



National Clinical Programme for Early Intervention in Psychosis

Behavioural Family Therapy

Best Practice Guidance Document

Version 5 - June 2024



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



HSE Mental Health Services

BFT Guidance Document, June 2024

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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 9](#)). 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 if required.

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

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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; a 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

This best practice guidance applies to all clinicians trained and practicing BFT family work and on the national data base. BFT can be delivered to a wide range of service users and families, not just first episode psychosis (FEP) presentations.

The National Clinical Programme for Early Intervention in Psychosis is focussed on service users presenting with a first episode of psychosis and aged between fourteen and sixty four years of age. The NCP recommends that BFT is offered to all service users with FEP and their families.

Other family interventions such as psycho educational groups, peer support, family peer support, systemic family therapy interventions, all of which have been found to have an evidence base and value to families, are outside the scope of this best practice guidance document..

1.3 BFT Database

A national database is held of all clinicians trained and currently, actively practicing BFT and attending supervision. It is updated annually by the National Programme Manager following updates from local trainers/supervisors/leads. This is in keeping with the NICE Guidelines recommendation that health care professionals, providing psychological interventions, have an appropriate level of competence in delivering the intervention and are regularly supervised by a competent clinician and supervisor (Section 5).

In order to ensure a robust and accurate data base, new entrants will be added to the data base annually following (i) completion of BFT training,(ii) evidence of attendance at supervision (section 5) and (iii) evidence of delivery of BFT to families (section 4.1). The local trainer/supervisor will confirm that all stages have been completed. BFT workers, who are no longer practicing, will be removed from the data base.

Those returning to practice following period of absence must follow the procedure in appendix 5 to enter the data base.

2. Clinical Implementation Pathway

2.1 Introducing BFT intervention to service users

At the initial assessment and care planning meeting, assessing clinicians should discuss BFT with the service user and family as one of the standard interventions offered within EIP services and strongly evidenced in psychosis. 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 (where possible) or online using an approved HSE platform 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 BFT Guidance Document, June 2024

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.

The following standardised assessments and outcome measure is recommended for use.

SCORE 15 –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 Data

Data is an important element in monitoring the uptake of BFT by families and the benefits to service users and their families. All BFT Leads will report on a number of quantitative metrics using a standard excel template. This information will be collated by the National Clinical Programme. This information will inform future planning and training/educational needs and the identification of key performance indicators. Non EIP teams, delivering BFT will record and collate data for use locally and nationally.

Key Performance Indicators

- 100% of families/service users with first episode psychosis are offered BFT
- BFT clinicians are offered supervision and attend on a regular basis; at least six sessions annually.
- BFT leads and Trainer /supervisors are offered three external supervision sessions delivered by Meriden NHS UK. It is recommended that they attend at least two sessions annually.
- BFT trainers/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 (or equivalent), Mental Health service managers. The National Clinical Programme maintains oversight of the operational implementation in clinical practice via the Implementation Advisory Group (IAG).

National Clinical Programme EIP

- Support the implementation of BFT as one of the named interventions in EIP National Clinical Programme.
- Invite a BFT lead to be a member of National Implementation Advisory Group
- Maintain a record of clinicians trained in BFT and update as required.
-
- Manage, review and report on BFT activity nationally.
- Agree and fund a training and supervision plan for BFT at national level to support local plans, to include clinicians and trainer/supervisors.
- Identify competencies for selection of staff to complete BFT training in partnership with BFT trainers group.

BFT leads, Trainer/supervisors and Family Intervention leads in EIP sites

- Advocate on the importance of family work in recovery of service users and their families.
- Provide leadership and expertise on implementation and evaluation of BFT in practice at local level.
- Leads will nominate a person to represent the group on National EIP IAG.

Mental Health Service Managers and EIP Hub Team

- Understand and support the importance of family work and BFT as part of a range of evidence based interventions offered to families and service users.
- Support trained clinicians to deliver BFT, as part of their clinical work, in a timely manner, with agreement for protected time for Clinicians to deliver BFT
- Identify and support demands for training in this intervention.
- Facilitate clinicians in the area to deliver supervision and training as required and to work in accordance with best practice.
- Provide the resources to cover local supervision and training sessions including IT equipment and HSE approved online platforms, venue, catering and administrative support
- Review the uptake of BFT by families within their area with local BFT lead, trainer/supervisor.
- Monitor data on the provision of BFT.
- Report to the National Clinical Programmes Office on any particular obstacles or difficulties in implementing best practice guidance for BFT.

EIP Hub Team (Hub and Spoke model) / Multi-Disciplinary Team (stand-alone model)

- Provide Clinical Leadership and Governance for the EIP clinical programme and BFT.
- Provide leadership and expertise on implementation and evaluation of BFT in practice.
- Collate data on BFT and collate in line with EIP site requirements.

4.1. Roles and Responsibilities

To ensure the effective implementation of interventions for psychosis in each adult CMHT and CAMHS, roles and responsibilities in respect to BFT, 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 (full time) EIP site areas

- *Support and supervise trained clinicians.
- *Support BFT clinicians locally and provide training with other trainers/supervisors.
- *Clinical caseload, minimum of 6 families.
- *Attend external and peer supervision.
- *Delivering BFT training as required.
- *Provide clinical input for complex EIP presentations to meet the needs of the EIP site catchment area.
- * Ensure adherence to clinical governance
- *Maintain data base of trained and practicing Practitioners
- *Monitor for timely access and engagement with BFT across teams
- *Document intervention in service user chart as per local policies and procedures and recommended practice.
- *Collect data and submit nationally.
- *Attend EIP hub/Multi-disciplinary team and advisory team meetings to represent BFT service, as core EIP family intervention, National Clinical Programme.
- *Identify additional unmet family support and intervention needs within EIP catchment.

BFT Lead Non – EIP site areas

- *Support and supervise trained clinicians
- *Support BFT clinicians locally and provide training with other trainers/supervisors
- *Clinical caseload of at least 2 families.
- *Attend external and peer supervision
- **Delivering training as required.
- Provide clinical input for complex EIP presentations.
- Ensure adherence to clinical governance
- *Maintain data base of trained and practicing Practitioners.
- *Monitor for timely access and engagement with BFT across teams.
- *Document intervention in service user chart as per local policies and procedures and recommended practice.
- *Collect data and submit nationally.

BFT Clinician (two trained clinicians per 50,000 CMHT / 1 per CAMHS Team)

- *Develop a culture of family involvement in CMHT to ensure each family is offered BFT as standard. (Evidence base for FEP + enduring psychotic illness, depression bi-polar)
- *Agree protected time with line manager to reflect BFT commitment.
(Estimated time: 2 days per month pro rata and depending on case load).
- *Recognise the central role families play in improving outcomes in psychosis
- *Deliver BFT intervention to families – at least one family at any one time.
- *Document interventions in service users chart as per local policies and procedures.
- *Collect monthly data and complete data sheets.
- *Attend supervision monthly (minimum 6 sessions annually) in local area and national CPD events.
- *Follow the procedure in appendix 5 when returning to practice following a period of absence.

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 - Supervision

- 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 six sessions per year to be registered.
- Clinicians should attend ongoing training days as appropriate to ensure their skills are updated.

BFT Trainer/Supervisors including Leads - Supervision

- External supervision will be commissioned by the National Clinical Programme.
- Each BFT trainer/supervisor must attend a minimum of 2 out of 3 external supervision sessions annually to be registered as trainers/supervisors and to maintain their skills and competence.
- Peer supervision can be organised within Regional Health Areas which will be led out by BFT leads.

5.1 Training:

BFT Clinician - 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.

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- 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 or deliver the training online using agreed HSE platform.
- After training clinicians will be added to the register annually following completion of BFT training, attendance at supervision (section 5) and delivery of BFT to families (section 4.1).
- Data on numbers trained in each CMHT must be submitted to the National Clinical Programme.
- Training Certificates will be issued by the local BFT trainer.

Trainer/ Supervisor Training

Trainer/ supervisor training will be accessed via the Meriden Programme to meet programme recommendation of minimum, two trainer /supervisors per mental health service area.

5.2 BFT National Group

The BFT group will hold 3 business meetings annually. Each Mental Health Service will select at least one BFT lead or trainer/supervisor to represent them at the meeting. Meeting can take place online using an agreed HSE platform or face to face if required. 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 fulfil 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/link to HSE leaflet on GDPR.
<https://www.hse.ie/eng/gdpr/hse-data-protection-policy/>

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 [patients 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: Trainers/Supervisors by CHO – June 2024

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

Appendix 5: Procedure for returning to BFT practice after a period of absence (not including maternity or sick leave) June 2024

1. BFT practitioner to contact his/her line manager to reach agreement with them to deliver BFT in line with NCP EIP BFT Best Practice Guidance Document.
2. The line manager must satisfy themselves that the staff member can meet the requirements of delivering BFT and be registered to practice e.g. actively working with one family, returning monthly statistics, attending monthly group supervision (minimum 6 sessions per year), to ascertain if they can provide time commitment to same. Once agreed the line manager should email the BFT lead /supervisor confirming the above.
3. BFT practitioner to discuss learning and training needs with local BFT lead/Trainer/supervisor and an agreed written plan put in place. Refresher training may include updated reading material, videos, shadowing and role plays.
4. BFT practitioner to discuss referrals for family work at the Community Mental Health_team meeting and advise that they will be available to take referrals from an agreed date.
5. The NCP EIP is notified of the name of the practitioner and his/her name is included in the BFT data base and mailing list. A confirmation email and copy of the Best Practice Guidance Document, highlighting the requirements to maintain competence in the delivery of BFT are sent to the practitioner.