu.edu.au
[3] School of Nursing, The Hong Kong Polytechnic University, Hung Hom, Kowloon, Hong Kong SAR, China; jacqueline-ph.sin@polyu.edu.hk
[4] School of Nursing and Midwifery, Edith Cowan University, Joondalup, WA 6027, Australia; i.ngune@ecu.edu.au
[5] Faculty of Nursing, Chiang Mai University, Chiang Mai 50200, Thailand; daniel.bressington@cmu.ac.th
* Correspondence: r.gray@latrobe.edu.au

Family intervention for schizophrenia is one of the clearest examples of the evidence-to-practice gap in mental health care. Despite over four decades of evidence and explicit clinical guideline recommendations, audit data from England and Wales show that mental health services do not routinely offer family intervention to people with schizophrenia and their families. This is hard to justify: relapse in people with schizophrenia is common, and families often provide substantial practical and emotional support to their relative. Family intervention, delivered by trained mental health professionals, is intended to improve communication, reduce stress and help prevent relapse [1,2].

In this editorial, family intervention—also described as family work, behavioural family therapy and family psychoeducation [1,3,4]—refers to structured psychoeducational and behavioural work delivered by mental health professionals with specific training and supervision, including mental health nurses, psychologists, psychiatrists and other clinicians. They work with families or carers, involving the person with schizophrenia where possible, to develop an understanding of the illness and skills in communication, problem-solving and managing crises. Family includes relatives and other significant people identified by the person with schizophrenia as having a caring or supportive role.

Early research explored how relationships between people with schizophrenia and their relatives were associated with the risk of relapse. The term 'expressed emotion' describes relatives' emotional responses towards the person with schizophrenia, including warmth, criticism of the person or their behaviour, hostility and emotional overinvolvement, such as excessive protectiveness or self-sacrifice. Vaughn and Leff [5] found that greater criticism and emotional overinvolvement were associated with relapse during follow-up. A subsequent meta-analysis found that criticism was associated with a higher risk of relapse, whereas greater warmth was associated with a lower risk [6]. These findings helped inform family interventions that support communication, reduce stress and help families manage the challenges of living with schizophrenia.

Early randomised controlled studies by Leff et al. [3] in the UK and Falloon et al. [4] in the United States went on to demonstrate important reductions in relapse rates when structured family work delivered by clinicians was added to usual treatment. Subsequent research has generally supported the efficacy of family intervention. A recent systematic review and network meta-analysis compared 11 family-intervention models across 90 randomised controlled trials involving 10,340 participants [1]. At 12 months, the primary assessment timepoint, almost all models were associated with a lower probability of relapse

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than treatment as usual. For family psychoeducation alone, the network analysis estimated an odds ratio for relapse of 0.18 (95% CI 0.12–0.27), corresponding to an estimated 10% absolute risk of relapse (95% CI 7–14%), compared with 37% for treatment as usual: absolute risks were modelled estimates rather than raw pooled rates. Confidence in the estimates, however, ranged from moderate to very low, and no included study was determined to be at low risk of bias.

Given the evidence, one might reasonably assume that people with schizophrenia and their families are routinely offered family intervention. The available data suggest this is not the case. The 2018 National Clinical Audit of Psychosis (NCAP) core audit, covering mental health services in England and Wales, reported that only 12% of patients in contact with their family had been offered family intervention. In the same audit, family intervention was unavailable for 21% of patients and available but not offered to a further 20%. These patients therefore had no opportunity to accept or decline the intervention [7].

Access to family intervention appears better in early intervention services in England. A secondary analysis of NCAP data from these services collected from 2018 to 2021 found that 62% of patients were offered family intervention and 21% received at least one session [8]. These findings suggest a contrast with general adult services, although the populations and audit periods differ and receipt of one session does not establish completion of an intervention. The NCAP State of the Nation Report 2024, published in 2025 and covering the 2022/23 and 2023/24 audit cycles in England and Wales, documents more recent progress alongside continuing gaps in provision. In early intervention in psychosis services in England, the proportion of people recorded as having been offered and taken up family intervention increased from 21% in 2021/22 to 29% in 2023/24 [9]. Uptake, however, does not necessarily equate to completion of treatment.

Patient perspectives also need to be considered when examining uptake of family intervention. A scoping review of 33 studies examining barriers to family involvement in care for people with severe mental illness identified patients' concerns about privacy, autonomy, stress, burdening relatives and potential strain on family relationships [10]. The review concerned family involvement broadly, rather than family intervention specifically, so these findings should not be interpreted as evidence that people with schizophrenia are generally reluctant to participate in family intervention. They do highlight the need to offer family intervention respectfully and collaboratively, allowing people to decide whether they wish to participate.

Such concerns may influence whether people accept family intervention, but they do not adequately explain why services lack the capacity to provide it or why it is not routinely offered.

Access to appropriate training and supervision may be a core barrier to delivery. The Thorn Initiative, established in the early 1990s at the Institute of Psychiatry in London and the University of Manchester, both in the UK, initially focused on equipping community mental health nurses with skills in evidence-based psychosocial interventions [11,12]. Its year-long programme combined classroom teaching, workplace practice and clinical supervision, with family intervention as one of three core modules. By 2004, it had expanded to 13 centres across England and Wales [12], yet clinicians continued to lack opportunities and support to apply their skills [13]. A later evaluation of Thorn and behavioural family therapy training similarly highlighted the need for organisational support alongside skills development [14]. Training alone is insufficient without supervision, protected time and a clear role in delivering family work [15,16].

Family carers and other significant people who provide unpaid care also need education and support in their own right, even if the person with schizophrenia chooses not to participate in family intervention. Research has documented poorer mental wellbeing

among carers supporting people with psychosis than in the general population [17]. Their needs should not be considered solely in terms of their capacity to support someone else. The UK National Institute for Health and Care Excellence (NICE) recommends offering carers an education and support programme as early as possible, whether delivered as part of family intervention or separately [2].

Recent guidance raises concerns about the priority given to family intervention. The 2016 Australian and New Zealand guideline stated that family psychoeducation should be offered routinely [18]. The 2026 guideline instead suggests that family/whānau/carers "may be offered family-based interventions", grading this as a weak recommendation [19]. The recommendation drew extensively on the Cochrane review by Chien et al. [20], which included 26 RCTs involving 1985 people with schizophrenia or schizophrenia-like disorders and 2056 family members. That review, of which one of us was an author, had a deliberately narrow focus: trials had to compare family intervention with standard care and report outcomes for both the individual with schizophrenia and a family member. It therefore considered a substantially narrower evidence base than the 90 trials included by Rodolico et al. [1]. Trial numbers alone do not determine the strength of a recommendation, but this difference in scope raises questions about how the broader evidence informed the guideline. The weak recommendation also contrasts with NICE guidance to offer family intervention to families who live with or are in close contact with a person with psychosis or schizophrenia [2]. We are concerned that less directive guidance may reinforce the low priority already given to family intervention.

Roadmap to Implementation

The barriers to implementing family intervention are not new. They remain broadly consistent with those identified by Fadden [16] two decades ago: put simply, mental health services are not organised in ways that facilitate delivery.

People with schizophrenia should be offered family intervention and, if they choose to take it up, have equitable access to a high-quality intervention involving the family members or supporters they identify. Consistent with NICE CG178, services should provide at least ten planned sessions over three to twelve months [2].

Family intervention can be offered while the person with schizophrenia is acutely unwell, whether in hospital or the community, or at a later stage of recovery. Goals should be agreed collaboratively, and the approach should be explicitly non-blaming, recognising the challenges faced by everyone involved [2].

Mental health services need enough trained and supervised clinicians to meet demand for family intervention. Universities and other educational providers can support this by offering accessible training for qualified mental health professionals, including mental health nurses, psychologists and psychiatrists. Training should develop clinical competence through supervised practice, with ongoing supervision available once clinicians begin delivering family intervention [14,16].

Beyond training, mental health services need to protect clinical time, identify a clinical champion and establish a clear pathway for referral and delivery. Routine audits should record whether family intervention was available and offered, whether it was accepted and delivered, and the reasons for non-offer or non-participation. Audits should also monitor sessions completed, intervention fidelity, and the experiences of people using services and their families or supporters [15,16].

Ensuring that family intervention is offered to people with schizophrenia and their families is long overdue. The evidence base is not perfect, but it is good enough to require services to act. Family intervention should be routinely available. Mental health services need to ensure that clinicians have the training, supervision and time to deliver it.

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