# National Clinical Programme for Early Intervention in Psychosis

## Behavioural Family Therapy

## Standard Operating Procedure

**Version 3.0 – May 2019**

National Clinical
& Integrated Care Programmes
*Person-centred, co-ordinated care*

HSE Mental Health Services

**Reader Information:**

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|---|---|
| **Title:** | Behavioural Family Therapy (BFT) Standard Operating Procedure (SOP) |
| **Purpose:** | To provide a robust standard operating procedure for the delivery of BFT as part of the early intervention in psychosis (EIP) clinical programme. |
| **Applicable to:** | Mental Health Services |
| **Document Author:** | Office of National Clinical Advisor and Clinical Programme Group Lead and National Clinical Programme for Early Intervention in Psychosis |
| **Related policy documentation** | A Vision for Change – Report of the Expert Group on Mental Health Policy 2006<br>NICE Guidelines – Psychosis and Schizophrenia in adults 2014<br>NICE Guidelines – Psychosis and Schizophrenia in Children and Young People 2013<br>NICE Quality Standards – Psychosis and Schizophrenia February,2015<br>Nice Guidelines – Implementing the Early Intervention in Psychosis Access and Waiting time standard Guidance April 2016 |
| **First published:** | September 2015 |
| **Revised:** | October 2017 |
| **Revised:** | April 2019 |
| **Review date:** | October 2020. *Unless there are any changes in legislation or in clinical practice* |
| **Implementation** | This SOP will be sent to all Executive Clinical Directors, Mental Health Leads, clinical leads and BFT Leads for dissemination to clinicians and teams. |

## Contents:

## 1. INTRODUCTION

Behavioural Family Therapy (BFT) is an evidence based intervention delivered to families by trained Mental Health Staff. It engages the family from the start and works with the family using the provision of practical help and information (Table 2 page 7). Support is provided to all members of the family including siblings and children using this approach. Research has shown that BFT is effective in reducing stress for service users and their families and that it can significantly reduce relapse rates and hospitalisations, and promotes recovery. Research and guidelines suggest that family work should be offered as soon as possible after the onset of a psychotic episode. Families should be re offered BFT during the three years of the Early Intervention in Psychosis (EIP) Programme.

**The following principles underpin practice – Table 1**

- Families are valued and their role in supporting the service user is acknowledged by teams at the first appointment.
- A collaborative working relationship between families and services
- All families are informed about and offered a BFT intervention as standard in accordance with best practice
- BFT is delivered by qualified/competent staff on CMHTs who attend monthly supervision

### 1.1 Evidence

According to the NICE Guidelines (2009) regarding schizophrenia, family intervention should be offered to all families who live or are in close contact with the service user. This can start at the acute phase or later (including in-patient settings). These interventions should include the service user if practicable, be carried out between 3 months – 1 year, take account of family's preference either for single family intervention or multi-family group intervention, such as McFarlane (2002, 1994), take account of the relationship of main carer and the person with psychosis,

and have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work.

Currently, an evidence based family intervention - Behavioural Family Therapy (BFT) Fadden (2009) approach has been developed and implemented in most mental health services in Ireland for service users with first episode psychosis and their families. Its main focus is on a 'here and now approach' rather than the past; collaborative approach at a pace that suits the family and where decisions are agreed between the family worker(s) and family members; it involves everyone in the family who wants to take part; information sharing to enhance understanding; focuses on early warning signs, relapse prevention and management of situations by the family; helps families to identify effective problem solving strategies; and helps families develop helpful and effective methods of communication. One of the main advantages of this approach apart from its flexibility to adjust it to suit each family is its ability to create joint understandings, developing agreed relapse prevention plans and problem solving which occurs with service users and their families, thereby making it more likely that stress, tension, felt burden reduces and a shared pathway forward is created. In addition, single family meetings also have the flexibility to meet families/significant others quickly.

Relapse rates for single family meetings after 9 months range between 0-8% (control 59-83%), while relapse rates at 2 years are 25-40% (control 59-83%) (Falloon et al 1982; Leff et al 1982; Hogarty et al 1986; Tarrier et al 1988). In a Cochrane review Pharoah, Mari, Rathbone and Wong (2006) reported that individual family approaches gave a reduction in relapse rates, reduction in hospital rates, better adherence with medication, and reduced costs of care.

### 1.2 Scope of SOP

This SOP applies to service users presenting to mental health services with a diagnosis of First Episode of Psychosis and aged between fourteen and sixty four years of age as per the remit of the National Model of Care for Early Intervention in Psychosis in Ireland.

Other family interventions such as psycho educational groups, peer support, systemic family therapy interventions, all of which have been found to be of use are outside the scope of this SOP.

### 1.3 BFT Register

A national register is held of all staff trained and currently delivering BFT and attending supervision. The register is updated every 6 months by the National Programme Manager following updates from local services. At the beginning of 2019 there were 191 clinicians registered. In addition, there are currently 27 BFT trainers/supervisors. 6 clinicians have completed the accreditation process of their work as defined by Meriden NHS England.

## 2. Clinical Implementation Pathway

### 2.1 Introducing BFT intervention to service users:

At the initial EIP assessment and care planning meeting the Consultant Psychiatrist/EIP key worker should discuss BFT with the service user and family as one of the standard interventions offered within the service. A follow up contact should be made by the BFT clinician to introduce BFT to the family and to explain it in more detail within 2 weeks. Written information should also be provided.

### 2.2. Assessment for BFT

The BFT clinician assigned to the family should record the date of referral and make contact with the family to arrange a suitable time for initial engagement within two weeks.

### 2.3 Individual assessment of each family member

Following individual assessment of each family member, the BFT trained clinician should update the CMHT on the agreed plan with the family. Reports should be recorded in the medical file in accordance with local policy.

### 2.4 BFT Sessions

The family should be offered the sessions at home unless there is a strong case for another venue and at a time that is convenient for them. The location of the intervention should be based on clinical needs of service users and their families as discussed with the team.

In general each family will receive 10-15 sessions. Each session lasts for one hour. The number of sessions will vary depending on clinical need. The content of what is offered is based on an assessment of the needs of each individual family, and therefore will vary from family to family. Family intervention should include the person with psychosis if practical.

**Table 2: An outline of the BFT sessions include**

- Meeting with the family to discuss the benefits of the approach
- An agreement with the family that they are willing to try the approach
- Assessment of individual family members
- Assessment of the family's communication and problem solving skills
- Review of the assessment information on the family's resources, problems and goals
- Meeting with the family to discuss/plan how to proceed and the establishment of family meetings
- Information-sharing about the mental health issue and reaching a shared understanding
- Early warning signs and relapse prevention work – development of 'staying well' plans
- Helping the family to develop effective communication skills
- Supporting the development of the family's problem solving skills
- Booster sessions
- Review and on-going support or closure

### 2.5. Documentation:

Each BFT clinician should document a record of their intervention in the service user's clinical file as per local policy and procedures. This can be recorded in the continuous progress notes or within a family intervention section created in the chart.

Individual family member assessments must be stored in a separate section in the service user file with a covering sheet (appendix 1). The BFT clinician should take responsibility to ensure that the CMHT is aware that it contains confidential and sensitive third party information. The purpose of holding this information is to provide optimal support to families and cannot be used for any other purpose. The storage of this information is to ensure compliance with the Data Protection Acts 1998, 2003, and GDPR 2018 and relevant HSE Policy. An information sheet for family members is provided in appendix 2.

### 2.6 Discharge

On completion of BFT a summary report should be included in the chart (sample template in appendix 3). Sometimes follow up sessions may take place if the family require occasional 'booster' sessions.

Services may be able to offer a range of additional supports to families including a carers group and psycho-education groups, these should be discussed at the weekly team meeting and families advised according to their needs.

## 3. Evaluation and Metrics

### 3.1 Clinical Assessments and Outcome Measures:

In order to ensure that BFT is delivered as part of the National Clinical Programme for Early Intervention in Psychosis it is important we measure the impact of the intervention on service user outcomes and experience. It is recommended that each family has the following assessments at baseline and on completion of BFT course.

The following standardised assessment and outcome measure is recommended for use

**SCORE** –is a self-report outcome measure designed to be sensitive to the kinds of changes in family relationships that clinicians see as indications of useful therapeutic change. It is intended to be serviceable in everyday practice; short, acceptable to service users and can be used across the full range of BFT work. It is recommended that it is administered at the individual assessment meeting (before intervention), at the final meeting and 6 months post meetings.

**BFT Questionnaire:** A short questionnaire has been developed which can be used with families' pre and post BFT work to measure satisfaction with the intervention. This measure is not validated or standardised.

**HSE Your Service your Say:** If families wish to make a comment, compliment or complaint they should be encouraged to do so. Further information is available at http://www.hse.ie/eng/services/feedback/

### 3.2 Metrics

Data is an important element in monitoring the implementation of BFT and the benefits to service users and their families. Each EIP Hub Team will be expected to report on a number of quantitative metrics using a standard excel template. This information will be collated by the National Office. This information will inform future planning and training and the identification of key performance indicators.

### Key Performance Indicators

- 100% of families/service users with first episode psychosis are offered BFT
- Each BFT trained clinician to see at least one family at any one time and record the intervention on data sheet to reflect family work
- Each BFT Lead (with protected time) to have a minimum caseload of 2 families at any one time and record the intervention on the data sheet to reflect family work
- 60% attendance at supervision sessions by all BFT clinicians.
- BFT Trainers/supervisors must attend two out of three external supervision sessions delivered by Meriden NHS UK.
- BFT supervisors support each other locally through peer supervision sessions.

### 3.3: Research and Audit

Research and audit proposals will be developed in the context of the Early Intervention in Psychosis national clinical programme.

## 4. GOVERNANCE

The governance of this intervention lies with each CHO Area Management team and CHO. The National Clinical Programme Office maintains oversight of the operational implementation in clinical practice.

**Office National Clinical Advisor and Clinical Programme Group Lead – EIP Programme Clinical Lead**

- Support the implementation of BFT as one of the named intervention in EIP National Clinical Programme.
- Identify competencies for selection of staff.
- Develop a training and supervision plan for BFT.
- Maintain a national data base of clinicians trained in BFT and publish annually
- Manage, review and report on BFT activity data nationally

**CHO Mental Health Area Management Team**

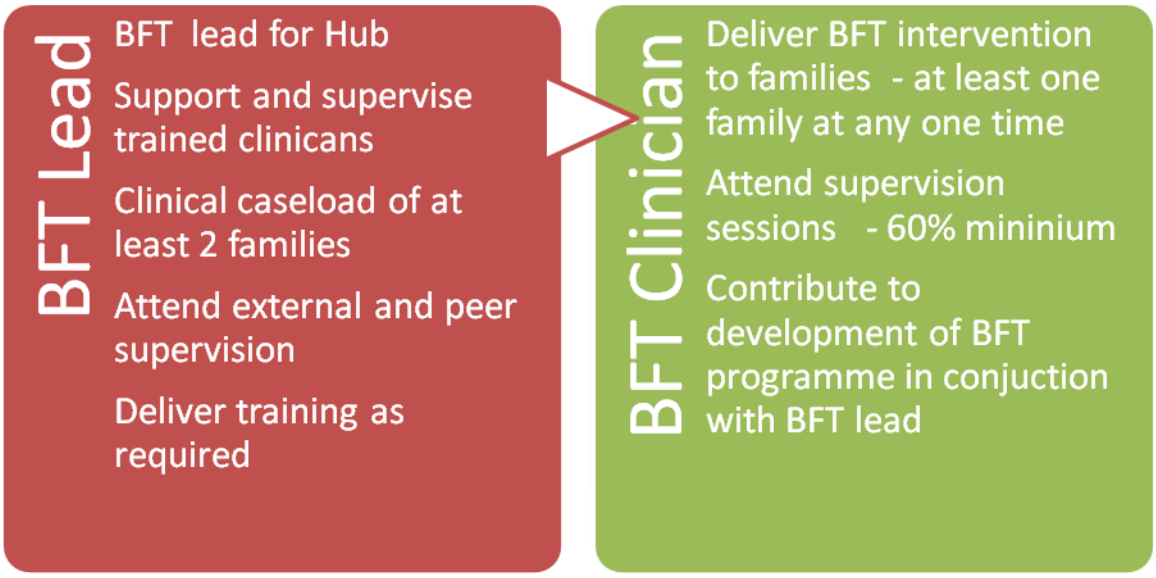
- Ensure all line managers are aware of the requirements of BFT as one of the named interventions in EIP National Clinical Programme.
- Support trained clinicians to deliver the intervention in a timely manner
- Identify future demands for training in this intervention and report to the National Office
- Facilitate clinicians in the area to deliver supervision and training as required.
- Provide the resources to cover local supervision and training sessions including venue catering and administrative support
- Monitor data on the provision of BFT and report nationally as required.
- Report to the National Clinical Programmes Office on any particular obstacles or difficulties in implementing the SOP for BFT.

**Early Intervention in Psychosis Hub Team (EIP Hub Team)**

- Provide Clinical Leadership and Governance for the EIP clinical programme and BFT.
- Provide the leadership and expertise for BFT delivery
- Collate data on BFT data.
- Report to CHO Mental Health Area Management Team on BFT

### 4.1. Roles and Responsibilities

To ensure the effective implementation of interventions for psychosis in each adult CMHT and CAMHS, roles and responsibilities have been assigned and are listed below. An estimated time for each clinical component is included where appropriate. This is a guide and may vary locally.




**BFT Lead**

- Attend EIP Hub meetings.
- Ensure issues of clinical governance are brought to the Clinical Lead and Hub Team.
- Maintain register/database of clinicians trained in BFT in the area.
- Monitor access to and engagement with interventions for psychosis across all teams.
- Monitor data and report to Clinical Lead as per Hub policy

- Support BFT clinicians locally and provide local training with other BFT trainers/supervisors.
- Maintain own EIP clinical BFT caseload (minimum 2 families) at a given time
- Provide clinical input for complex EIP presentations to meet the needs of the hub/mental health area
- Attend external supervision and peer supervision sessions with regard to BFT case work and the process of supervising other clinicians.
- Document intervention in the chart as per local policies and procedures
- Collect monthly data and complete data sheets
- Provide BFT supervision to clinicians, trainers and supervisors within the Hub

**Lead Role:** 0.5 WTE

**CMHT Level: BFT Clinician (2 Clinicians per 50,000 CMHT/One per CAMHS Team)**

- Develop a culture of family involvement in care in the team to ensure that each family is offered a BFT intervention as standard.
- Recognise the central role that families play in improving outcomes in psychosis
- Caseload of at least one family at any one time
- Document intervention in the chart as per local policies and procedures
- Collect monthly data and complete data sheets
- Attend supervision monthly in local area
- **Estimated time: 2 days per month pro rata and depending on case load**

## 5. Supervision and Training

NICE Guidelines recommend that health care professionals providing psychological interventions should have an appropriate level of competence in delivering the intervention and be regularly supervised by a competent clinician and supervisor.

**BFT Clinician**

- Each BFT trained clinician must attend supervision to maintain their skills and competence.

- Supervision will be provided locally each month and facilitated by local BFT trainers/supervisors.
- Each BFT clinician must attend a minimum of 60% attendance of sessions offered per year to be registered.
- Clinicians should attend ongoing training days as appropriate to ensure their skills are updated.

**BFT Trainer/Supervisors including Leads**

- External supervision will be organised by the National Office.
- Each BFT trainer/supervisor must attend a minimum of 2 out of 3 external supervision sessions annually to be registered.
- Peer supervision will be organised within CHO regions which will be led out by BFT leads.

**5.1 Training:**

Training will be provided by local trainers/supervisors to meet the needs of local CMHT's.

- BFT training is for 5 days and is open to all mental health professionals working on CMHTs.
- Training can be organised over 2 weeks to reduce impact on service delivery.
- Staff selected to attend must meet the agreed national criteria.
- Training ratios are set as 2 trainers to 10 trainees.
- Each CMHT (50,000 pop) should have 2 BFT trained clinicians with one BFT trained clinician on each CAMHS team (100,000). Training places must be offered to teams in order to meet this standard.
- Where geography permits, 2 EIP Hubs can join together to train a larger number and share wider experiences.
- Local services must fund the venue, catering and mileage costs of staff to attend.
- Data on numbers trained in each CMHT must be submitted to the National Office.

- All DVDs, manuals and handouts for training will be supplied by the National Office for first training course only.

## *5.2 BFT National Lead Group*

The BFT lead group will hold 3 business meetings annually. Each Mental Health Service will select one BFT trainer/supervisor to represent them at the meeting. Minutes and actions agreed will be circulated to all in a timely manner. The format and agenda will be agreed in advance in accordance with agreed Terms of Reference.

## *APPENDICES*

### Appendix 1: Confidential Information sheet for files

Behavioural Family Therapy (BFT) Notes
Early Intervention in Psychosis National Clinical Programme

**CONFIDENTIAL RESTRICTED INFORMATION**

Access to this information **shall be** restricted to authorised medical, nursing and healthcare professionals who are responsible for providing or supervising BFT practice. The information shall be maintained in line with the Data Protection Acts 1988, 2003 and EU General Data Protection Regulation (GDPR 2018).

The information in this restricted section of the chart contains personal sensitive third party information about this service user's family.

General progress notes in relation to BFT are documented in the clinical case notes section of the chart along with other clinical interventions.

Thank You

**Appendix 2: Behavioural Family Therapy (BFT) Family Assessments - Information for family members**

## 1. What happens to your assessment information?

We hold your assessment information on paper/computer in a restricted secure section of the file in accordance with the Data Protection Acts 1998, 2003 and GDPR 2018. We keep your information to:

- Guide BFT sessions and record your needs and goals;
- Keep our administrative records up to date.
- Assist with education and research (any personal details are anonymised or clear and unambiguous advance consent has been received).

We will only keep data for as long as needed to fulfill the purpose for which it was collected and in line with HSE records policy.

## 2. Who sees your information?

The relevant community mental health team, CMHT, comprising medical, nursing and healthcare professionals who are responsible for providing or supervising BFT care can see your information. You may request right of access to records by way of a written request under the Freedom of Information Act 2014 and the Data Protection Acts 1988,2003 and GDPR 2018. A summary letter will be sent by the CMHT if your family member/friend moves to another service this will include information on BFT sessions.

## 3. Sharing information with other parties

We will get your written permission before releasing any information about you to others. However, we may not do this:

- When a court or tribunal orders us to disclose your family members medical information;
- When a request is received from the Gardaí for the purposes of investigating a crime.
- *For the purpose of preventing, detecting or investigating offences* against children.
- Where there is a substantial and immediate risk to a person's welfare.

- *If required by or under any enactment or by a rule of law or order of a court.*

***I agree and consent that***

☐ I have read the information sheet and have received a copy to keep. I have had a chance to ask questions about the information that is kept about me and understand why it is kept and how it is used or disclosed in accordance with the Data Protection Acts.

☐ I have received a copy of HSE leaflet on GDPR.

☐ I am consenting that any anonymised data can be used for the purpose of audit and research

You can withdraw or change your consent at any time by contacting your BFT clinician.

**Name:** _____**Signature:** _____

**Date:** _____

**Appendix 3: Sample BFT discharge Summary Report**

## BEHAVIOURAL FAMILY THERAPY [BFT] DISCHARGE SUMMARY

Consultant's name
Clinic Address Date:

**RE: Patient name DOB address.**

Dear Dr. _____,

I/We would like to inform you about [patents name] engagement in BFT. The ___ family was referred by ____ on _____.: The _____ family was referred for BFT to address _____[describe here the context of the referral. IE: refer to what the referral agent requested of you]

The _____ family underwent _____ BFT sessions commencing on _____ and ending on _____. Individual assessments were carried out with family members and which identified the family stressors, and individual Goals of each participant. The therapist engaged with the family member around the following aspects of the BFT programme:

- Information sharing
- Early warning signs
- Relapse signature
- Communication skills
- Problem Solving

The _____ family engaged very well with the programme and in their evaluation they reported significant reduction in family stress levels and increased family coping skills. It was also clearly evident that communication skill were more effective.
The _____ family were offered booster BFT sessions should they be required in the future.

If you would like to discuss any of the above with me, please contact me at the above number.

Yours sincerely

_____
Therapist name & Discipline

## Appendix 4: BFT Trainers/Supervisors by CHO – May 2019

| HSE CHO Area | EIP Hub Area | BFT trainers/supervisors |
|---|---|---|
| **1** | Donegal | 1 |
| | Sligo/Leitrim | 1 |
| | Cavan/Monaghan | 0 |
| **2** | Mayo | 2 |
| | Galway/Roscommon | 2 |
| **3** | Limerick/Clare/North Tipperary | 2 |
| **4** | Cork | 3 |
| | Kerry | 0 |
| **5** | Waterford/Wexford | 2 |
| | South Tipp/Kilkenny/Carlow | 1 |
| **6** | Dublin South East/Wicklow | 1 |
| **7** | Dublin South City/South East | 1 |
| | Kildare/West Wicklow | 2 |
| **8** | Laois/Offaly | 1 |
| | Longford/Westmeath | 1 |
| | Louth/Meath | 2 |
| **9** | Dublin North City | 2 |
| | North Dublin | 1 |
| **Homeless Team Dublin** | | 1 |