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Family interventions in psychosis

Guidelines for
psychologists
and practitioners
supporting families
and social networks

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Division of
Clinical Psychology

AUTHOR

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CONTENTS

Foreword	4
Contributors	5
Executive summary	6
Note on terminology	7
1. Introduction	9
A family member's view	10
2. Evidence base	12
3. Different ways to work and collaborate with families and social networks	16
The core – Family-friendly/sensitive and inclusive practice	17
Different forms of family-friendly/sensitive and inclusive practice	20
Support and information for significant others	20
Family/carer peer support	23
Structured family interventions and integrated approaches	25
Systemic approaches: Systemic practice & family and systemic psychotherapy	30
4. Common processes in family interventions	34
The therapeutic relationship and engaging all the family	34
Assessment and the initial consultation	35
Subsequent sessions	37
Co-therapy and therapy teams	38
5. Working with diversity	39
Attending to diversity in family interventions	40
Working with Race	41
Working with religion and spirituality	42
Neurodevelopmental conditions and learning disabilities	43
Working with outside agencies and interpreters	43
Tools for working with diversity	44
The role of the psychologist	45
6. Journey through the system: Family work in different services	47
Early intervention services	48
Crisis and acute services	48
Secondary care community services	49
Dual diagnosis services	50
Forensic services	51
7. Adaptations for different family groups	54
Managing risk	61
8. Training and supervision	67
9. Implementation	74
10. Measuring outcomes for families	79
11. Conclusions and aspirations	84
References	86
Appendix A: Training & Supervision in Family Work	96
Appendix B: Approach Method Technique Framework	100

FOREWORD

These guidelines provide an overview of the current state of practice and knowledge regarding family interventions in psychosis and provide a guide for psychologists and other family work practitioners, regarding how to support and deliver these family interventions in services. Providing family interventions and support for families is essential for good practice and good outcomes for service users and their families. The importance of family support for people with psychosis and other mental health challenges has been further highlighted by the Covid-19 pandemic. In many areas, remotely delivered family interventions have enabled families to continue to provide support whilst their loved one has been less able to access their usual mental health services.

Many of the recommendations made in this document could apply equally to other difficulties alongside psychosis, for instance bipolar disorder is often considered within the same recommendations and training programmes. Of particular note is that dual diagnosis and a diagnosis of 'personality disorder' should not be considered exclusion criteria for family interventions. We have focused on family interventions for psychosis as this is where the evidence and experience is within services. We also hope that this document will be of help to service users, carers and family members in knowing what they should expect from services and what constitutes good practice whatever mental health problems their family member faces.

Families have long requested more support and thinking regarding their position in services. We know they provide such vital support for their loved ones and are deeply affected by the development of distress in their family member. Services have struggled however to move from an individualised view of mental distress and have often tried to work solely with the individual rather than the family as a whole. More and more the evidence confirms when the whole family is involved and supported, better outcomes ensue. This is now backed by policy; however, implementation continues to fall behind these recommendations. It is hoped this report will provide additional understanding of how to support family work, what family support works and overcome some of the barriers to implementation.

CONTRIBUTORS

These guidelines were written by a working party comprised of mainly clinical psychologists drawn from the NHS and universities, along with other mental health professionals including family and systemic psychotherapists, nurse practitioners and experts by experience, who all have expertise in working with families affected by psychosis. They were brought together by the professional body, the British Psychological Society Division of Clinical Psychology and the Faculty of Complex Mental Health and Psychosis. At the end of the report is a list of resources and papers which the report draws on.

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Executive summary

- Involving the family and significant others in working with people with psychosis should be an essential part of the standard service provision.
- Families should be seen as a resource and their knowledge valued.
- Families need to be supported with their mental health to improve outcomes for all.
- Family interventions should be seen as standard practice and offered to all families at every stage of a family's journey in services.
- A wide view of who is in someone's 'family' is important, including children, siblings, and people who are not biological relatives, such as friends and other members of the community.
- Psychologists and family practitioners have a role to advocate for, support and deliver family inclusive practice training for all staff working with people with psychosis, whether they work in a clinical or non-clinical role. It is everyone's role to be involved in providing support for families.
- Services should aim to train staff to provide a range of approaches to working with families and have access to qualified family and systemic psychotherapists to provide supervision and training.
- Anyone delivering family interventions (as described in document) needs substantial training and support and should work in accordance with the training required for each approach (see training section).
- Live supervision and co-working are essential for inexperienced therapists when delivering family interventions.
- Everyone delivering family interventions needs access to supervision on a regular basis by an experienced and qualified clinician with the relevant training.
- All staff should approach their work with a sensitivity to differences and inequalities. Training, community engagement and self-reflexivity are vital for attending to needs of a diverse population.
- Each family member may have their own individual needs which require support.
- Families should be encouraged to share their expertise through peer programmes and services should employ paid carer advisors to support practice.
- Services need to provide a range of different family interventions and acknowledge that families may need different kinds of input at different points in time.
- Services should appoint family intervention leads to develop an implementation strategy, support the development of practice and measure outcomes.
- Psychologists should work alongside other health care professionals in the delivery and implementation of family inclusive practice and family interventions at strategic and clinical levels, and need training and support to do so.
- Doctorate training for psychologists needs to include teaching and experience in family interventions/therapy with families as an essential competency.
- Secure video-conferencing platforms or mobile phones should be used when in-person family intervention sessions are not possible (e.g. during the Covid-19 pandemic) and to connect geographically-distant family or network members to sessions.

Note on terminology

We have attempted to use terms which keep the person central to our thinking and which do not imply that there is only one or a correct framework of understanding.

'Family interventions' is used as an umbrella term to include the whole range of different approaches to working with families. We recognise that the word 'interventions' may have negative connotations, as it could imply that families need an 'intervention' by professionals. Alternatively, 'interventions' could wrongly be seen as not requiring substantial training or therapeutic skills. The phrase 'working with families' may be preferred. Nonetheless, 'family interventions' is commonly used in many other documents, including the NICE Guidelines, and in the interests of consistency we therefore use it here. It is intended as an inclusive term covering the whole range of approaches, and each of the main approaches and the differences between them are explored in the document.

'Family' is used in its broadest and most inclusive sense. This is used as a shorthand for family, carer and social network, and could include anyone who is important to the service user, who may or may not be a biological relation. We acknowledge that the word 'family' might define our thinking about who to include in interventions. Therefore, we suggest practitioners ask service users about significant others from extended family, social and care networks who they wish to invite to appointments. This is preferable to imposing definitions which run the risk of reinforcing dominant, oppressive and exclusionary assumptions of Eurocentricity (Singh, 2009) and heteronormativity (Hudak & Giammattei, 2010).

'Carer' is often used to describe a family member or other close individual who provides a caring and supportive role with a substantial time commitment. Family members may not always feel comfortable with the term **'carer'**, which can imply a formal, paid or imbalanced relationship, and when used in this document should be taken to refer to anyone involved in supporting the client.

The terms **'client'** and **'service user'** are used to describe the identified person with the diagnosis or experiencing distress who is receiving help from services. Both are subject to debate; however, they are used here as they are the terms most commonly in use by psychologists. The term, 'person at the centre of concern' may be preferable to some. These are used interchangeably throughout this document depending on the context.

Throughout this report we have referred to experiences, behaviours and difficulties rather than 'symptoms' of 'illness', so that we are not implying any particular theoretical framework, for example, a medical understanding.

We use the term **'psychosis'**, as this term is often used within the UK to configure services and research. We recognise this is a problematic concept and it may be preferable to use other terms in clinical practice (DCP, 2013, 2015; Johnstone & Boyle, 2018). Again, we do not intend to imply an acceptance of any particular framework of understanding, and we have avoided where possible the use of the controversial diagnostic term 'schizophrenia', which is questioned by many psychologists, psychiatrists and other professionals (Boyle, 2002; Read and Dillon, 2013; Johnstone, 2014).

We use the term **'ethnic minority'** to refer to all groups except the White British group. We use this in preference to the acronym BAME, which stands for Black, Asian and Minority Ethnic. In this, we are following the style guide of the UK Government's Race Disparity Unit (see <https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity>), and the recommendations of the report of the Commission on Race and Ethnic Disparities (Sewell et

al., 2021). It is acknowledged however that the term ‘ethnic minority’ can also be seen as problematic or unhelpful. Conflating all ethnic minority identities into a single category may falsely imply that diverse people, and the challenges they face, are all the same. The term may sometimes even serve to hide or minimise issues, and not everyone who may be identified by others as belonging to an ‘ethnic minority’ necessarily accepts this label or finds it helpful. Nonetheless, the term is commonly used and readily understandable to most readers, and hence it is used in this document – while acknowledging its limitations. Any discussion of psychosis would be incomplete without acknowledging the mental health impact of long-term systemic disadvantage and inequality of access to services, and this issue was considered to warrant a specific chapter. It is recognised that the approach of devoting a chapter to issues of diversity may run the risk of side-lining the issue, and we have attempted to overcome this by attending to issues of diversity throughout, while also devoting a chapter specifically to the topic.

We have included descriptions of family interventions from people who are experts through experience. Some have chosen to use their own name, some have chosen a pseudonym and some prefer to remain anonymous.

It is important to differentiate between the different professions involved in family work. Family and systemic psychotherapists is a protected title accredited by Association of Family Therapists (AFT). They are fully qualified family therapist who have trained for at least four years and are registered as psychotherapists with UKCP. Family intervention and systemic practitioners may be trained in some systemic or specific family intervention competencies after completing a diploma or shorter course. They are not however registered as psychotherapists.

Therapy/intervention: Throughout this document the term ‘therapy’ is used to describe some family interventions. In order to be described as therapy, this work should be done by a qualified psychotherapist or qualified clinical psychologist. They have the skills to integrate specific interventions within a therapeutic relationship tailoring the interventions for each family’s needs. Other professionals can deliver short interventions under the supervision of a qualified therapist or co-working with a therapist.

1. Introduction

Steven Livingstone and Jo Allen

When someone is affected by psychosis, they will often turn to those closest to them. Families typically provide the bulk of support for people suffering with mental health problems, but require assistance to provide this support. Seeing a loved one in distress affects the whole family and therefore the whole family require support for their distress. It seems obvious that support from services should be provided for the whole family, and the whole family can be part of the solution; historically this has not been the case. Currently family interventions in psychosis are supported and recommended by a range of national and local policies and guidelines (NICE, 2002, 2014) – yet service provision often falls short of what is recommended. There is a significant discrepancy between the recommendations in the NICE Guidelines and routine practice in most services. NICE Guidelines state that family intervention should be offered to everyone who experiences psychosis, or are at risk of developing a first episode of psychosis, who are in contact with their family (NICE, 2014). With the increased funding and support in Early Intervention in Psychosis (EIP), figures have increased from 1–3 per cent to up to 25 per cent of service users. However outside of EIP levels continue to be relatively low at around 1 per cent of service users (RCP, 2020; Haddock et al., 2014).

There are multiple reasons for the lack of family interventions in services, including inadequate planning in services to support supervision and implementation (Eassom et al., 2014). The significant investment in family intervention for psychosis as part of the NHS England community transformation will hopefully lead to change. We are yet however to see the impact of this change and services continue to report lack of prioritisation of family interventions. For many years there was a commonly held misperception that family therapy blamed families for their relative's difficulties. This legacy may mean that professionals are reluctant to open up conversations with families as they are fearful of seeming to apportion blame – thus missing an opportunity for understanding and providing support which could reduce the difficulties the family faces.

Another reason for poor provision is a lack of clarity around what family interventions should look like and who should be providing what intervention. Currently there are a range of family interventions available, with different routes into training, and different models of service delivery. This can make it difficult for those who manage and commission services to know what to provide. It can also be difficult for psychologists to understand their role in offering interventions, as well as for family members, carers and service users to know what they could or should expect.

This document seeks to clarify these issues, by presenting each of the main models used when working with people with psychosis, summarising the differences and also the commonalities between them. We have taken a broad approach, including both family inclusive practice and all different forms of family intervention. This document is not intended primarily as a review of the evidence. We have attempted to make it clear where a particular position is evidence-based, but the document aims to go beyond the existing literature reviews, and provide practical recommendations that will support the real-life application of family intervention in an NHS setting.

We have chosen to include both methods that are supported through research and those approaches and techniques which are valued in practice-based evidence (in as far as they are in

keeping with the general principles of the evidence). This is because we acknowledge that in order to reach all practitioners and all families we need to be flexible in our approach and technique.

It is recognised there is no one 'best' way of working with families, and the document seeks to offer guidance while remaining inclusive and avoiding becoming too prescriptive.

The issue of the appropriate training required to work with families is complex and varies between different ways of working. We have attempted to strike a balance between recognising that some practitioners may be very experienced and competent without the need for additional training, while also describing the specific training and supervision that may be required to support good practice within a particular approach.

A FAMILY MEMBER'S VIEW

As a carer who has benefitted from family interventions, I am very pleased to support these family intervention guidelines. They are a very welcome approach and from a carer's perspective, a significant offer of support to families. The adoption of this document represents for me, increased confidence that families will be able to get information about services, 'be heard' and be able to take part in developing 'solutions' for themselves and their families.

My family accessed family interventions for psychosis, three and a half years after my son's illness began. Initially, we found ourselves distressed and unable to access support through our GP for what we could see was a developing crisis. We were completely unprepared for the situation and the crisis became so serious that we had to call the police – it was the only option open to us according to the GP. This was the first of four events during which he was detained under Section 2 and then 3 of the Mental Health Act. Each of these events has been traumatic and their cumulative effect left us as a family in need of psychological support.

The impact of this has been significant on the family, it is probably worth saying that the issues we experienced have changed over time and continue to do so. At first we felt that this was a problem that could be remedied with the right treatment and counselling for my son, but we soon realised that what we were facing was much more complex.

As a family accessing services, we initially wanted practical support and felt we had to navigate our way through 'the system'. At no stage had anyone sat us down to explain what the diagnosis meant – bipolar/schizoaffective disorder, or 'who was who' in services. The provision felt confusing and fragmented. In addition to this we began to see the lack of consistency in support (we have had six care coordinators during the time we have been using services) – to us, there was no consistent approach to managing my son's condition.

This was further complicated because we had to insist that we were involved in decision making. Services deemed my son an adult and therefore communicated only with him, leading to missed appointments, no understanding of what was happening to him or how best to support him. We had to fight for recognition as valid 'carers' and to learn to navigate the system of various clinicians involved.

Two and a half years after my son's first episode, we were approached by the psychologists in the Early Intervention for Psychosis (EIP) service, offering to support us as a family. To be honest at the time we still felt that if my family member could 'just' get better everything would be all right and that the focus should be on helping him. A further hospitalisation for him led to other members of the family becoming unwell with depression and stress related conditions linked to feelings of helplessness, guilt, and so on. It was at this point that I sought help for myself and was

offered a 30 minute structured intervention which required homework tasks in a separate service. I declined this offer as I did not feel this was the correct service for me. I felt, without knowing of its actual existence that a more systemic approach would be what we needed.

We were offered two initial family sessions with the psychologist at the EIP team but my son's participation was something we felt was really important, and he did not want it. We left matters until summer 2017, when we were again approached by a member of the family intervention service who had previously worked with us at the EIP service, she reiterated the offer of support and said it could be any of us that attended. The service we received was a breath of fresh air!

The approach used was a perfect example of the contents of these guidelines: we received support that felt personalised to our situation. The team acknowledged that we had a hierarchy of needs and that the most practical ones needed to be addressed first. For the first time, the team organised a network meeting with all professionals involved in my son's care, this meant we could discuss his moving into supported housing and other important issues. For the first time there was a consistent, 'co-produced' approach to my son's care.

Alongside the network meeting, we were offered individual and family sessions of psychological support, which helped us to work through difficulties. The sessions were non-judgmental and we felt safe in being able to express our feelings and to work towards resolving them. These sessions were rewarding to the extent that a year on, we feel that we have been enabled to develop coping strategies, and we have been able to use the 'way of being' and methods we observed in the meetings to work through challenging situations. We have continued to rebuild and accept a 'new reality' for ourselves as a family.

The most significant outcome is that my son has not gone back into hospital. In this past year, we had a situation that could have developed into a crisis but the family intervention team, psychiatrist, care coordinator and key worker from the supported accommodation came together with us as a family to offer support and a plan, leading successfully to avoidance of a rehospitalisation. The pattern of an annual hospitalisation, I am relieved to say, has been averted.

I am hopeful that with this approach, the increased cooperation of my son (who now feels his views are valued and taken into consideration) and the various supporting professionals working together, alongside us as a family, my son will continue to improve his prospects for the future, and we as a family will continue to move forward.

My hope is that every family can be supported to access provision like this. It is empowering and has given each member of my family tools to go forward, and we feel that we can support each other better. I realise that resources are limited but I am sure that the longer-term benefits in cost reduction, brought about through developing families' resilience and coping strategies, alongside co-production of care planning, is the only way to develop a meaningful approach to mental health support.

2. Evidence base

Jo Allen and Steven Livingstone

'It helped me understand more about myself and it helped me to communicate with my parents, so it was useful.' (SU)

KEY POINTS

- Family interventions reduce relapse and re-hospitalisation.
- Family interventions improve carer wellbeing.
- Evidence is based on different approaches and therefore guidelines have not specifically recommended any specific approach.
- Further research is needed to understand what is helpful in family interventions and explore outcomes beyond reduction in relapse and re-hospitalisation.
- Practice-based evidence needs to be considered when understanding what works in family intervention.
- Practice-based evidence indicates that, with minor adaptations, family interventions can be delivered effectively via videoconferencing platforms – but further research in this area is required.

The research supporting family interventions for psychosis is extensive and has consistently found family interventions for psychosis to have a positive impact on relapse and re-hospitalisation rates in the UK (Claxton et al., 2017; Bird et al., 2010; Pharoah et al., 2010). One of the main studies used in the NICE (2014) guidelines is the Pitschel-Walz, Leucht, Bauml et al. (2001) meta-analysis of 25 original studies, which evidenced the impact of meeting with families and supporting their understanding of the condition. This meta-analysis showed this work improved relapse rates by 2 per cent, when the person with the diagnosis was included and the intervention happened over at least three months. Some studies report as high as 50–60 per cent improvement on outcomes as compared to treatment as usual (McFarlane, 2016). Furthermore, the involvement of families has been demonstrated to significantly reduce suicide risk (Onwumere, Bebbington, Kuipers et al., 2011).

Also cited in the updated NICE (2014) guidelines is the update to the Cochrane Review of Family Interventions (Pharoah et al., 2010). There are 53 randomised-controlled trials included in this review. These studies show consistently that family interventions reduce relapse and hospital admission. They also show family interventions improve social impairment and relationships within the family. The studies in these meta analyses have varied intervention content including multi-family, individual and behavioural and psychoeducation approaches.

The other side of the picture is the significant impact that family interventions have on carer wellbeing. Research shows that caring for a loved one can create mental health problems for families, and carers can themselves end up under the care of services and unable to work and support their loved ones (Boydell et al., 2014; Onwumere et al., 2015). Rates of depression can be high, with between 30–40 per cent of carers reporting clinical levels (Addington et al., 2003; Kuipers & Ruane, 2000); and at least one-third report trauma type symptoms (Barton & Jackson,

2008). Family interventions substantially improve carer wellbeing, although this support may need to be sustained to produce longer-term benefits for families (Claxton et al., 2017).

NICE guidelines for schizophrenia recommend family interventions for those at risk of developing psychosis, those experiencing first episode and those with longer-term psychosis. They suggest this can start either in acute phase or subsequently. They recommend that family intervention should:

1. Include the person with psychosis or schizophrenia if practical.
2. Be carried out for between 3 months and 1 year and include at least 10 planned sessions.
3. Take into account the whole family's preference for either single-family intervention or multi-family group intervention.
4. Take account of the relationship between the main carer and the person with psychosis or schizophrenia.
5. The guidelines also suggest a specific supportive, educational or treatment function, and include negotiated problem solving or crisis management work.

McFarlane (2016) outlines the main types of family intervention. In the UK the following are currently the most common approaches:

1. Individual family consultation.
2. Family psychoeducation.
3. Modified forms of family therapy.
4. Peer support information and support.

Most randomised-controlled trials look at psychoeducational or behavioural family therapy approaches. Although most of these studies are described as family interventions and include information sharing, they vary in their delivery. Multi-family groups have been shown to offer positive outcomes, but also involve high drop-out rates. Some of the evidence has been developed in Europe and the US (Carrà et al., 2007; Chien & Chan, 2004; McDonnell et al., 2006; Bradley et al., 2006). There are also many studies not included in the randomised controlled trial (RCT) evidence which support a variety of family therapy and family intervention approaches (Bertrando et al., 2006).

Small scale studies not included in these meta-analysis, which have not yet amassed RCT evidence but show promising results and are in line with the guidelines, include integrated approaches, systemic family therapy and Open Dialogue (Seikkula et al., 2001; 2010; Burbach & Stanbridge, 1998; Bertrando, 2006; Chuttoo et al., 2019).

Open Dialogue is an approach which is currently gaining wider recognition. This is a whole system approach to family work which epitomises family inclusive practice, as the family are included in the entire decision-making process and involved in therapeutic change processes. The outcomes from naturalistic studies in Finland are impressive, with 82 per cent of those diagnosed with psychosis no longer experiencing psychotic experiences and 86 per cent returning to work or in education at five year follow up (Seikkula, Aaltonen, Alakare et al., 2006). This is compared to the UK where estimates suggest 55 per cent of people have remitting or continuous psychotic experiences and disability and only 8 per cent are in employment (Rethink, 2012). However, these results are from small-scale studies, and at the time of writing we do not have results

from UK-based Open Dialogue randomised-controlled trials. Any claims about the efficacy of the approach in a UK setting must therefore be made with caution.

Naturalistic studies are increasingly valued in the UK as practitioners and policy makers come to realise that RCTs are not always the best indicator of what is possible in practice. This is because individuals can be chosen for research in a way they cannot for normal practice, and implementation issues affect what is possible in practice in terms of training and skills development. Some interventions do not lend themselves well to RCT evaluation, partly because they are not easily standardised and rely heavily on the interpersonal qualities of the specific clinicians involved. These approaches are welcomed nonetheless by experts by experience and families, and appeal clinically and intuitively to experienced clinicians. Therefore, it is important to not ignore this evidence. This can be thought of as practice-based evidence.

At the time of writing there is no published evidence regarding the delivery of digital family interventions for psychosis, but there is evidence for the benefits of remotely delivered behaviour therapy-informed parenting interventions (Comer et al., 2017; Dadds et al., 2019; Kohlhoff et al., 2020; Tsami et al., 2019), therapist- and parent-supported internet-based CBT for children and adolescents with OCD (Comer et al., 2017) and online couple interventions (Doss et al., 2016, 2020a, 2020b); see Helps and LeCoyte Grinney (2021) for a meta-narrative review. Wrape and McGinn (2019) produced a series of case studies illustrating practice guidelines for working remotely with couples and families. They highlight particular delivery challenges of managing privacy and confidentiality, safety of family members, building a relationship with all family members and changes to the process of the therapy. Dausch et al., 2009 describe a case of family-focused therapy (FFT), an empirically-supported, manual-based treatment, successfully delivered via videoconferencing to a service user and his mother. The client was a 30-year-old veteran with a diagnosis of schizoaffective disorder who had had multiple hospitalisations and experienced chronic auditory hallucinations and self-harm. They concluded that videoconferencing may have enhanced the treatment by making the process of communication and problem-solving more explicit.

In response to the Covid-19 pandemic clinicians have started to deliver sessions remotely and clinical practice guidelines have been developed (AFT, 2020; BPS, 2020). Practice-based evidence is developing, it is also becoming clear that video sessions can enhance engagement and openness for some family members as they feel less anxious or overwhelmed by social demands (Cronin et al., 2021). Whilst this could potentially lead to better engagement and outcomes for some people with psychosis, others may disengage because the technology feeds into their pre-existing concerns and fears. Some service users are 'digitally excluded', because of lack of access, lack of familiarity with technology, or lack of a private and quiet space to engage in an online session.

SUMMARY

Research has shown the value of family interventions and therefore has supported its implementation in practice. Family interventions improve outcomes for both service users and family members and have an impact on service provision as they reduce re-hospitalisation and support recovery. Different approaches to family intervention are present in the research, with clear guidelines in NICE (2014) about the essential components of the work needed to achieve outcomes. Different forms of family interventions will be referenced in these guidelines as either their role in establishing a strong evidence base for the approach or from their merit in evidence-based practice, as long as they are consistent with the NICE recommendations. In all of

the research mentioned, one finding is consistent: in order to treat psychosis effectively, family members and carers should be involved.

Obviously the most beneficial input that we've had is from the family intervention. I honestly don't think we would be where we are today... it was helpful not only for him, but for me. (...) it really made us feel stronger and more positive and I think, the time when everything is negative around you, every system, every process, every person you meet, if you find the light at the end of the tunnel, if you see that light, you don't give up, and when you don't give up you're still fighting, when you don't see that light I can see why a lot of families break up, how people can end up in hospital and stay in hospital, I can see how people end up homeless, because there's no other way. (Ayub, SU).

RECOMMENDATIONS

- Further research, particularly RCT's, are needed, to explore effectiveness and efficiency of different forms of family interventions commonly used in the UK.
- Research is needed to explore the effectiveness of digital family interventions.
- Practice-based evidence and service evaluations need to be acknowledged when supporting family interventions.

3. Different ways to work and collaborate with families and social networks

Jon Crossley and Simon Platts

KEY POINTS

- There are many different interventions that professionals can use to work with families and social networks, and there are potentially multiple roles for psychologists within each of these.
- Mental health practitioners need a core set of skills and values that are the foundation for all of the approaches; family-friendly/sensitive and inclusive practice.
- Different types of interventions are non-hierarchical – each has their own benefits and may be more useful or appealing to families and social networks at any given time. Choice and delivery of the right intervention at the right time is seen as most important – although different interventions require different skills and levels of training.
- Video conferencing or phone links can be used to overcome many convening difficulties for all of these types of interventions.

INTRODUCTION

There are multiple ways that services can interact with families and social networks, and it has been common to think about these as existing at different levels. Four levels of intervention have typically been described, which were considered to reflect advancing levels of complexity, reflecting skills gained from increasingly extensive training programmes. These levels were: (1) family-inclusive practice; (2) structured family interventions and systemic practice approaches; (3) family and systemic psychotherapy; (4) supervision.

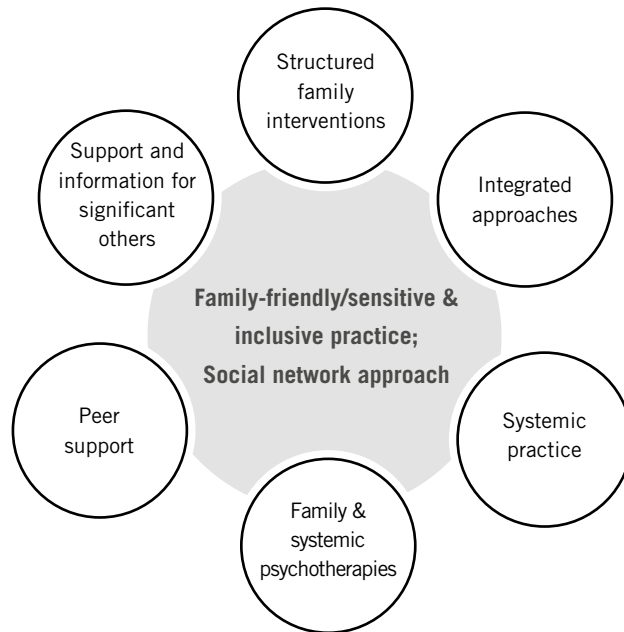
Organising family interventions into levels of practice is easy to understand and clearly delineates the skills and training required to carry out the tasks/interventions. The idea however that higher levels reflect more complex interventions does not account for the different forms of complexity at each level. Moreover, the idea of family-inclusive practice as a specific level of intervention detracts from it being understood as good, everyday practice integrated into all interventions for all mental health practitioners (Easson et al., 2014).

The different ways of working with families and social networks can alternatively be represented using a 'flower model'. At the core of the model is family-friendly/sensitive and inclusive practice, which represents the ethos and values that should be held by all practitioners and people working in healthcare settings. Around the centre are different options for working with families and social networks. These different options are seen as just that – different; and so they are presented non-hierarchically.

In this chapter we summarise the different ways of working that comprise the flower. As practice develops other 'petals' may need to be added. Each of the ways of working we discuss requires

a range of skills and knowledge. Psychologists have different roles to play in each of these interventions, from offering support and supervision to providing direct clinical practice. Clinicians do however require adequate training and support to execute these roles.

THE CORE – FAMILY-FRIENDLY/SENSITIVE AND INCLUSIVE PRACTICE



KEY POINTS

- The values and activities related to family-friendly/sensitive and inclusive practice should be the bedrock of all work in mental health services. This means involving families in every part of the system, developing a whole family approach to care and providing a welcoming attitude to families.
- Connecting with and listening to families in a service changes their experience and their relationship with the service user, and can impact outcome for the service user as well as the family.
- Psychologists have a role to advocate for formal family inclusive practice training for all staff; preferably a two- or three-day course about working with families.
- Creative ways of connecting with families can support better relationships and increased involvement of families.

OVERVIEW

Family-inclusive practice is a principle that has become embedded in mental health policy and service frameworks. This is in recognition of the multiple people affected alongside the designated/referred service user, when problems exist within a family/social network.

Working in partnership with families through a whole family approach to care (SCIE, 2011) has been understood to be an important aspect of work with children for many years, but increasingly its value has also been recognised in adult mental health services in general, as well as in specific areas such as substance use (Copello & Orford, 2002). The World Health Organization (2004)

has endorsed the idea of closer partnership between service providers, service users and families, to both improve the quality of services and to empower service users and families. In the UK this position has been reinforced by legislation such as the Care Act (2014), which has required services to recognise the role of significant others and to support those in a caring position. There are also guidance documents such as Triangle of Care (Worthington et al., 2013) which outline important elements of involving families. Another important development is the inclusion of the principles of family-inclusive practice in the UCL competencies (Roth & Pilling, 2012) for family interventions for psychosis. This means it will be included in the national training programme for family interventions in psychosis.

THINGS TO CONSIDER/ISSUES

- Family-inclusive practice is not a straightforward notion (Martin et al., 2017), and several obstacles to it have been identified (Furlong, 2001). Mental health services tend to work with individuals, and systems are not set up to routinely see people as part of a family or network. Practitioners therefore often only target perceived 'problem families' (Eassom et al., 2014).
- Recommendations for more expert-driven family interventions has potentially created a disjuncture from routine engagement of families, with a shift instead towards a more interventive approach that practitioners may not feel they have the skills or confidence to implement (Easson et al., 2014).

In order to support the establishment of family-inclusive practice, psychologists can embody the philosophical assumptions and practice of a family-friendly/sensitive and inclusive approach in all their interactions with clients and MDT colleagues. Psychologists' training and position in services enables them to work using different methods, to establish a culture that values and supports families and social networks. This includes contributing to the development of policy and the organisation of services in ways that routinely engage families; establishing systems for holding regular review meetings with families; providing a voice in meetings which supports family-inclusive practice; working with families in therapy; and running support groups.

Furthermore, psychologists are well positioned to provide supervision and training which supports staff members' interactions with families and offers a reflexive stance towards dominant/culturally normative ideas about families. Psychologists can question ideas about how families 'should' be (thereby reducing cultural bias), while simultaneously thinking about how power operates in families and the power resources of families (thereby reducing the risk of abuses of power and social injustice/inequality); see for example, Johnstone and Boyle (2018). One example of this is addressing narratives about particular family members as problematic or critical. Psychologists have a role in supporting thinking beyond these thin descriptions to understand why a loved one might be presenting in this way, for example, fighting to get the best care possible. The support to staff can also be provided directly, by co-facilitating family support groups and assessments/review sessions with families where they support engagement of families with services. Most training programmes for clinical psychologists should enable them to fulfil this function. However additional training and support for psychologists to take up this role may be required. Systemic theory and training has important contributions to make in this area. Furthermore, this role should be supported by all professionals.

RECOMMENDATIONS

- Psychologists, alongside other Healthcare Professionals (HCPs), have a role in advocating and supporting the family and carer strategy, and in supporting carer leads as key allies in this work.
- Families should be routinely invited to meetings unless the service user specifically declines this. In this instance, carers have a right to their own independent support.
- Family members' needs are to be attended to as well as service users.
- Psychologists have a role in supporting the employment of carer advisors and their visibility at all levels of the organisation.
- Psychologists should play a role in developing family inclusive practice across all areas. They should support reflexivity in developing positive and collaborative relationships with families.
- Systemic and family psychotherapy training is important in developing an understanding of circular relationships, and in the examination of difference and reflexivity in relationships. Psychologists should be supported in training and work alongside other disciplines to develop systemic thinking in services.

GOOD PRACTICE EXAMPLES

- East Sussex Early Intervention Service offer one-off Family Meetings to the family/close friends of every service user who joins the service. They hold the meetings at the family home or in a local clinic, depending on the family's wishes. Two staff lead the meetings, one of whom is trained in family interventions and one who is generally the Lead Practitioner for the service user. Through this meeting they hope to communicate the value of the whole family approach, as well as supporting the assessment of people in relation to those with whom they are close. If the family wish to meet together again, they offer ongoing family interventions. They have found that the majority of families take up the opportunity to meet for a Family Meeting, and that approximately two thirds of those families choose to meet for ongoing Family Work.*
- Some services hold monthly Family and Friends groups in which family members can get together to find out more about psychosis and the mental health services, as well as having time to share experiences. Staff and family members co-produce the groups, working together on planning, setting up and facilitating the groups and other activities e.g. walks, meals, as requested by the group.*
- 'I worked individually for a long time with a black British lady in her 30s. She had a 9-year-old daughter where there were child protection issues owing to the mother's repeated experiences of mania. When unwell, her daughter would go and live with my client's mother (grandma). Each time mum was admitted, it was traumatic for daughter and grandma and they often felt excluded by services. As part of individual therapy, I worked with mum to think about how to include all family members in her relapse plan. In the days leading up to her most recent admission, I remained in close phone contact with grandma, allowing her to voice her worries and providing updates on what services were doing. After a distressing process of my client being detained in hospital involuntarily, I de-briefed with grandma over the phone and sent her a Trust information leaflet written for young children whose parent is in hospital. We discussed how she could go through this with her granddaughter, giving her some ideas on the words she could use to explain what was happening. She spoke through tears to express her thanks to me for keeping her involved at such a distressing time.'*

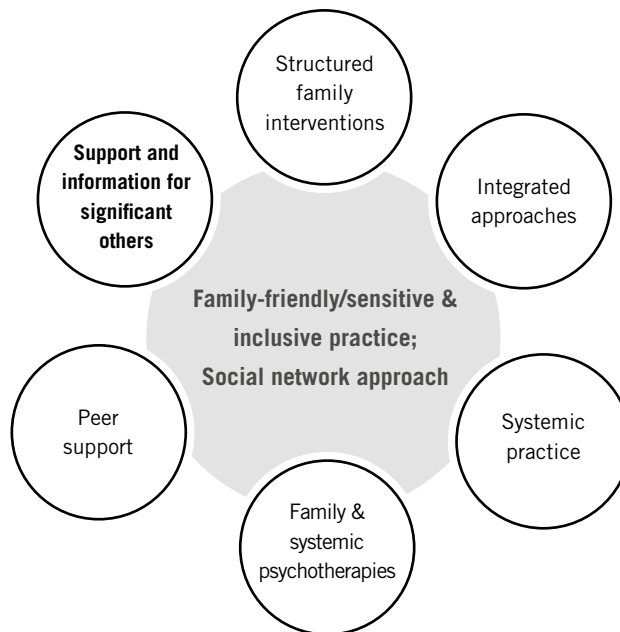
d. *Social Network Approach: Open Dialogue*

Open dialogue is a way of organising services as well as a set of practices (and stance) for being with people to support therapeutic conversations. Open Dialogue was developed in Western Lapland, Finland (Seikkula et al., 2006) and it is an example of family-inclusive practice, as the approach advocates a social network approach to care. Open Dialogue invites the family and social network to engage in regular meetings adapted to the needs of the individual and family, as an immediate response to (psychotic) crises. No decisions about treatment are made outside of these meetings. It involves the routine and expected inclusion of social network members, equal partnership, deep listening and co-production principles (Martin et al., 2017). When collaboratively agreed with the network, other approaches such as family intervention sessions or individual therapy can be implemented alongside the social network meetings.

DIFFERENT FORMS OF FAMILY-FRIENDLY/SENSITIVE AND INCLUSIVE PRACTICE

Family-inclusive practice provides the foundation for all the numerous ways of engaging and supporting families, which are now discussed in turn.

SUPPORT AND INFORMATION FOR SIGNIFICANT OTHERS¹



'It was more having someone to talk to that fully understood the situation ... that didn't have any bias, because some things I felt I couldn't tell family or friends 'cos they didn't understand the nature of Ian's illness.' (Sally, wife)

¹ This is often referred to in government policy as 'Carer Support and Education'. We have chosen the expression 'Support and Information for Significant Others' due to problems with the concept of 'carer' and the notion that professionals 'educate' the people they work with. This is discussed in greater detail below.

KEY POINTS

- Support should be available to all significant others who provide care to the individual. This can support recovery, reduce distress and limit the need for additional services for the service user and the family.
- Support can range from active and supportive listening to more structured/focused interventions. Staff should be ready to provide a sympathetic ear to significant others and support should be provided for more focused interventions.
- Support can be provided individually or within the context of groups (e.g. Family & Friends groups).
- Sharing of information should be carried out wherever possible, based on the premise of a mutual and reciprocal exchange of ideas and knowledge between 'experts by experience and experts by profession' (p.3; Faulkner & Thomas, 2002). Professional knowledge is understood to be one of many perspectives and is not deemed to be superior to the knowledge of the significant others.

OVERVIEW

Family members/significant others provide a vital role for service users. They require both information to be shared and support for themselves, so they can carry out this role. They also hold important information which can support better provision of care for the service user. However, the needs of service users and family members have often been viewed as conflicting or competing (Furlong, 2001). At times this is because the level of conflict that has arisen in the crisis has led the service user to report they do not want family involved in their care. This polarising dynamic of viewing the service user and family needs as conflicting is unhelpful, as it overlooks the multiple points of view brought by family members and limits opportunities for conversation and engagement with the family. It is important to consider all elements of confidentiality of both the service user and carers, and to support carers and consult with them even if they are not able to be informed about the details of the care. All services need clear guidance and training on confidentiality. Psychologists have a role in developing skills for all mental health workers in order to manage such complexity.

Observing and supporting a family member experiencing psychosis can be stressful and can lead to further mental health difficulties in the family. For this reason, formal assessment of carers' needs is a requirement of the Care Act (2014), and it is important that families establish effective partnerships with services. Thus it is important to provide one-to-one supportive relationships and offer individual carer interventions.

'Seeing Dawn [Support Time & Recovery Worker] on a regular basis meant I could have a bit of a break from watching Ian 24/7... I remember one time you were seeing him every other day, and I waited for a bath until you were there, because I daren't leave him long enough to have a bath.'
(Sally, wife)

THINGS TO CONSIDER/ISSUES

- No training is required to provide a listening ear for significant others. However, family-inclusive practice training can be helpful to support this practice. Staff need to be encouraged to recognise this as part of their role and given time to complete it. They should also be provided with a space to work through difficulties in their relationships with family members, as distressed families can come across as critical, which staff may find difficult.
- Support and education for carers may be delivered in the context of a structured, integrated or systemic approach. It is suggested this will have an impact on carer wellbeing as well as outcomes (Sin et al., 2017).
- There have been some connections made between how families appraise their family member's difficulties and their own coping (Onwumere et al., 2015). Brief individual carer interventions (e.g. Roddy et al., 2015) and online support (e.g. Gleeson et al., 2017) for family members have shown to be helpful in these situations.
- It can be helpful to discuss the idea of 'carer', recognising how this label can create an unhelpful hierarchy within families and obstruct more 'normal' and reciprocal family/intimate relationships (Watts, 2008).
- Issues of confidentiality can make it difficult to support carers. However regardless of the service user's wishes, all family members and carers have a right to support (Department of Health, 2014).

Psychologists have a role in nurturing a culture where significant others who provide care are valued. The method for doing this includes providing training, supervision and support structures that guide professionals in their work with those significant others (e.g. enhancing understanding and empathy). Psychologists along with other professionals may contribute directly through their clinical practice with families, meeting with family members individually, by providing supervision, and by delivering training both about the ethos of work (e.g. recovery values) and specific skills (e.g. working with individuals or families).

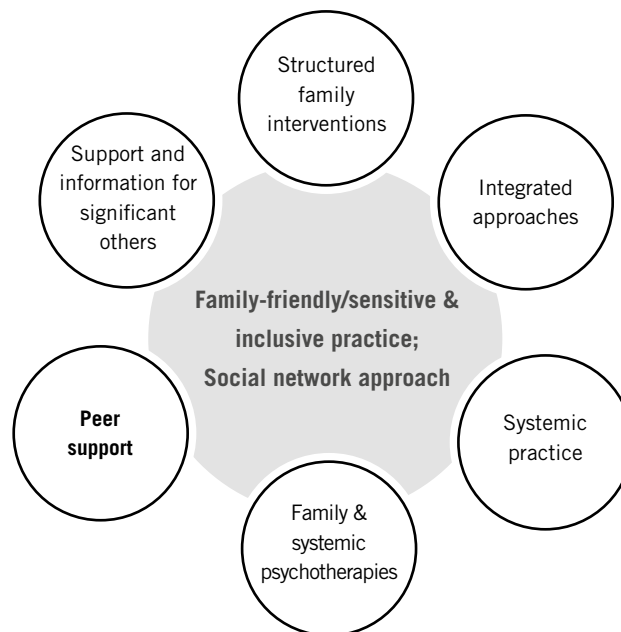
RECOMMENDATIONS

- All services should be offering individual or group carer interventions.
- Practitioners should attend to the multiple perspectives that families bring about their family member who is experiencing psychosis.
- It is recognised that the idea of 'educating' families about terms such as 'psychosis' and 'schizophrenia' has limitations, including endorsing a medical perspective, implying professionals have the answers and potentially undermining the knowledge and expertise of the service user and family members. Instead, it is recommended that we engage in mutual sharing of ideas and knowledge based on the principle of Expert by Experience and Expert by Profession.
- Care coordinators should be supported to deliver carer support for significant others as part of everyday practice.
- All services should provide support for mental health practitioners to reflect on their relationships with families through supervision or consultation.

GOOD PRACTICE EXAMPLES

- a. *Roddy et al. (2015) describes the rationale, content and outcomes of a pilot study with individual carers, which suggested that a brief approach could help address low mood and carer distress. They offered up to five sessions, where the content was informed by FI whilst also focusing on the needs identified by each carer. This included sharing information about psychosis, practical problem-solving to address personal goals and signposting to appropriate additional support. All carers also received help to improve sleep.*
- b. *'Many of the carers referred to me for a carer intervention are really looking for greater understanding of their loved one, which could be reached in family intervention with the service user present; however, many people with psychosis prefer to keep their families and their treatment separate (perhaps as a result of stigma). This leaves family members or carers coming individually to think about how they can improve their relationship with their loved one, and not just to think about their own personal wellbeing or what resources they have.'*
- c. *'Once a year we offer a carer event to support families getting involved with the service. We give something back to them such as laughter therapy sessions or massages. We invite all local carer organisations and different professionals to talk about services and what is available for families.'*
- d. *During the Covid-19 crisis one service offered weekly telephone check-ins with carers in the community psychosis teams. This work enabled a supportive relationship with families and aided engagement in other family interventions and the team as a whole.*

FAMILY/CARER PEER SUPPORT



KEY POINTS

- Support from peers who have had experience of services themselves can be very helpful to service users and families.
- Peer support can be provided by people with lived experience of psychotic experiences, or their significant others who have had experience of their difficulties and/or contact with services.
- Peer support should be a paid role within established training, support and supervision structures, although some time-limited voluntary ‘developmental’ posts may also be acceptable for people who do not feel ready for paid employment.

‘These are practitioners who model hope, insight and inspiration for staff teams, clients and their families.’

OVERVIEW

Establishing peer support roles within mental health services, as well as the structures to support this, recognises the expertise that arises from experience of mental health difficulties and interaction with services. Peer support can help clients, families and social networks manage problems more effectively and navigate their way through services, in addition to providing visible proof that recovery is possible (Anthony, 1993).

‘Peer workers have the ability to restore the faith of support networks based on their willingness to be open, transparent and authentic.’

THINGS TO CONSIDER/ISSUES

- Peer support workers require some form of training and substantial support to deliver this role. Although there are limited training programmes available currently, peer support mentor courses should be encouraged.
- Peer supporters are well positioned to co-produce service re-organisation and delivery, focusing on what is helpful for people in distress and their families.
- Peer support workers will require support to navigate the system and develop clear objectives for their role.
- Some have argued that the term ‘peer support worker’ identifies the individual as having previously accessed mental health services, and that this level of personal disclosure would not be expected of any other position (Recovery in the Bin, 2015). Moreover, there can be an expectation placed on Peer Mentors to tell their story, which again would not be expected of others and can negatively impact on the emotional wellbeing of the Peer Mentor. These are tensions that require conversation and consideration. More generic job titles such as ‘Support Worker’ may put less pressure on those in the role.
- Employment of peer support workers (including carers) can be misunderstood by services. Education may be required to support colleagues to understand what people with lived experience can offer, and the importance of putting boundaries around the work, as peer support workers should not be expected to deliver complex therapies without the appropriate training and experience.
- Carer advisors and carer peer support workers are a welcome addition to any team and provide unique and valuable support for other family members in distress.

‘For someone to be able to say, “Well I used to do exactly the same thing and this is how I got past it” was worth its weight in gold quite honestly.’ Family member, Nottingham

Psychologists can help to create a culture where people with lived experience (designated service users and family members) are valued as part of service provision, by establishing structures that support the person in roles such as Peer Support Worker.

Psychologists can also provide supervision and training about the ethos of work (e.g. recovery values) and specific skills (e.g. working with individuals or families) that help the Peer Support Worker in their role. To be consistent with the premises of peer support and the user movement, this could be co-produced with people with lived experiences, demonstrating to others (e.g. colleagues) how important and meaningful the lived experience perspective is. They can also support service developments that enable peer support workers to have a role in the organisation, including barriers to participation, such as overly formal meetings that may leave people feeling disempowered and out of place.

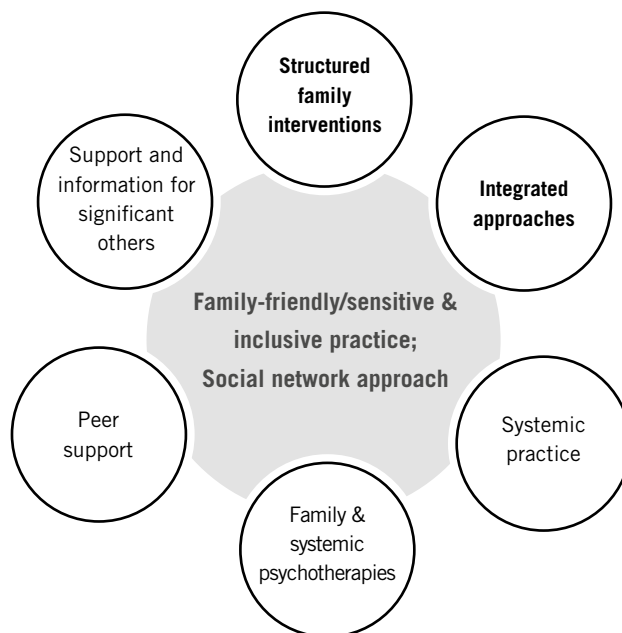
RECOMMENDATIONS

- Psychologists should be involved in creating and supporting peer support worker/mentor roles, and reviewing their integration into the system.

EXAMPLE OF GOOD PRACTICE

- In the Family Intervention and Support Service in Croydon, a carer peer support worker is employed by the Trust and supports clinical work and organisational development, supporting training and employment of staff. They also provide individual and group carer peer support which has been invaluable to the families in the service.*

STRUCTURED FAMILY INTERVENTIONS AND INTEGRATED APPROACHES



KEY POINTS

- Working with families to help develop understanding and more effective communication and coping is supported by research and recommended by NICE (2014).
- Several guides have been written that clearly describe methods of improving understanding and communication in a structured manner. These are structured family interventions, which allow the overall approach and specific skills to be learnt and followed (e.g. Falloon et al., 1984; Kuipers et al., 2002).
- Examples of Structured Family Interventions would include Behavioural Family Therapy, some forms of CBT-FIp or psycho-educational approaches.
- Training is typically brief which is affordable for services and manageable for staff who continue to hold competing clinical responsibilities. In order for this work to be effective, support (including protective time for consistent session planning) and supervision for these roles is essential. Family and systemic psychotherapists are well placed to provide support for this work given their depth and breadth of experience and knowledge in working with families.

'What I benefitted from was that the voices that I hear were a bit more clarified. Before I thought I was just taking medication but I became more understanding what the voices were all about and I feel a bit less pressurised now' (wife who was the identified service user with husband in family work)

OVERVIEW

When people are having experiences such as hearing distressing voices, feeling suspicious and expressing ideas that others do not share or understand, this can heighten the mental distress of significant others and the relational stress within the family, which may further influence these difficult experiences. Research has found working with families to develop understanding and more effective communication and coping skills, can help the experiences to be less problematic and distressing for the individual.

A range of structured interventions has been developed both for individual families and multifamily groups. These approaches have been well researched (Pharoah et al., 2010) and culminated in a robust evidence base, showing that structured family intervention is effective in reducing further experiences of psychosis and hospitalisations, with improvements sustained over time (Fadden, 2006). The behavioural, cognitive-behavioural and (integrated) cognitive-systemic orientations are discussed below.

'We didn't understand what the problem was, but we were given some information about the symptoms and after that we knew'.

BEHAVIOURAL FAMILY THERAPY (BFT)

Behavioural Family Therapy (BFT) is a psychoeducational approach to working with families that was originally developed by Ian Falloon in the 1980s. It has a robust evidence base (Falloon et al., 1982; Pharoah et al., 2010). The approach is a practical, skills-based intervention that usually takes 10 to 14 sessions to deliver (see website for further developments: www.meridenfamilyprogramme.com). Mental health professionals trained in the approach previously attended an initial five-day training course. However now this training is

at least 10 days of training combined with 12 months of supervision as stipulated in the NHS England national curriculum. It is also recommended non-therapists for example care coordinators without additional therapy qualifications should work in co-working relationships with experienced FI practitioners.

'The learning of skills was the main thing and through that we learnt to deal with our problems and issues.'

The approach is not a 'package' where components are delivered to all families. Rather, it is an individualised formulation-based approach where the intervention is based on the assessment of that particular family and their specific needs. Equally, the pace and timescale of the support offered varies from family to family. In this collaborative approach, the therapist and family together determine what the agenda will be. Family work is generally offered in the family home unless the family prefer meeting elsewhere, to make it easier for family members to attend.

The elements of what is offered are drawn from those listed below:

- Meet with the family to discuss the benefits of the approach
- 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 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 (e.g. active listening, making requests, expressing pleasant/difficult feelings)
- Supporting the development of the family's problem solving skills
- Review and on-going support or closure

'I always remind F to carry on doing those things. My son always says he likes my food the best. It helps so much to tell someone you appreciate them.'

CBT-BASED FIP

CBT-based family intervention for psychosis (FIP) is a personalised, structured therapy approach designed to improve both service user and caregiver outcomes by facilitating cognitive and behavioural changes. There are evidence-based treatment manuals (e.g. Barrowclough & Tarrier, 1997; Kuipers et al., 2002), and these emphasise a few key therapeutic activities to help the family and service user to make such changes. These include:

- creating a safe and non-blaming space with an emphasis on supporting positive communication styles
- encouraging each family member to share information about their own experience of psychosis, in order to help them to re-appraise their experiences
- improving knowledge about psychosis including dispelling common myths and helping to reduce stigma
- promoting active collaborative problem solving around current issues which cause family tension
- improving family relationships and encouraging more positive family communication

- developing more adaptive coping styles
- facilitating the processing of emotions (e.g. anger, guilt, shame, loss)
- explicitly focusing on reducing the risk of future episodes

'Helping us understand mental illness. I learnt a lot about it I didn't know.' (Father)

CBT-FIP usually takes place in the family home in order to help with engagement, especially for those struggling with low motivation. Written psychoeducation materials are often used in early sessions, with the explicit purpose of structuring discussion around key issues in order to help family members share their own perspectives.

Two therapists are present to facilitate the family discussion and manage the shared agenda. Therapists take an active role in the session and have multiple tasks, organised around the therapeutic activities mentioned above.

Families are encouraged to set up 'homework' activities which are developed as a natural consequence of discussion in session, and then completed between sessions. Therapists are conscious of effectively managing the content and pacing of each session so it is accessible to all the family. There is opportunity in each session for feedback.

INTEGRATED FAMILY APPROACHES

Systemic and psychoeducational approaches are increasingly being integrated (Bertrando, 2006; Burbach & Stanbridge, 1998, 2006; Burbach, 2013; Lobban & Barrowclough, 2016).

Integrated approaches contain a range of ingredients from different approaches but these will usually include systemic interviewing skills, such as circular questioning and the exploration of interactions which are maintaining problems (Hedges, 2005; Tomm, 1988), and behavioural and cognitive behavioural skills such as problem solving, communication skills training and cognitive reappraisal and reframing (Falloon et al., 2004; Kuipers et al., 2002).

The main aim of the sessions is to enable therapeutic conversations which identify strengths and resources and encourage the development of a sense of agency and hope for the future (Bertolino & O'Hanlon, 2002). This often involves the exploration of beliefs and interactional patterns, the development of recovery narratives, the refinement of coping skills, and the encouragement of mutual support and empathic understanding.

Burbach and colleagues have developed an integrated FI framework (Burbach, 2018, 2016a) involving seven phases: (1) the provision of information and emotional and practical support; (2) identification of resources within the person, family and wider network; (3) encouraging dialogue and mutual understanding; (4) identification and alteration of unhelpful patterns of interaction; (5) improving stress management, communication and problem solving; (6) relapse prevention planning; and (7) ending. Every session is structured as a 'mini intervention', which enables clinicians to offer standard NICE-concordant family interventions or a briefer intervention if this is sufficient to meet the particular needs of a family.

'How best to manage it and how best to understand what had happened and what it meant to my wife and I.' (Client)

THINGS TO CONSIDER/ISSUES

- Family interventions are designed to focus on what matters to families and what is shown through research to support better outcomes, however thorough assessment of needs and choice is vital.
- It is important that the families are not regarded as to blame for difficulties, especially given the history of families feeling blamed and stigmatised through the use of (unsubstantiated and prejudicial) terms such as ‘schizophrenogenic mother’ (Johnstone, 1999). With all approaches there is a possibility that families will feel responsible for their loved one’s difficulties. Clinicians need to be able to explore these feelings with families and support an understanding of mutual influence whilst showing families they are not blamed for psychosis. For example, communication skills are only delivered if these are seen to be an important area of change to the family.
- It is important to recognise the range of skills required to deliver these interventions, in order to avoid them being experienced as critical or uncaring towards families in times of distress. Supervised practice is vital (see chapter 8 for further information).
- Structured family interventions can be helpful in facilitating conversations between families and professionals about what the problem is and the experience of psychosis, and to support the learning of specific coping strategies.
- It is important to attend to abusive relationships in families if they are suspected. In this instance, it may be necessary to discontinue family work and instigate risk management and safeguarding processes.
- Many families experience interventions based on present problems and skills learning as less threatening, as it does not require discussion of the past or give the suggestion of engagement with ‘therapy’.
- Family and systemic family psychotherapists are well placed to provide support around working with cultural differences, given that systemic theory and training integrates an understanding of the cultural contexts in which family and couple relationships are embedded.
- The extent to which team members are implementing culturally sensitive practice should also be monitored and evaluated. For example, although a Family Interventions approach could be seen as appropriate for people coming from non-Western cultures, where the inclusion of family members is often valued, others have argued that FI approaches can privilege and recommend Western modes of interaction (e.g. eye contact) that may be incompatible with the expectations of non-Western families. Current FI approaches usually recommend adaptations to the approach to make FI more culturally sensitive, for example, getting someone’s attention rather than making direct eye contact, and Culturally-Adapted FI packages have been developed (Edge et al., 2018). It is however also worth noting that while approaches developed in a Western context tend to predominate, it can be helpful to also learn about approaches drawn from a non-Western context (such as ‘Tree of Life’, Ncube, 2006). Rather than looking to ‘adapted’ Western models, these may be more relevant to service users from minoritised backgrounds, while also enhancing clinical practice with all service users regardless of background (Afuape, 2011).

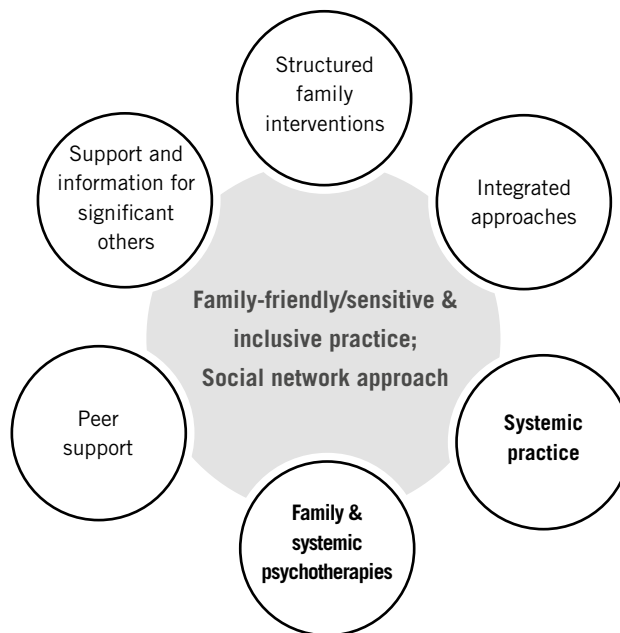
‘The integrated model was very helpful in allowing me to develop an intervention that is in line with beliefs, values etc. There are some parts of the training that have been easier to “hang onto” and some that I need more help to hold in mind.’ FI worker Sussex

Because of their training in therapeutic approaches, psychologists are likely to grasp the important elements of structured approaches and deliver these in a nurturing, empathic way. In addition, their experience of training and supervision in teams make them well placed to provide support for structured approaches with appropriate training, for example through co-working or live supervision. Psychologists do however need additional training to be able to support family interventions, as it is currently not an essential component of clinical psychology training. Supervision of family workers is important in maintaining the provision of family intervention over time. Psychologists also have a role in evaluating the use and outcome of structured interventions, for example measuring the proportion of families being offered and/or accessing FI.

RECOMMENDATIONS

- Sensitivity in all approaches to FI is required, foregrounding the voice of the service user and supporting exploration of different ideas about the problem rather than subscribing to an ‘expert’ view.
- FI can be adapted to improve cultural sensitivity and relevance for people from non-Western backgrounds. Additionally, it can enhance practice to learn about approaches developed in non-Western contexts.
- Consider barriers to implementation including lack of time available for care coordinators to provide family interventions, and service cultures of limited support and supervision for interventions.
- Delivery of communication skills needs to be done by experienced family intervention workers.

SYSTEMIC APPROACHES: SYSTEMIC PRACTICE & FAMILY AND SYSTEMIC PSYCHOTHERAPY¹



¹ When we discuss ‘Family and Systemic Therapy’, we are including approaches that have an accredited training programme, such as training in Narrative Therapy, Brief Solution Focused Therapy and Open Dialogue (three-year training).

KEY POINTS

- Systemic approaches involve a range of theories and practices with very different philosophical positions, from the earlier modernist approaches (e.g. Structural Family Therapy, Milan school) to the postmodern approaches developed since the 1980s (Post-Milan, Narrative, Solution-Focused Therapy, Open Dialogue).
- Contemporary systemic models prioritise consideration of socio/political levels of context.
- Systemic approaches can attend to the complexity of the presentation when a skilled and flexible response is required, compared to the more consistent approach followed within the framework of a structured intervention.
- Systemic therapies are effective, acceptable to clients and cost effective for a range of presentations, including adults with experiences of 'psychosis' or a diagnosis of 'schizophrenia' (Stratton, 2016).
- Systemic family therapy fits with NICE Guidelines regarding family interventions for psychosis, as it provides support for families and works on family relationships.
- Some families find systemic approaches a good fit for their needs, as they focus less on skills learning and more on open conversations.
- Systemic therapies vary, but have certain features in common, such as the principle that multiple people influence the difficulties experienced in the system, and multiple people will also influence the solutions. This broadens ideas about 'who the client is', and so they are not restricted to working with – or overly focusing on – the referred person.

'The family therapy has been an extremely important bond between the services of care and the family. We have grown as a family to understand the difficulties and challenges of caring for my brother who has severe psychosis. We have learned the meaning of the psychosis – it has been extremely educational... The most important part of the family therapy has been the reflection and listening without judgement... That is the wonderful thing about the family therapy – it embraces the difference without judgement.' Fari

'It was very difficult to communicate with my son at that time, I don't want to keep asking him questions, how are you feeling, that's all I was doing, and that was him telling me, without having to speak to me, of what was going through his head, even if he was just characterising people's roles around him. It was the first time I actually heard him if that makes sense.'

THINGS TO CONSIDER/ISSUES

There are different levels of training in the systemic approach, including introductory and intermediate levels which enhance systemic skills. Only Masters-level training leads to qualified family and systemic psychotherapy status.

- Clinical psychology training courses typically provide systemic teaching, and several courses are accredited by the Association of Family Therapy as providing training at a Foundation Level in Systemic Practice – however, this is not a compulsory part of all training courses.
- Although some of the innovators of systemic approaches often used one-way mirrors (e.g. Selvini-Palazolli et al., 1978, 1980), it is now more common to have all practitioners in the room and to reflect in front of the family/social network (e.g. Seikkula et al., 2001). This is to increase transparency and minimise the potential for suspicions or paranoia about what professionals are doing or thinking.

'It's about listening in a different way, and so you can see it and listen in a different way, you're absorbing this ... less involved listening.' Comments on the use of reflection within a systemic approach.

- Contemporary systemic family therapy can be very helpful in supporting difficult conversations within families who have been struggling with problematic dynamics, partly because the reflecting team allows new perspectives to be explored and multiple professionals to be involved.

'[The therapists] were bouncing ideas off each other, cos it got me thinking, "That's your idea, and that's your idea....what's my idea?!" ... You're a psychologist, you're a nurse, I'm me.... whatever view you hold, you've still got your ideas and I've got to make my own.' (Ian, service user)

Psychologists can support different roles within systemic practice and family therapy depending on their training and experience. All psychologists can support the underlying philosophy of systemic practice through valuing multiple perspectives, acknowledging the importance of context, taking a relational stance and promoting curiosity and an interest in circular processes in relationships. The systemic orientation also values self-reflexivity and psychologists can help to develop this, for example by exploring the assumptions and experiences of clinicians within pre- and post-session discussions, and locating these within social contexts. This may include an exploration of personal beliefs and social discourses about how families 'should' operate, and hence aid clinicians in maintaining curiosity towards the families they are working with, and to think about the potential impact of their own social contexts and styles of interaction on the families. Discussions of this nature, help clinicians to feel supported, develop in their role and maintain a systemic perspective.

Methods for systemic practice can vary. As well as therapy sessions with a reflecting team, it can also include supporting flexibility and multiple perspectives in supervision and thinking about circular patterns of behaviour in meetings. Psychologists can be lead practitioners, co-worker or reflecting team member, thereby encouraging the mutual development of skills with colleagues through joint working, as well as demonstrating the value of multiple perspectives in the work.

RECOMMENDATIONS

- Systemic practice and the contribution of systemic and family psychotherapists can be particularly helpful with complex issues and where families would like support to explore dynamics in the family.
- Where possible, reflection should be used during systemic family work (e.g. a reflecting team), to help increase the range of different perspectives available to families and to promote transparency.
- Reflecting teams should be positioned in the same room as the family and therapist, especially if suspiciousness or paranoia have been demonstrated by the service user.
- Supervision sessions need to be structured according to systemic practices to help enable collaborative practice, promote relational thinking and to utilise the resources of the individual or group in supervision (Bertrando & Gilli, 2010; Razzaque, 2019; Seikkula, 2012; Lyngaard et al., 2001).

'I've learnt...to not rely on [some people] too much...emotionally, and that's improved our relationship.'

This chapter has provided an overview of how psychologists can work with families and social networks, or support the work of colleagues in this area, across different types of family-orientated practice. A framework presenting these ideas is available in Appendix B.

4. Common processes in family interventions

Frank Burbach and Isabelle Ekdawi

KEY POINTS

- All family approaches focus on interpersonal relationships rather than intrapersonal factors. They are concerned with improving communication, both verbal and non-verbal, and with the reduction of stress/conflict within the family/network.
- A strengths-based, non-pathologising, non-blaming collaborative therapeutic stance is common to all family models.
- Clinicians hold the assumption that family members are acting with the best of intentions, even if they are inadvertently contributing to the problems.
- A key task for the therapist is to form a therapeutic connection with each member of the significant system, by seeing them as a whole person and making sure that they feel heard. This includes absent members, by asking those present to consider what their views might be (and possibly to encourage them to attend future sessions).
- All family clinicians collaboratively agree the focus of the sessions with family members – this may include agreeing to work on a range of goals that might appear contradictory, and working hard at getting everyone on board.

This chapter will distill the common processes which underlie the various models of FI. All models should follow the NICE guidance and ultimately the evidence and thus:

1. Acknowledge the relationship between the main carer/family member and the person with psychosis.
2. Use a supportive education or treatment focus, exploring problem solving and crisis management work.

Roth and Pilling (2012) have developed further these into competencies exploring important tasks in FI. These tasks can however happen in a variety of ways. The breadth of family approaches enables a variety of tools to draw on in supporting families to achieve these goals. Although the field was originally distinguished by theoretical rivalries, these have diminished over the years and there is increasing recognition of the similarities between the models (Burbach, 1996, 2013, 2018). We hope that this chapter, which describes the common processes (and acknowledges some key differences), will facilitate the routine implementation of FI in mental health services. Breadth of tools in delivering family work is important in creating choice and attending to the needs of a diverse population. This needs however to be balanced with pragmatism about what is achievable within the limits of services.

THE THERAPEUTIC RELATIONSHIP AND ENGAGING ALL THE FAMILY

Although models emphasise different concepts and techniques, they can all lead to positive outcomes as long as family members experience a sense of connectedness, hope, mutual understanding and warmth (Gracio et al., 2015; Lambeth & Barley, 2001). The therapeutic relationship also requires

attending to family members' needs and adapting to these when they change, and thus the sessions are 'family needs led' (Alanen, 2009). A respectful and curious stance also facilitates the ongoing therapeutic dialogue and helps ensure that the sessions are relevant and productive.

'The fact that they were obviously listening so intently, that's part of what people want, is to be heard with a capital H, and I thought that was just marvellous'

'Parents are concerned about being judged. This didn't happen. We were not made to feel responsible or judged or put in a box in any way.' (Mother and father)

The key task for the therapist is to form multiple therapeutic alliances and create a 'safe space' (Friedlander et al., 2011). This is done by emotional attunement (Seikkula, 2011; Seikkula & Trimble, 2005), responding to all the members of the family/network in a meaningful way and ensuring they have an equal voice. This means that in some cases the therapist would need to address power differences, including discrimination on the basis of gender, culture, class, religion, sexual orientation, etc. (Burnham, 2012). In order to do so, the therapist needs to feel sufficiently comfortable and competent, which means they need to have confidence in their therapeutic model and the therapeutic process (see further information on this in Chapter 5). This may include clinicians generally feeling at ease with 'not knowing', not being the 'expert'. A therapist engaging with a sense of confidence helps the family/system to feel a sense of hope and leads to better outcomes (Carr, 2009; Allen et al., 2012; Pilling, Roth & Stratton, 2011; Roth & Pilling, 2012).

'The way you do this is important, the way you talk to us, the way you ask us questions, it's not like you're going through a process, it's hard to describe or explain why.' (Mohammed, Service user)

All approaches attend to the importance of the therapeutic relationship and highlight the value of self-reflexivity. Cognitive-behavioural approaches highlight the importance of empathy and collaborative working for the development of the therapeutic alliance (Evan-Jones et al., 2009). Systemic theory contributes here in terms of techniques to explore our assumptions about normative family systems, as well as therapists' inner dialogue, and how this contributes to the conversation (Rober, 2005). The value of exploring culture in the development of the therapeutic relationship is explored further in Chapter 5.

ASSESSMENT AND THE INITIAL CONSULTATION

CONVENING

Different family intervention models approach the start of the therapeutic work in different ways. The key tasks will always include seeing if there is the possibility of a connection between the person with psychosis and their family/network and the therapists. In some cases, meetings are held with individual family members in order to assess this and in other cases, this is largely done in the first family/network meeting although there would also have been several phone conversations with family members prior to this. This may be particularly important for families from cultures different to the therapist's, and where power dynamics are particularly at play, and this may support the building of a therapeutic relationship.

Establishing who to involve in the FI sessions should be done by first contacting the person with psychosis to establish who is concerned about the situation, who is significantly affected by it, and who could potentially help them with their recovery (Fredman & Rapaport, 2010). Whilst it may be necessary to contact each member of the network who might be invited to the first meeting, it is often possible to convene the family sessions by speaking to one or two members of the family/network.

These initial convening conversations need to be tailored to the concerns and perspectives of the different family members, in order to begin to engage the family/network. In some cases, the family members will raise specific concerns, but in others it may be useful to suggest that family meetings may help them to ‘talk about their experiences’, ‘plan for the future’, ‘prevent relapse’, ‘reduce everyone’s stress levels’, ‘develop/refine coping strategies’ and ‘helping you get what you need from health systems’.

‘The therapists were pleasant, calm, helpful and patient. You didn’t feel oppressed in any way.’ (Mother)

BEGINNING A MEETING

The first family/network meeting should begin with introductions and may include a social phase or ‘problem free talk’ which deepens a connection, helps develop a whole person perspective, and elicits some of the resources within the system. Engagement of all members of the system is seen as crucial, and will be one of the primary tasks for the therapists in the first session.

The next step may vary depending on approach: A behavioural approach may focus on setting an agenda and explore options available. A systemic approach would usually then ‘track the referral’, clarifying the sequence of events/story of their journey to today’s session. For all approaches it is important to engage the family in family work by exploring each of their concerns and agreeing a focus for the work.

EXPLORING THE PROBLEM

All approaches will explore the problem in the first session with the intention of developing a collaborative way of working with the family. This is done in different ways. A CBT approach might be to explore different appraisals of the problem and explore cycles that might be occurring in the family as well as understanding the needs of each family member. A systemic approach would track the development of the systems/problems; mapping the effects of the problem on the network members; exploring their attempted solutions, previous interventions tried and service response to their help-seeking; and exploring the times when they are coping more effectively and the problems/symptoms are perceived as less severe.

‘Because before we didn’t know about her illness – no experience, nothing. My husband and my son... they thought she was acting, then after the family work...they understood little by little the problem.’ (Mother, Family D)

Some models such as psychoeducational models will meet with members of the family separately to discuss how they see the problem and talk about their own needs, as well as seeing the family together. Often this could be a place where conversations about family culture and power can be introduced. Ultimately it will be important to enable an open relationship about different understandings between the therapist and the family in a collaborative way (see Chapter 5 for more details).

‘They were very open, sympathetic and shared their views.’

‘The therapists didn’t take sides or become judgmental, but listened to the problems we had as a family.’

*‘It was possible to ask questions and discuss things. They would give frank answers.’
(Mother and father)*

AGREEING A FOCUS FOR THE WORK

All models would aim for a shared sense of purpose and this can be achieved in different ways. More structured approaches might introduce options for discussion and agree how these fit with the family's goals. In some cases, family members have clear, shared goals, but in others their goals may appear quite different and the role of the therapists is to help find connections between them, superordinate goals, or to acknowledge differences and ask the family to decide how to prioritise. A final task is to ask if the family members would like to meet to have further sessions and to agree the next session.

'They were very interested in the problems we were having as well as Philip's [son]. That was the first time that had happened, they knew that we were having problems, we were worried and we were suffering from stress. They realised that.' (Mother & father)

'Jenny has been able to use her relapse strategy and has not had a full-blown episode.' (Mother & father)

SUBSEQUENT SESSIONS

Family intervention models use different methods and techniques, ranging from primarily focusing on responding to people's words and working with the therapists' internal voices and embodied responses (systemic/dialogical), to teaching/practicing communication and problem solving skills (Behavioural Family Therapy). The different models and their methods are discussed more in Chapter 3. However the various methods and techniques have a common purpose, which is to create and facilitate a safe space in which family members can have helpful or therapeutic conversations. These therapeutic conversations could include the sharing and validation of feelings, developing a sense of hope, and developing a sense of agency, refining coping strategies, developing understandings and new perspectives, developing new skills, etc.

All approaches are intended to increase warmth and support improved relationships which has a significant impact on outcomes (Bertrando et al., 1992; Breitborde et al., 2007; Ivanovic et al., 1994; Garety et al., 2001; Kuipers et al., 2006); Some of this may be achieved through the exploration of patterns of behaviour and beliefs, by tracking particular incidents, or by learning communication or problem-solving skills as well as exploring family histories. All approaches would support the focus on understanding of difficult experiences (particularly psychosis) and coping strategies associated with this, some might do this in an explicit and direct way and some might explore indirectly and through conversations about each person's needs and their relationships.

'What helped was changing our communication between ourselves, improving that. Avoiding certain triggers.' (Client and wife)

'They were clearly communicating well as a network. Everyone seemed to know what was going on elsewhere in the service and what they were doing and we admire that, because it's not common.' (Mother)

It can be helpful to conclude each session by reflecting on what has been useful and what has been less useful, and what the focus might be in the next session. It is often useful to agree some tasks to be completed between sessions – these can include noticing something, thinking about something, practicing a skill, or achieving a behavioural goal.

It is the responsibility of the therapists to maintain safety within the sessions (e.g. to ensure that everyone is treated with respect and that everyone's voice is heard, and also to ensure that

concerns regarding risk and safeguarding are picked up on and dealt with). Using supervision and developing self reflexivity is important in ensuring this.

'I think the two people we had, they gave a different perspective and, if we said something, maybe one could verbalise it differently from the other and it was a good thing to have two different personalities.'

CO-THERAPY AND THERAPY TEAMS

Different approaches support different co-working relationships in family work. However given the complexity of managing several people in the room it is acknowledged by most approaches that there are benefits to working with a colleague although there are logistical challenges (Burbach, 2016b; Williams & Morris, 2015). Having colleagues to work with facilitates the development of multiple perspectives and the reflections/sharing of ideas between co-therapists or between members of a reflecting team (Andersen, 1991, 1995), and allows for open communication with the family. Working with colleague(s) also enables mutual support and live supervision in what can be complex and challenging clinical situations and contributes to their ability to create a safe therapeutic space (Jones, 1993).

Colleagues will be positioned differently depending on the therapeutic approach. Structured approaches, such as CBT based FIP, use the model of 'co-therapy', where 2 workers are both in the position of 'therapist', and tasks can be divided between them. Within a systemic or open dialogue approach, colleagues are positioned so that one therapist is the main interviewer, and the other(s) are positioned as 'reflecting team', allowing them to take on different positions and to reflect between themselves or with the interviewer, in the presence of the family, facilitating transparency.

When developing co-working relationships in family work it is important to:

- Set clear expectations for the co-working relationships in terms of tasks and roles.
- Allow time to meet before and after sessions to discuss either formulations and plans for the sessions or support self-reflections and self-positioning depending on model.
- Establish a supervisor to support the work and support the developmental needs of both practitioners with access to individual discussions as well as group.
- Set up an expectation that mutual feedback should be provided by co-workers after every family session, as a standard reflective tool for learning.
- Consider each of the co-workers' strengths and areas of developmental need, so that they can support one another to 'plug the gaps'.

It is important to pay attention to the co-working relationship as this is often an important marker and example for the family of collaborative relationships.

'They had two very clear roles and confidently interacted with us and each other.'

Within our FI service, we often co-work with another MDT professional. I worked with one colleague who I found to be directive and pejorative in her interactions with the family. I struggled in considering how to address this as she was not used to the model of regular mutual feedback. We also attended group supervision together so that didn't feel like a safe place to raise the issue, yet it felt disloyal and creating too much of an issue to seek out an individual meeting with a supervisor.

5. Working with diversity

Naureen Whittinger, Isaac Akande and Natasha Lyons

'I felt it was tailored to our family and how we could fix the problems between us'

KEY POINTS

- The importance of widening our view of families and social networks is particularly significant when we are thinking of working with diversity.
- It is important that service users from ethnic minority backgrounds and their families are involved in care planning.
- There should be good access to high-quality interpreting services and flexibility to work outside of traditional settings and regular audits should be conducted to monitor parity of access for all ethnic and/or racial groups.
- It is important for practitioners to be curious about the multiple and diverse ways in which families manage difficulties and distress and consider the possible impacts of their own personal identities within the family intervention.
- Where disparities in access and/or completion rates for family interventions exist for particular groups, there needs to be a commitment to understanding the barriers to engagement and addressing them in a meaningful way. This might involve building trust and understanding through close partnerships with referrers and community groups.
- People from ethnic minority groups experience multiple health inequalities, including being less likely to be offered psychological interventions. To develop an equitable service, it is vital that practitioners identify any biases in referral processes and the mechanisms by which structural racism may be impeding engagement, experience and outcome within family interventions.
- Family interventions training must equip practitioners to work with diversity and centre anti-racist and anti-oppressive practice. Practitioners should commit to ongoing self-reflexivity and curiosity about their own and families' socio-historical context and develop competencies in bringing this into their work with families.

INTRODUCTION

Diversity in the context of family intervention may be defined as the social variations that exist between and within individuals and families (Totsuka, 2014). The expansion of Social GRRRAACCEEESSS (Burnham, 2012), which stands for gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality, highlights the complex and evolving nature of the dimensions covered by the concept of diversity. Within society, these social variations correspond with power and privilege, thereby consigning structural advantage or disadvantage and maintaining dominance of some groups over others. Intersectionality theory (Crenshaw, 1989) states that these identities interact, compound, mitigate and intersect with one another, thereby shaping how one navigates through the world. To understand another's experience of social inequality requires consideration of ethnic background as well as age, appearance, gender and so on. As practitioners, our own aspects of

difference intersect with those of our service users and our own context and confidence influences what we explore (Butler, 2015).

To illustrate working with difference, we have selected three broad identities: 'race'/ethnicity, faith/spirituality and neurodiversity to focus on in this chapter. This does not however negate the importance of other identities, nor do we intend to reduce the complexity of human experience by locating all individual experiences within group identities. We hope that some of our reflections and guidance will be applicable to intersectional practice in the context of family work, however it remains important that readers seek specific resources and experiential training opportunities where available.

As described in the terminology chapter, 'family' is a shorthand for a range of relational structures, acknowledging that the word 'family' might define our thinking about who to include in family interventions. We suggest practitioners ask service users about significant others from extended family, social and care networks who they wish to invite to appointments. This is preferable to imposing definitions which run the risk of reinforcing dominant, oppressive and exclusionary assumptions of Eurocentricity (Singh, 2009) and heteronormativity (Hudak & Giammattei, 2014).

Family interventions provide opportunities for conversations about diverse experiences, for example, through attending to Social GRRRAACCEEESSS. However, cultural norms, discrimination and injustice may impact the engagement and responses of family members. For example, shame or fear of judgement might lead family members to generate socially desirable statements and omit beliefs or values that are important to them. Furthermore, mental health consultations for people with a schizophrenia-spectrum diagnosis, including family interventions, typically neglect issues important to service users such as their sexual needs (McCann, 2003). The explanatory role of patriarchal oppression and gender-based violence (Brown, 2020) as well as racial trauma (Ahsan, 2020) may also be commonly overlooked. Practitioners should be cognisant of these factors, maintain curiosity and create a space for exploration in a manner that is led by the service user and family.

Clinical guidelines for psychosis and schizophrenia (National Institute for Health and Care Excellence (NICE), 2014) recommend adaptations to assessment and interventions for people from diverse ethnic and cultural backgrounds. Additionally, to facilitate the provision of culturally appropriate interventions, NICE advises clinicians to seek specialist supervision and develop partnerships with community organisations. An independent review of the Mental Health Act (UK Government, 2018) recommended that NHS England develop a Patient and Carer Race Equality Framework, which specifically aims to support access to family therapy for people from ethnic minority backgrounds. An important aspect of this work will be to increase access to practitioner psychology and/or family therapy training in the service of a representative workforce (Myrie et al., 2020; Turpin & Coleman, 2010; Williams et al., 2006). This is discussed further in Chapter 8.

ATTENDING TO DIVERSITY IN FAMILY INTERVENTIONS

Practitioners should endeavour to create safe spaces for families by attending to aspects of power and privilege in the therapeutic space and the potential for discrimination and oppression within dialogue. They should especially consider the impact of visible aspects of themselves and the professional system and look for opportunities to open conversations about these differences and/or similarities. This is of particular importance within a profession as homogeneously white, female and middle-class as clinical psychology and other practitioners likely to be offering family work (Longwill, 2015; Williams et al., 2006).

Practice example: Clinicians worked with a family where the parents were a (female) same sex couple. At their request, separate sessions for the couple were arranged. This gave them the opportunity to explore some concerns that they found difficult to express with other family members present. This included their worries about their status as a gay couple having led to difficulties for their children (such as bullying at school) and their sadness that their relationship had not been accepted by some of their extended family.

WORKING WITH RACE

In the UK, increased incidence rates of psychosis within ethnic minority groups, especially for Black people (Fearon et al., 2006; Kirkbride et al., 2012) highlights a critical need for family interventions that are accessible and acceptable to people from diverse racial backgrounds (Edge et al., 2016). Studies suggest that membership of a marginalised ethnic group (Selten et al., 2020) social disadvantage and linguistic distance (Jongsma et al., 2020) are the greatest predictors of the increased incidence in certain groups. This reflects the multiple disadvantages faced by people from ethnic minority backgrounds across the lifespan. Through attending to social and contextual factors in family interventions, these important elements of understanding can be brought into the conversation improving the quality of the relationship and hopefully outcomes.

Mental health settings are not immune from the pervasiveness of interpersonal and institutional racism. In the UK, a disproportionate number of people from ethnic minority groups are detained under mental health legislation and subjected to longer admissions and restrictive practices, including compulsory admissions, restraint and seclusion (Bhui et al., 2018; Crisp et al., 2016). Such stark inequalities have been widely reported for decades with no alleviation of the racial disparities. For people from ethnic minority backgrounds, institutional punishment, detention and social exclusion across the lifespan can create a cycle of avoidance and disengagement with mental health services, which can contribute to poor outcomes and more restrictive clinical practices (Bhui et al., 2018; Keating & Robertson, 2004; Schoer et al., 2019). Black people are also more likely to come into contact with mental health services through the criminal justice system than White British people (Bhui et al., 2015) and less likely to see someone from their own racial/ethnic background when they do enter services (UK Government, 2018). In the service of increasing engagement for groups that are underserved, it is important that practitioners working with families are aware of these issues and take steps in addressing racism where it is reproduced.

On an individual level, family practitioners should seek to reduce racial and ethnic inequalities by acknowledging their own perspectives, leaning into the discomfort of one's own racism, seeking counter stories from marginalised perspectives and confronting ideologies that perpetuate racism (Ahsan, 2020; Combs, 2019). As for all families it is important that care and attention is taken to involve families from ethnic minority backgrounds meaningfully in care planning as discussed in Chapter 3. In addition, there should be good access to high-quality interpreting services and flexibility to work outside of traditional settings and regular audits should be conducted to monitor parity of access for all ethnic and/or racial groups.

Practice example: In Croydon, to support access to the service for people from ethnic minority backgrounds, clinicians regularly talk to referrers about positive outcomes for diverse families through family interventions to demonstrate that family interventions can be helpful for minoritised ethnic communities. Ethnicity data is audited regularly and reviewed. Where referrals aren't representative of the wider community and/or service user group, positive action is taken.

When working with service users who experience linguistic barriers within the mental health context, practitioners need to be prepared to adjust session pace, adapt their questions and be conscious that styles of emotional expression may differ from their own. To assist families in exploring more of what makes sense and matters to them, practitioners should move away from an ‘expert’ position and facilitate joint exploration of family beliefs and practices in a manner that gives space to truths outside of the therapists’ vantage point. This requires a shift from postulations based solely on dominant understandings of distress, wellbeing and healing (Memon et al., 2016).

‘We had a problem with understanding the language and understanding our culture and it would have been better for someone from an Asian background to explain our problems to. We are from Sri Lanka and our culture is different.’ Mother of service user

Psychological assessments and practices are neither objective nor neutral. Many innovations in the development of family interventions for psychosis were underpinned by research on the associations between high Expressed Emotion (EE) in family relationships, specifically criticism, hostility, or emotional over-involvement, and increased relapse rates (Butzlaff & Hooley, 1998; Weintraub et al., 2017). Any evaluation of the dimensions of EE should however consider the family’s cultural context and norms; for example, emotional involvement varies across different cultural groups according to expectations regarding what constitutes ‘caring’ and appraisals of their relative’s difficulties (Bhugra & McKenzie, 2003; Rosenbarb, 2006). See Ade-Serrano & Nkansa-Dwamena (2020) for detailed guidance on working therapeutically with people from ethnic minority backgrounds.

‘I wouldn’t change much, but I did feel they were dealing with a different culture when it came to our family. If they had a little bit of understanding of our culture, it might have helped.’ Son of service user in Family E

WORKING WITH RELIGION AND SPIRITUALITY

Religion and spirituality are often interwoven into family life, and for some people, can be integral to their recovery process. Practitioners often experience barriers to incorporating spirituality in therapy despite evidence that service users can find this helpful (Holmberg et al., 2017). Service users with experience of psychosis have described holding shared religious beliefs, being part of a religious community and jointly participating in religious activity with family and friends as beneficial, however feared judgement from within and outside their community (Heffernan et al., 2016). Family interventions can facilitate discussions that incorporate all aspects of religion and/or spirituality that hold personal salience. Moreover, it may provide the opportunity to explore adaptations that would facilitate religious observance, for example, listening to scriptures when reading is difficult.

Practice example: Jamaal, an observant Muslim refugee, was preoccupied with the voice of his late mother, causing him to isolate from other family members. His worker respectfully enquired about his beliefs about death. Jamaal described how his mother had supported him throughout his life, including assisting him to safety, but he had not completed his duty to care for her at end of life. Recalling a verse in the Holy Qur’an that reminds mankind that death is inevitable, was helpful to him in moving towards an acceptance of God’s will.

Practitioners should consider what their own spirituality and/or religion means for them in relation to their work with families. They should explore differences with sensitivity and an awareness that individual, sectarian and geographical factors influence the expression of religion and spirituality.

Some religious principles may encourage or permit the adoption of family structures, rituals or gender roles unfamiliar to the clinician. Practitioners should be prepared to accept a position of not knowing and be courageous in working towards overcoming the barriers to exploring and working with religion and spirituality (Holmberg et al., 2020).

Practice example: Ruth is a 17-year-old woman from a Plymouth Brethren family. Practitioners recognised their limited awareness of the practices of the Plymouth Brethren and their worries about saying the wrong thing. Supervision provided an opportunity to consider how they might ask curious, but respectful questions to try and understand more about Ruth's background within the context of family therapy sessions. The family were able to discuss their religious beliefs and their views on gender roles and morality throughout the work.

NEURODEVELOPMENTAL CONDITIONS AND LEARNING DISABILITIES

Where psychosis coexists with a neurodevelopmental condition and/or learning disability, this adds complexity for both the family and professional care system. Family interventions can support families to understand and manage the different ways members with both autism and schizophrenia-spectrum diagnoses may express distress (Bell et al., 2018). NICE (2016a) recommends adjusting the method of delivery and therapy duration where individuals have a learning disability or cognitive impairment; this could be through shorter sessions, frequent breaks, assistance with therapy tasks and routine review sessions. Practitioners should ideally engage in preparatory work with the family to establish viable communication methods. Slowing down sessions, having a clear structure and communicating the session plan can also alleviate anxiety for family members who might otherwise struggle with uncertainty.

For adults with both autism spectrum disorder and learning disabilities, NICE (2016b) recommends structured family approaches that emphasise behaviours rather than cognitions and facilitate collaborative progress towards therapeutic goals. Alternatively, systemic family therapy might create space for valuable reflections on power and context (Bownas & Fredman, 2016). Offering choice and tailoring family interventions for individual families is recommended. This is particularly the case considering the absence of high-quality research exploring the effectiveness of family therapy for people diagnosed with autism spectrum disorder, let alone those who also have experience with psychosis (Spain et al., 2017).

Practice example: Clinicians worked with a family where the father, who was the service user, had a diagnosed learning disability. The family intervention was underpinned by Behavioural Family Therapy, which involved the use of written cues to support the development of communication and problem-solving skills. In collaboration with the family, practitioners adapted these resources to create pictorial cues. The pace of the intervention was also adapted to allow the introduction and practice of skills over two or three sessions rather than just one. Practitioners attempted to focus on strengths rather than deficits, highlighting the contribution of the service user in supporting others in the family to engage in pleasurable activities.

WORKING WITH OUTSIDE AGENCIES AND INTERPRETERS

A long and continuing history of institutional oppression and violence against marginalised groups contributes to ongoing mistrust of mental health services and beliefs that psychological interventions are reserved for certain groups (Byrne et al., 2017; Keating et al., 2002). Building trust through partnerships with community groups and religious leaders and working outside of traditional clinic settings are ways in which family interventions can reach, and subsequently

benefit people who would not otherwise access mainstream services. Support from specialist services may also aid the intervention process within family therapy.

Practice example: When working with a deaf family, the practitioners co-worked with a charity for deaf people that facilitated access to a sign language interpreter who could connect with the family and their specific challenges. This fostered increased trust between services and the family.

The British Psychological Society's (BPS, 2017) guidelines on the use of interpreters offers practical advice on several issues associated with the use of interpreters (see also Tribe & Morrissey, 2004). The guidance notes: 'it is fundamental to avoid discrimination by ensuring equal access to psychological services for non-English speakers, including those who use sign language' and suggests that, if one family member is comfortable using English but others are not, then it is preferable to use an interpreter rather than ask that family member to interpret. Delivering family interventions with an interpreter means that dialogue invariably takes longer, with extra time needed for checking the family's understanding. Meeting the interpreter prior to the session is essential in helping them to understand the purpose of the work and the importance of interpreting without omissions, additions or distortions.

In arranging an interpreter, service user and/or family preferences and disinclinations towards people with specific dialects and/or from particular ethnic backgrounds should be noted. Intergroup oppression and prejudice, or a history of political violence can inhibit trust and engagement with some groups, not to mention run the risk of retraumatisation. Families from close-knit communities might prefer an interpreter from a different region due to understandable concerns about someone from their network learning private details about their family. It is important that practitioners explore the family's satisfaction with the interpreting provision and where there is a poor fit, an alternative interpreter should be sought. Providing there are no issues with the provision, it is usually preferable to book the same interpreter to ensure consistency across sessions.

The inclusion of individuals from outside the service user's close network requires careful consideration. Practitioners should note interactions between outsiders and members of the family and be cautious about information the service user and/or their family may not wish to share. However, having someone present who shares aspects of the family's socio-cultural background and/or can interpret nuances of their language and culture can enrich the family intervention process.

TOOLS FOR WORKING WITH DIVERSITY

Within the training and supervision context, various ideas for exploring Social GRRRAACCEEESSS have been proposed by Burnham (2012) and others (Divac & Heaphy, 2005; Totsuka, 2014). Practitioners should be supported to gain knowledge of a range of tools and adaptations to standard practices that will support them in their work with different families. For example, alternatives to the standard genogram such as cultural genograms (Hardy & Laszloffy, 1995), ecomaps (Hartman, 1995) and family mapping exercises (Tasker et al., 2018). A number of adaptations also exist for working with intercultural couples (Reibstein & Singh, 2020; Singh & Dutta, 2010).

In addition to attending to the service user and/or their family, practitioners should be supported to explore their own family experiences; for example, to reflect on differences between themselves and families with respect to ecological context, migration and acculturation, family organisation and family life cycle (Falicov, 1995). Practitioners, especially those whose background and/

or appearance is allied with privilege, should be prepared to engage with any discomfort that might arise from interrogating one's own assumptions; for example, unpacking what it means to be white (Nolte, 2007). Those from minority backgrounds should be supported to connect with the richness of their experiences and how it may manifest in therapy; for example, psychological therapists from ethnic minority backgrounds (Odusanya et al., 2017; Spalding et al., 2019) and practitioners who are migrants (Kissil et al., 2013).

An example of good practice based in research is from the project team exploring culturally adapted family intervention for families of individuals of African and Caribbean origin with a schizophrenia-spectrum diagnosis (Edge et al., 2018; Edge & Grey, 2018; Jensen et al., 2021). The project consisted of several adaptations to improve engagement and provide a culturally adapted intervention, including meaningful co-production with experts by experience, cultural competency training for therapists and the inclusion of family support members where a service user did not have access to their biological family.

THE ROLE OF THE PSYCHOLOGIST

- Psychologists can take active roles in identifying and addressing barriers to access for minority and disadvantaged groups, including monitoring access to family interventions through regular audits. Where disparities exist, this should be addressed through creative efforts (see for example, Edge et al., 2018; Jensen et al., 2021).
- Individual appointments remain standard practice in most adult mental health teams. Inviting service users to bring family members to standard appointments is one way to engage families outside of specific family interventions (Batten et al., 2020) and there is a role for psychologists in leading on such initiatives within services.
- Psychologists may be actively involved in the development and/or delivery of training in family interventions within their service context. They can ensure training programmes include a focus on diversity, anti-racism and anti-oppressive practice.
- Psychologists can contribute to developing the literature base for family interventions by conducting service evaluations that involve a representative sample of participants and sharing good practice. It is important for such projects to consider contextual factors, including racism, poverty, social exclusion and oppression.

FURTHER RECOMMENDATIONS

- Practitioners need to be willing to acknowledge strengths and learn from families, especially in relation to culture, racism, other forms of discrimination and abuse, models of mental health and spiritual beliefs.
- Service users should be invited to play an integral role in their care planning, including choosing who constitutes 'family' for them. Some families may prefer to meet in non-traditional settings. Online interventions should be offered if families prefer this way of working, particularly when this allows for the inclusion of family members who are geographically distant.
- Practitioners should recognise that many people from minority backgrounds will have a history of difficult relationships with statutory services. It is important to acknowledge the role of structural inequality and power relations and allow time to build trust.
- Based on the presence of any health inequalities that exist for specific ethnic minority groups and/or other minoritised communities within family therapy provision, it is crucial for practitioners to investigate the underpinning barriers and subsequently work towards addressing them. For example, highlighting positive outcomes to clinical teams, joint visits with referrers and 'myth busting' about what therapy is and who it is for. See the BPS (2020) report on *racial and social inequalities: taking the conversations forward* for information on the five Rs framework for tackling inequalities and racist practice.
- Many family approaches adopt a *non-expert* position. However, it may be necessary to flexibly offer more direction where this fits with the service user and/or their family's preferences and expectations.
- Supervision is vital for building skills around working with difference and reflecting on what the practitioner brings to their relationship with each unique family.
- Work needs to be undertaken to support a representative workforce. Families are more likely to feel understood if they are represented within the psychological workforce. All family practitioners should be trained and supported to reflect on racial and ethnic inequalities and support conversations around difference and diversity.

It should be noted that a myriad of visible and invisible aspects operate within families at any given time, thereby offering the practitioner multiple lenses with which to understand and appreciate each family's restraints and resources. Although a lot has been written about the challenges of engaging and working with diverse groups, practitioners who take courageous steps towards meaningfully engaging with issues of diversity will encounter experiences with families that inspire, illuminate and expand their repertoire.

6. Journey through the system: Family work in different services

Patricia Smith and colleagues

KEY POINTS

- Family services vary a great deal across settings, in configuration and availability. Early Intervention Services tend to be better resourced than many other teams, but still typically lack capacity to offer input to all families in the way the NICE guidelines recommend. Family services tend to be expanded or curtailed according to available resource provision, rather than service need. All services need support for families.
- Given the uneven provision, families may move through services without ever being offered family support. Alternatively, they may be unaware until they move on from a better resourced service, such as EIS or Forensic, that the family support available is minimal or absent in their new team. Family support and intervention should be offered in each service. Particular care should be taken in adjusting to transitions between services which can be distressing for families as well as individuals. Families may take some time to accept support for themselves so support should be continuously offered
- Carers of people who used substances have reported significantly higher levels of anxiety than carers of people who do not use substances (Cleary et al., 2008). Substance misuse issues occur across settings. Specific training for staff working with families of those with dual diagnosis should be provided.
- Families need support to navigate and coordinate their loved ones care through the complex mental health system and other services, such as police or forensic services.
- There are some specific themes and practice recommendations within different settings, depending on the service context and circumstances that brought the service user into the setting.

INTRODUCTION

This chapter aims to discuss some of the issues affecting families and couples across the main mental health services. It is split into specific service settings for easy reference, however there are commonalities and differences. Early Intervention, Crisis and Acute, In-patient Rehabilitation, Community Secondary Care, Dual Diagnosis, and Forensic settings are discussed, although of course other configurations can be found.

Research suggests carers are often the first to become aware of their relative's mental health difficulties and seek help (Carter, 2011). Early contact with services varies, and may include children and adolescent mental health services (CAMHS), Early Intervention for Psychosis (EIP) services, and admission teams. At each stage, different family issues may be prominent, including understanding diagnosis, managing familial stress, exploring recovery, negotiating care systems, and managing care-giving. Linked to this, different aspects or approaches in family interventions may be more important at different stages. This chapter aims to illustrate specific service issues and commonalities across services, along with clinical examples, recommendations and learning points.

EARLY INTERVENTION SERVICES

Early Intervention in Psychosis services were set up to provide specific early support for people experiencing psychosis for the first time. In the original approach family support was seen as key. However how local services have implemented these services has varied. In 2015 the EIS Access and Waiting Time Standard (NHSE, 2015) was introduced. EIS teams are now mandated to offer a package of care compliant with NICE guidance and associated quality standards including family interventions. Although in many places this has led to an increase in provision and certainly highlighted the need for family interventions, the additional funding and the widening of the EIS remit has not always translated into increased resources for local teams.

EIP services should be the first point of contact for a person experiencing first episode psychosis (FEP). At this difficult time, families can experience elevated anxiety, anger, distress, and fear, partly because they may struggle to understand what their loved one is experiencing, or what to expect in future. Family inclusive practice is important at this stage to support adjustment to this difficult experience.

'It was 18 years too late... we felt it was suitable for someone at the beginning, not where we were at.'

A common factor across all approaches is that family interventions provide a space to address complex feelings. Service users and families may feel disbelief that there is a mental health issue. If it is a new experience, families can feel lost and uncertain about how to best manage the changes. Some families may feel guilt for initially seeing the changes as a behavioural problem, especially if this led to delay in seeking help or treatment. Families can express feelings of loss and grief over the changes in their loved ones. These feelings can be expressed as frustration and anger. On the other hand, families may feel closer to one another as adversity brings forth the strengths and resources in the family.

If the loved one becomes withdrawn, and uninterested in self-care or activities, families may react by doing more for them, and in the process put their own life plans to one side. These issues easily result in family discord and can impact on the service user. Additionally, family members may be less inclined to recognise their own needs at this stage, as they focus on their loved one and the help they need. In this context, family interventions can support the maintenance of individuals' personal and social functioning.

The purpose of family interventions in an EIS setting is to support the early engagement of clients, their family and network in a manner that is de-stigmatising, tolerates differing perspectives and highlights supportive resources within the client's network. Information sharing and sitting with families' distress are particularly important in this setting.

Early intervention services often support younger people who are more involved with family members and have younger members who use technology, therefore using different methods of supporting families are important.

CRISIS AND ACUTE SERVICES

'When you are in periods of crisis, you want the help then and if you don't get the help you become despairing.'

Admissions to hospital can provide access to interventions, containment and respite from external stressors. Research has also suggested a crisis can also be an opportunity for change (Seikkula et al., 2001). However, hospital admissions can also be experienced by many as distressing and frightening (Schizophrenia Commission, 2012). Family members may find wards intimidating (Askey

et al., 2009) and experience the same degree of ‘burden’ and ‘burnout’ as nursing staff (emotional exhaustion, depersonalisation and reduced personal accomplishment; Angermeyer et al., 2006).

‘It came at the right time, at the time I was unwell and my son was in a clinic so it helped us a lot to motivate the spirit.’

Family members often report feeling unacknowledged by hospital services, with concerns about communication and exclusion from care planning. They want health professionals to listen, answer questions, and understand their relative’s mental health (Radcliffe et al., 2012; Brennan et al., 2016; Olasoji et al., 2017).

The short-term nature of crisis services means FI needs to be flexible, and range from therapeutic conversations, to psychoeducation and problem solving, to family therapy.

FI within a Home Treatment Team (HTT) setting may be of considerable value, but is not commonly available in the UK at present. HTT is shown to be effective in reducing self-harm and hospital admissions (Dieterich et al., 2010; While et al., 2012), and importantly, a HTT may be experienced as less stigmatising (Cornelis et al., 2018).

Studies have found family interventions in an inpatient setting to be well received by families and carers, to reduce complaints and improve family inclusive practice. (Carter, 2011; Radcliffe et al., 2012; Taylor et al., 2016). Ward and HTT staff may require further training or protected time to take part in FI provision and support family inclusive practice (Griffiths et al., 2020).

In conclusion, available studies and practitioner experience indicates that it is extremely important to work with families during and after admission or crisis. This offers an opportunity to work closely with families and service users, to reduce distress, and potentially facilitate earlier discharge from inpatient settings.

SECONDARY CARE COMMUNITY SERVICES

Service users and their families enter secondary care with variable previous experience of services. Families may have experienced contact with only EIP, or conversely, with multiple teams. Many service users will have experienced repeated acute admissions before arriving in secondary care (Joint Commissioning Panel for Mental Health, 2016). They may or may not have experienced family work, and may still struggle to make sense of on-going mental health issues, and the mental health system itself. The whole family may also have experienced admissions and relapses as traumatic events that require support to process (Brennan et al., 2016).

In this context, restoring trust in services may be the first stage of engaging with families, which may require a complex process of flexible engagement. If this is successful, common issues that arise include families’ struggles with a sense of grief for lost elements of the loved person’s personality, and possibly the loss of future ambitions for them, as well as acceptance of enduring or intermittent mental health issues. The challenge of families providing on-going support to the service user is a common issue, and feelings about this may change as the family and service user grows older. Negotiating appropriate levels of independence and connection can be important at this stage. Families may fear their loved one experiencing another relapse and may struggle to find appropriate distance in the relationships in efforts to prevent this.

Because of the complexity involved at this stage in someone’s journey, family meetings may need to be held with different members of the family at different times. Therapies which enable an idiosyncratic and flexible approach are very helpful, in allowing maximum flexibility and space in taking into account the specifics of the individual current family.

'We've actually had this safe space in the sessions, the space we wanted to have... I think there's an understanding that we all needed a safe space, like where [service user] is saying he didn't have one, I felt like I didn't have one ... we all needed it.'

It may be important to allow space for historic events to be explored and processed, for all family members to support recovery for all.

Trauma such as sexual abuse and violence are relatively high in psychosis (Schafer & Fisher, 2011) and may be represented through family generations. Other family members may need support to access services for themselves. Space to safely voice and process this is extremely important. It may be necessary to convene sessions individually sometimes, to allow for some issues to be given voice.

'It helped me to say things ... I've never spoken to anyone about, ever. I feel freer and less guilty because talking helped me realise that if someone takes advantage of you, it's not your fault. I feel free now because I talked it through a lot more than when I first started, because now I have freedom to speak.'

DUAL DIAGNOSIS SERVICES

Approximately 40 per cent of people who present with psychosis also misuse substances at some stage of their life (NICE, 2011). Substance misuse in families is associated with additional stresses and burdens, including increased conflicts and abuse; disrupted routines and communication; financial pressures; criminal justice involvement; isolation and emotional problems (Orford et al., 2010). As a service-user explained, *'a normal lifestyle isn't possible, it's a constant battle. People end up not eating, staying up all night, borrowing or stealing money or even sex working to fund use.'*

There are also increased risks of relapse of mental health problems/crises. One family member noted the risk of relapse from cannabis for her daughter: *'Skunk is a big problem; she struggles to manage it because she is vulnerable. She finds it hard to take on board that the reason she keeps going back into hospital is the skunk'*. Interpersonal conflicts may arise when families become frustrated with persistent substance use that the person using does not perceive as problematic (Barrowclough et al., 2006).

Given the emotional burden on those caring for people with addictions, family members may need additional or separate input, particularly focusing on finding more effective ways of coping and enhancing social support (Copello et al., 2010).

Interpersonal conflicts may arise when families become frustrated with persistent substance use that the person using does not perceive as problematic (Barrowclough et al., 2006). Family members may underestimate the client's difficulties with psychosis; blame the individual for substance misuse; may find it particularly difficult to put the responsibility back to the service user; or make excessive sacrifices (i.e. time and finances) to resolve problems (Barrowclough et al., 2000). There can be a breakdown of relationships. As one carer summarised, *'it's very stressful, there are times when [my child] is very unappreciative and ungrateful, so it can be hard.'* Unfortunately, it is common for service users with these difficulties to have limited or no contact with their families. It should also be noted that there are particularly high rates of childhood abuse and trauma in the dual diagnosis population (Horsfall et al., 2009), which in some cases may mean that people have grown up in care or do not want contact with families as adults. Where relationships have been maintained, these may be quite fractured, and it is likely that there will be high rates of expressed emotion (Barrowclough, 2003). Engaging people with dual diagnosis issues can be particularly challenging (Cleary et al., 2008). As one service-user explains, *'drugs are the first thing you think about and the last thing at night, nothing else matters; so, meetings*

and appointments are much less of a priority.' All efforts should be made to make interventions flexible to people's needs and involve service users where possible. However, when this is not possible, support and interventions should still be offered to family members and carers.

The provision of therapies (including FI) can potentially contribute to breaking a cycle of substance misuse. As a past service user explains, *'using drugs is often to do with not wanting to deal with the pain and realities of life.'* Taking a non-judgemental and non-critical approach to people's substance use can help with engagement, disclosure of use, and accurate assessment. Mental health professionals can *'help break down stigma and help families understand what's going on.'* As skilled therapists and senior members of teams, psychologists are able to model this position to others, including family members and other professionals.

This area of family work may present additional risks. Consideration should be paid to session location, aiming to enhance engagement and assess potential environmental risks. It is important to contract how you will manage intoxicated presentations, and make explicit when you would need to report specific disclosures of criminal activity. When working with families, it is essential to thoroughly assess the specific substances used, as well as the amount, frequency and method of use. This enables better understanding of risks and the impact of use on the family or system.

In keeping with the 'Stages of Change' model there is a need to match interventions to stages of motivation and goals (Barrowclough et al., 2000; Graham et al., 2003). When people are at different stages of change, it is advised to focus on those at the earlier stage with support to those at the later stage (Mueser & Fox, 2002). This may involve a functional analysis of the positives of and reasons for substance use, as well as the costs of decreasing use. Training family members in the principles of Motivational Interviewing has also been trialed and may be useful (Smeerdijk et al., 2014).

Whilst family members need to be supported to maintain a non-confrontational approach, they also need help setting appropriate boundaries for consequences of substance use on the family and in containing risks (Barrowclough et al., 2000, 2003; Mueser & Fox, 2002; Graham et al., 2003). Family interventions can play an important role in relapse prevention of both substance misuse and psychosis. A previous service user stated that after abstaining from substances, *'it was useful to have people to keep an eye on me, they need to understand and be aware of the signs for both.'*

FORENSIC SERVICES

Most people who experience psychosis will not encounter the criminal justice system. However, for those that do, offending behaviour may occur alongside, or be a consequence of, their psychotic experiences. For these individuals, as well as recovering from mental health problems, they also need to address their offending behaviour. This process may include the need to come to terms with issues of self-identity such as shame, alienation and shock related to the offence. Family, friends and carers of service users may also experience shock and trauma related to the offending behaviour and associated mental health difficulties. In some cases, family members may be victims or witnesses to offending behaviour.

Before any intervention can begin, the geographical challenges need to be considered. Most inpatient forensic services are medium secure (NHS Benchmarking, 2016). Such services cover large geographical areas, often incorporating a number of counties. It is common for families to have to travel over 60 miles to reach their 'local' medium secure unit. For those in conditions of high security, they may have to travel over 250 miles to reach their 'local' service. Therefore, the practicality of getting the family in the room together is an important consideration.

Families in contact with the forensic setting are likely to be struggling to negotiate a multitude of agencies including the criminal justice system, the prison estate, the probation and mental health services. Pre-trial, there may be a level of uncertainty about the outcome in terms of where the service user will go and for how long. There may also be legal constraints that limit certain conversations or prevent the family from having contact with the service user. Therefore, when to offer family interventions is an important consideration.

Central to the work can be the processing of the index offence (the crime that brought the service user into services) together with an understanding of the role that mental health difficulties played in the offending behaviour. This is important not only for the person who committed the offence but also for their family, who have to come to terms with their relative's actions. This can lead to the development of a shared strategy for relapse prevention and consequently risk management.

Where the victim is outside of the family unit there will be another family, likely in distress, and forever connected to the family in the room. This may or may not be discussed openly in the work or may be alluded to through symbolism. Often there are strong emotions including guilt, shame, anger or even envy associated with the other family.

About 13 per cent of victims are family members. Where a family member is the victim, they are more likely to be seriously or fatally injured (Nordström & Kullgren, 2003). These families are less likely to engage in family interventions (MacInnes, 2000). If they are willing to engage, consideration needs to be given to the complex array of emotions that may be associated with the offence.

Any family work done in forensic settings should be done in collaboration with the ward staff. It is recommended that ward staff should be aware of the session and the practitioner has all the relevant contact numbers – to call the ward if there are any issues. There should be handover to ward staff after the session. Risk assessments should be completed for all those involved and the emotional impact of such work considered.

FAMILY INTERVENTIONS DELIVERED VIRTUALLY IN A SECURE SETTING

There are real benefits for virtual FI within forensic settings where factors such as location and risk might have prevented this from happening. The regional nature of forensic units can mean they serve large geographical areas, making it difficult for families to attend. Forensic inpatient settings also often serve foreign nationals typically from local prisons. Additionally, there can be risk issues which might make it challenging for all family members to be in the same room.

The nature of forensic environments can add additional challenges to delivering family interventions virtually. Some service users and units might have restrictions which limit access to IT. Information governance and confidentiality should be discussed with all involved.

It is recommended to talk through how you will deal with the call dropping and ensure everyone is aware of their roles: e.g. service user will return the device to the office for support around re-establishing contact; FI practitioner will contact family members via phone if not able to resume the call and; plan for continuing sessions, test calls are helpful to maintain smooth running of a session.

In a low secure service in Sussex, we have procured tablet devices to support service users to remain in contact with their families virtually. We are also using these devices to offer virtual FI especially in the current context of clinicians working remotely during the COVID crisis. It allows the FI practitioner working remotely to link with the service user on the ward and family members at home using AttendAnywhere.

RECOMMENDATIONS

- Family friendly/sensitive and inclusive practice should be developed as the basis to family work, in all services.
- Working collaboratively and flexibly with families to provide a range of family interventions will meet the needs of families across services. Families need to be offered family interventions at every stage of their journey through services. Over time, families may benefit from more than one type of intervention. Consideration should be given to the level of complexity and risk and consider the most appropriate clinician with the appropriate skill mix.
- There are some specific considerations in each setting and those delivering family interventions need to have some understanding of what is important for that setting.

7. Adaptations for different family groups

Maria Griffiths, Sophie Holmes and Frank Burbach

KEY POINTS

- Family interventions can support a variety of different family groupings.
- Different considerations are needed for different groupings.
- Work to support those not in the room and the importance of supporting the welfare of children involved is important.
- Consider remote sessions via videolink when face to face sessions are not appropriate or to facilitate engagement of geographically dispersed families.

INTRODUCTION

The original evidence base for FI emerged primarily in the context of an adult child experiencing psychosis being seen with one or both older parents, most commonly the mother (Scazufca & Kuipers, 1997). Families will however present with many different kin relationships. Glynn et al. (2006) noted that the demographics of families being seen has changed over time in the context of recovery oriented services in the community, and that the FI literature should take fuller account of different kin relationships, such as couples and families with young children. Similarly, there has been a recent drive to highlight the needs of siblings, largely arising from the Early Intervention research context (e.g. Sin et al., 2008).

Family intervention for psychosis has to be able to respond flexibly according to the particular circumstances experienced by the person. Understanding the wide-ranging problems faced by families is the first step to working on identifying individual and unique solutions for families. This includes taking careful account of the cultural background of each family in order to understand the context for their difficulties. The same flexibility in family intervention is essential when considering who to include and how (see Chapter 5 for further conversation on this topic).

Changing involvement in family sessions often influences the nature of the work, and deciding who to include may relate to continuity of attendance. There may be different relatives, friends or partners coming to consecutive sessions or relatives may drop out and then re-engage later. This could reflect a range of issues such as demands on their time, or their ambivalence about their role in supporting the person experiencing psychosis.

Family member: 'Time was a difficult thing, time and the continuity to enable everybody to be there at one point; that was difficult. Some weeks one could be there, the other could not be there and although we spoke about it and filled each other in and maybe there were handouts left behind and we would distribute that among ourselves, it was difficult to keep that momentum so that we could go from one session to another and pick up continually.'

It is helpful, where possible, to agree in advance who will come to sessions, whilst remaining open to the inclusion, at any stage, of someone who has previously struggled to attend. Families

may also wish to include grandparents, aunts, uncles, and even nieces or nephews, with different needs and expectations for different generations.

Family member: 'We all took part, even auntie, she got an interpreter. The whole family went the first time and after a while it was just me and my husband and son who went to [the resource centre] for the family work.'

The person themselves may have strong wishes to include some family members, but not others. Families from different cultural backgrounds may be more or less inclined to involve extended family and other members of their community (Edge et al., 2016). The needs of different family members must then be considered, offering separate sessions for relatives to raise their own concerns or questions, even if the person experiencing psychosis does not wish to involve them. It is always useful to know from a family how they might usually approach such things, in order to respect each family's unique culture.

ISSUES TO CONSIDER FOR DIFFERENT FAMILY GROUPINGS

WORKING WITH PARENTS OF AN ADULT CHILD EXPERIENCING PSYCHOSIS

Referred families often comprise the person experiencing psychosis being seen with their parents, who may be providing significant and longstanding support. It is often important to think with the family about the nature of their relationships and how living with psychosis might have impacted on an individual's independence from their family which may be important to discuss.

'It helped me, it equipped me to move forward. I was, just the net for him and I wasn't allowing him to move, let alone move forward. I had to stand back a little bit and see where he was going, I had to observe, rather than push. You gave me a lot of skills that I didn't have.'

Additionally, older parents may also be facing their own health problems associated with ageing. Families will have huge variation in the amount of support and care provided by different members, which may not at first be apparent. Care may be provided mutually and the person themselves may have significant concerns about their older relatives' wellbeing. Although this can be a source of stress for the person experiencing psychosis, it may also provide them with a valued role in the family that should not be underestimated.

Practice example: A woman in her forties 'Sarah' was referred for FI with her older parents. Her mother had longstanding health needs associated with diabetes whilst her father had dementia. They were all concerned about the future which was creating additional stress at home, with a sense of urgency from the parents to see their daughter coping more independently. With the involvement of Sarah's sister and a support worker from the team, the family was supported to explore options for Sarah to move to supported accommodation, close to her parents so she could still visit them often. This allowed mutual caring to continue, with less stress for Sarah's parents.

FAMILY WORK WHERE PARENTS LIVE IN DIFFERENT HOUSEHOLDS

Where parents are separated or re-married there may be considerations about who can be in a room together. The possible involvement of new partners and any step-siblings needs to be weighed up with the person and might then necessitate some meetings with a new maternal family and others separately with a new paternal family. Meeting with the person and both their parents together can nevertheless be helpful even when they are separated, as possible conflict between ex-partners can be managed so as to reduce the impact on the person experiencing psychosis. Should this prove to be possible there are clear advantages in working together to provide the required support.

WORKING WITH COUPLES

Families that involve the partner of the person and potentially their children will have very different needs and issues to discuss. Gender is a significant factor to keep in mind, as 70 per cent of women with a diagnosis of 'schizophrenia' marry and yet only 25 per cent of men (Mueser & Gingerich, 2006). Marital outcomes are worse for both than for their peers without mental health problems (Grover et al., 2017). Marital outcomes for women experiencing psychosis show particularly high rates of divorce and separation (Mueser & Gingerich, 2006), which is likely to be an added source of stress on the family. Grover et al. (2017) notes that in couples where one partner has been diagnosed with bipolar affective disorder, marital outcomes are adversely affected by the complex and changing needs of one half of the couple.

The significance of couple distress as both a consequence of, and contribution to, mental health difficulties of all sorts should not be underestimated (Lebow et al., 2012). Emotion-focused therapy (Greenberg & Goldman, 2008) and behavioural couples therapy (Reibstein & Sherbersky, 2012) appear to show good outcomes for increasing relationship satisfaction and decreasing distress and conflict (Lebow et al., 2012) but there may be additional considerations when one partner experiences psychosis, depending on the extent to which this impacts on their daily life.

Expectations of the person with psychosis, held by their partner, can be problematic when they are either unrealistic or overly pessimistic. Some partners may have difficulty seeing the person as having an equal voice. Emphasis on their role as an independent adult, with a shared future and hopes about their life together, might be an important focus for the work.

Depending on their stage of life and when the person first experienced significant mental health problems, there may be issues of loss for the couple to consider, or questions about starting a family of their own. There will be different concerns if the adult couple met before difficulties were first experienced, than if they emerged after the relationship began. Some partners may have their own significant mental health problems, and care may be more reciprocal. The term carer may be rejected as they consider each other partners, or husband and wife, equally contributing to the relationship.

The couple will also have to manage any consequences arising from more acute episodes of psychosis or elevated mood, during which time the person may have behaved in uncharacteristic ways with particular implications for a couple, such as sexual disinhibition. In addition, the couple's sexual relationship may be adversely affected by the side effects of anti-psychotic medication (Montejo et al., 2015). There may also be a need to help them steer their way through the complexities of unshared history; when one partner has been affected by behaviour in the other that they have no memory of.

There may be important conversations to have about their relationship, sharing information about living with psychosis/mental health difficulties, communication skills, and the value of spending time together engaging in ordinary, non-mental health related activities.

Practice example: A couple married for 12 years were struggling to cope with the impact of the wife's recent history of distressing voices and unusual beliefs. Three episodes in the last two years had led to crisis admissions, leaving them both highly anxious. The husband had become hyper-vigilant to emotional changes in his wife such that she felt silenced and unable to voice any emotional reactions to the normal ups and downs of their relationship. Work with the couple enabled them to understand each other's concerns and validate their strong feelings, whilst developing a shared staying well plan that enabled the wife to voice what she found supportive

and what felt controlling. The plan also included a schedule for regular pleasurable activities they could do together, such as going to the cinema.

The adult couple may well have children together, or from previous relationships, and shared parenting may be more important than ‘caring’ for each other as people with mental health problems. Alternatively, some younger couples may be considering whether to start a family of their own. Their hopes may not be shared by others involved in supporting them, so they may need help to manage these emotive conversations.

WORKING WITH CHILDREN

It is thought that up to 50 per cent of people known to adult services will have children, whilst about a third of children seen by Child and Adolescent Mental Health Services have a parent with mental health needs who is under the care of secondary mental health services (Robson & Gingell, 2012). Women experiencing psychosis are almost as likely to have children as those without psychosis, whereas men experiencing psychosis are much less likely to have children (Mueser & Gingerich, 2006). A survey of an Australian population found that in a sample of 1825 people experiencing psychosis, over half of women and a quarter of men were parents (Campbell et al., 2012). Given the poor marital outcomes for women experiencing psychosis, it is likely that many are managing the parenting role as a single parent. In some families it will be important to consider who else in the extended family may be offering support, or wanting to be more involved in helping with child-care. Parents experiencing psychosis may have adult children, or they may be looking after very young children, and coping with pregnancy (with the issues of medication then very significant).

Parents experiencing psychosis report that relationships with children are highly valued and can be a protective factor, as well as finding that parenting demands are a source of stress (Mueser & Gingerich, 2006). Whilst many parents with mental health difficulties will provide excellent care for their children, it has been shown that children with parents experiencing psychosis are at increased risk of various negative outcomes including mental health difficulties of their own (Engur, 2017). Factors that might influence the child’s experience in such families include their age when a parent first experienced psychosis, experiences of the care system, exposure to trauma and separations (such as unplanned hospital admissions), contact with other supportive adults with whom they might have a secure attachment and the presence of other siblings. Many children will also find themselves in significant caring roles, not just for their parent with mental health needs, but also for younger siblings (Wardale, 2007).

Practice example: We worked with a mother ‘Shana’ who had recently been discharged from hospital following an acute experience of distressing psychosis. She was seen with her children aged 17, 15 and 9. Her eldest was 21 and did not want to participate because she had been in a carer role for both mother and younger siblings for several years and needed help to prioritise her own needs. She was offered individual support separately to the family sessions. The 9 year old’s involvement was managed carefully to ensure he was not exposed to content inappropriate for his age.

The provision of appropriate help to support both family functioning overall and the tasks of parenting has the potential to mitigate negative outcomes for children (Engur, 2017) as well as improving the relationship with their affected parent.

Parent experiencing psychosis: ‘Before my children wouldn’t walk with me in the street because of my mental health, but now they are quite happy to walk with me and realise the problems I have

and respect me more. Before the family work, they would have told me to go on my own, but now they walk with me and go to the supermarket and go shopping with me.'

Thompson, Griffiths, Allen and Jones (2019) surveyed a group of expert FI practitioners in the UK to determine what best practice might be with regard to children's involvement in FI. High levels of consensus were reported for a number of areas of practice. Clinicians thought that children should be included in the intervention but judgments should be made about which elements of the work they should be present for, taking account of the child's age and potential vulnerability. In all cases the needs of the children should be discussed with the family and key aspects of the intervention – appropriate to the child/ren's age – should be shared with children afterwards, should they have been absent. Care should be taken not to add to any inappropriate caring demands that might fall to the child/ren in the family.

Other adaptations which experts concurred on include the sharing of information about psychosis using means and language appropriate to the developmental stage of the children, agreeing ground-rules to manage children's exposure to conflict or distressing content, and using more active and visual methods to engage children (Thompson et al., 2019). Suggested child friendly techniques included the allocation of clear roles suitable for the child concerned such as timekeeper, note-taker or group illustrator. Games, role plays and technology were all considered to offer something useful to facilitate a child or adolescent's inclusion. There are many games offering child-friendly ways to discuss things – such as family strengths and ways of approaching problems – that do not rely on formal discussions (Lowenstein, 2010).

Practice example: In our early work with Shana's family we used an active 'game' to provide a vehicle for the children to share anxieties about their mother's difficulties without placing them under pressure to discuss things in depth. In later sessions when the teenagers were more engaged and willing to talk, their 9-year-old brother – who was a keen artist – took on a role of drawing the themes from our conversations and sharing them at the end of the session.

Parents experiencing psychosis may be acutely sensitive to criticism about their parenting and concerned about being scrutinised in family sessions. Along with concern to protect their children from the consequences of their mental health problems, this can make some parents reluctant to involve their children in sessions. Such concerns need to be addressed sensitively but explicitly, highlighting the potential benefits of involving the children whilst being open about the limits to confidentiality in the event of any safeguarding concerns. A strengths-based approach is one important way of helping to manage these concerns.

WORKING WITH SIBLINGS

Children might also be involved in situations where a young adult, for example in early intervention services, has younger siblings, usually teenagers. As with parent carers, siblings report positive and negative impacts of caregiving roles they may take on for a brother or sister experiencing psychosis (Bowman et al., 2017). However, working with siblings raises particular issues given that the experience of psychosis is likely to have affected the family during a critical phase of the sibling's development with implications for peer relationships, educational attainment and growing independence from the family (Newman et al., 2011). They may also have concerns about elevated risk for their own mental health and feel a range of strong emotions about the person experiencing psychosis, such as resentment, shame and guilt (Sin et al., 2008). Sin et al. (2008) also found that siblings reported taking a role in supporting the parent in the primary caregiving position – a role which could easily be unacknowledged by service providers.

Practice example: We worked with a family where the 12-year-old brother had mild learning disabilities. At first it appeared inappropriate to involve him as the parents talked freely in front of him about issues that the workers felt were inappropriate for a child to hear. However, over time he became key in identifying solutions for his sister's difficulties with their parents, and in brainstorming sessions he was a helpful resource for the parents, one of whom also had a learning disability.

Given that around 80 per cent of the UK population has one or more siblings (ONS, 2019) it should be anticipated that the majority of people using our services also have sibling relationships of some kind. Depending on the nature of the service, and age of the person experiencing psychosis, affected siblings could be children, adolescents or adults. Research suggests that siblings in general experience similar levels of grief and burden to parent carers, as well as stigma, fear and guilt (Bowman et al., 2017). As with parent carers, siblings also report some positive impacts of caregiving roles they may take on for a brother or sister experiencing psychosis (Bowman et al., 2017). However, sibling issues have, on the whole, been neglected in the research literature so there is little clear direction on how best to meet their support needs (Sin et al., 2015).

Working with young siblings raises particular issues given that the experience of psychosis is likely to have affected the family during a critical phase of the sibling's development with implications for peer relationships, educational attainment and growing independence from the family (Newman et al., 2011). They may also have concerns about elevated risk for their own mental health and feel a range of strong emotions about the person experiencing psychosis, such as resentment, shame and guilt (Sin et al., 2008). Sin et al. (2008) also found that siblings reported taking a role in supporting the parent in the primary caregiving position – a role which could easily be unacknowledged by service providers.

Sometimes adult siblings are the primary source of support for the person and it is important to note that the power differential may be experienced differently, by both the caring sibling and the person receiving care, than in the context of parental care. It will be important to understand how the adult sibling/s came to be in a key supporting role and what feelings this brings up for all concerned. Some adult siblings will have made significant sacrifices in their own life choices, in order to be available to their relative. Others will have competing demands from partners, children and careers.

There can be complicated feelings to address related to comparisons of life opportunity (spoken or unspoken) and beliefs about comparative 'success' in the family. Such things may be hard for siblings to discuss without help, particularly if the carer sibling lacks information to develop a good understanding of the nature of their brother or sister's difficulties. Sin et al. (2015) advocated a role for information sharing with siblings; having found that their involvement in family approaches does not necessarily reflect the extent of their involvement in offering support. They urge practitioners to take a pro-active approach to including siblings even if they do not identify themselves as carers.

WORKING WITH WIDER SOCIAL NETWORKS

Family intervention for psychosis typically involves relatives and/or partners, but around half of people in rehabilitation services do not have any contact at all with their family or have a partner. However, people will often have other important relationships which may include a close friend, or people in shared living situations (a landlord, residential homes, or shared accommodation). Family intervention sessions can be a helpful way to include anybody that is close to the person

in less obvious ways. Although the label 'family' might not be appropriate, the intervention may include similar aspects.

Practice example: A man in his forties who visited the pub daily, sitting on his own, had built up a strong sense of care from the publican, who was key to ensuring this man had contact with the local mental health team. Once he was engaged in services, ongoing conversations with him and the publican together enabled significant problem solving to take place, with improved understanding from the publican and other regulars in the pub.

This illustrates the important point that sometimes the person has important relationships with others that might initially appear remote or purely functional.

Practice example: A man in his fifties lived in lodgings; apparently fairly independently. Over time however, it became apparent that his landlady provided a high level of emotional support, and had significant concerns at times about his wellbeing. The word 'landlady' did not adequately reflect the true nature of their relationship.

In addition, sessions may be helped by including paid carers, who themselves may have limited understanding of why the person struggles with particular tasks and not others. In general, it is useful to consider anyone in the person's network who shows care and interest, whether they are the person's manager at work, a local religious leader or concerned neighbour. The benefits for the person can include much greater social inclusion, and more informed support from those in contact with them.

WORKING WITH FAMILIES WHEN THE IDENTIFIED 'PATIENT' DOES NOT WISH TO TAKE PART

There are many reasons why people experiencing psychosis might be reluctant to take part in a family intervention. Whilst their involvement should be encouraged, their absence should not preclude the family sessions going ahead. Practitioners should take sufficient time to explore fully with the person, and those close to them, the reasons for their non-participation as these can sometimes be overcome. The decision should also be revisited on a regular basis to ensure that the person has every opportunity to opt in.

Strategies to increase the chances of the person joining the work include planning sessions to be at the family home where the person might be more aware of the meeting taking place.

Family member: 'The main person, Delia, wasn't always there ... but it was important for us to go through it in order to increase our sister's understanding that we also at some time need some support and that this is not a journey that she is doing by herself.'

Being flexible, by inviting them to join for some small part of the meeting and keeping them informed about discussions that have taken place without them, is also important. A useful strategy can be to write letters to the person about the sessions they have missed, either jointly with the family or independently.

Practitioners should also consider that people experiencing psychosis and their family members may be more likely to engage in a service where offers of family meetings happen routinely from the beginning of their contact with the service and are repeated as often seems useful.

Family member: 'At various points, I got asked if I was interested, and I kept saying no, because at that point I was focused on getting my son right, I thought if my son's right, everything will be right, and so this went on for about two years ... and the ability of the FI service and the care coordinator to tell me, every time I seemed to be struggling, you know that's there, that's there,

that's there, so it's reminding, because at times you don't think that you need it. So it's a process that happens.'

In the absence of the person experiencing psychosis, one carer might be seen alone, or several members of a family could be seen together. Whilst meeting with families in the absence of the person brings additional complexities – such as managing what gets shared about and with the person concerned – it also affords certain opportunities. Regardless of the person's involvement, family intervention brings the family closer to the team providing care and facilitates the delivery of care in partnership with them. Communication between services and families is often better as a result.

When exploring reasons for not wanting family work to go ahead, practitioners should consider the possibility that there may be some history of trauma in the family that is hard for the person to speak about. Childhood trauma increases the risk of psychosis in adulthood (Read et al., 2005; Hardy, 2017) and there is evidence that child abuse is a risk factor for the later development of voice-hearing and distressing beliefs (Read & Gumley, 2008). Such trauma histories are likely to affect engagement in a range of complicated ways, which may not be explicit. More broadly, the nature of the person's attachments in the family should be considered, bearing in mind what is known about the range of factors influencing attachment. These include the higher prevalence, for people experiencing psychosis, of loss of a parent in childhood through death, or separation through divorce or episodes in institutional care (Read & Gumley, 2008). An understanding of the person's attachment history might therefore be helpful in informing decisions about who to involve in a family approach, and how.

WORKING WITH ABSENT FAMILY MEMBERS

It is important to hold in mind how absent members are included. Practitioners need to agree what information will be shared, with and by whom. In the interests of open collaborative working this should be as free and full as possible, whilst taking care to manage any risk (e.g. of abuse to others, or of increasing the person's distress and possibility of relapse). There will be occasions when only limited feedback can be given.

The use of technology to include people who may otherwise struggle to attend should be accommodated. This could include using video platforms/phone on loudspeaker, as discussed below. Alternatively, they can be included separately through feeding in their comments from emails or phone conversations.

As with all aspects of FI, flexibility is crucial. Each family will already use its own ways of communicating with each other and have ways of sharing information with each other – or not – after the session has ended. By asking about these family ways, existing communication strengths can be highlighted and developed further in ways that have most meaning for the family concerned.

MANAGING RISK

MANAGING RISK ISSUES AND CONCERNS THAT MAKE SEPARATE MEETINGS ESSENTIAL

The presence of risk in our clients' lives must always be a consideration given that a range of studies indicate high levels of trauma histories and vulnerability to violence as both victim and perpetrator. Young adults experiencing a first episode of psychosis appear to be at increased risk of violent behaviour and legal involvement, relative to the general population, particularly in

the context of substance misuse (Rolin et al., 2018, Large & Niessen, 2011). While many of our clients have no violence in their histories, those that do are arguably those most likely to be offered FI due to the concerns raised in their wider care. By supporting the network of people and professionals involved in families' lives, greater attention can be paid to 'safety' (Mottaghypour & Bickerton, 2005). Acknowledging that family intervention might often involve increased emotional arousal and may be held in the family home and/or out of office hours (even in health service buildings), it is important when planning the sessions to ensure that risk to staff is considered and lone working policies are adhered to. Staff may be inclined to minimise the risks when for example knowing the family well and/or are working in pairs, however complacency should be guarded against. Those leading and supervising implementation of the intervention should ensure there are systems in place to accommodate the needs of staff working in the more flexible circumstances that family work may require.

Practice example: Staff conducting family sessions out of hours are required to complete a template with the details required by an identified 'buddy' to ensure their safety. This sheet also details the personal and policy driven contingency plans should the expected contact not be made following the session.

RISK TO FAMILY MEMBERS

Any family member could be vulnerable to abuse from other family members. Although people experiencing psychosis are more likely to have been victims of violence, a review of the evidence does suggest a modest association between experiences of psychosis and perpetration of violence, most commonly within the family (Onwumere et al., 2018). Onwumere et al.'s 2018 review indicated that family caregivers – and most particularly female caregivers who reside with the person – are at risk of markedly increased rates of violence, yet the nature and impact of this phenomenon remain poorly understood. Risk to the caregiver may be further compounded by reluctance to report a loved one to the police.

In some situations, a collaboratively planned intervention may at times increase risks within the family, at least in the short term. Family members may wish to set limits on what they are prepared to do for someone, or tolerate (such as offering financial assistance which indirectly supports alcohol misuse), which could lead to increased aggression from the person towards their relative. This would therefore need to be tackled cautiously and with clear, agreed strategies in place to manage any anticipated increase in risk.

RISK TO THE PERSON EXPERIENCING PSYCHOSIS

Given the links between trauma history and psychosis, practitioners should be alert to the possibility that the person experiencing psychosis is at risk of abuse from family or local community members, who may never be involved in the intervention. Alternatively, practitioners may be working to support relatives to step back from care, which carries the potential for increased risk of neglect or financial exploitation of the person concerned. Sometimes the anxiety of relatives, particularly parents, is based on very real experience of the person being homeless, vulnerable to extreme self-neglect or frequent admissions under section. It is often part of a psychologist's role to help the family negotiate their way through the dilemmas posed by these common and anxiety-provoking scenarios.

It is essential that practitioners offering family intervention are able to have conversations about these issues, without necessarily including everyone. Carers may not feel able to fully articulate or disclose information pertaining to risks (whether of abuse, or relapse) in the presence of the person experiencing psychosis or other members of the family. Indeed, it may not even be

appropriate for them to do so, particularly when it could result in increased risks to themselves or others. If there is any suspicion of risk that is not being shared, it would be appropriate to offer separate meetings to give people every opportunity to talk about their concerns.

Family member: 'When you are in one another's presence you're not as open and honest as you should be and in order to accept the help, you have to be open and honest, without offending your husband.'

It is also essential in such circumstances to work in close partnership with other team colleagues involved in the person's care, and for this to be made explicit with the family.

Practice example: We worked with a couple from India where there were concerns about domestic violence and whether the children were at risk of emotional harm through witnessing this abuse. We struggled to engage the MDT in sharing the responsibility for assessing and exploring this risk with the family; the care coordinator had reduced their involvement as soon as the family work started, owing to caseload pressures. We addressed this by exploring the issues with the care coordinator, documenting our concerns and agreed actions in the clinical notes and sharing our dilemma with the team manager and MDT. We were keen to emphasise all we could do to help within the family work, but that it required collaborative working from the MDT to make this possible. The care coordinator took responsibility for assessing the risks more regularly and we were then able to work with the family to develop a 'safety plan' for all family members to follow. This distinguished 'acceptable/normal' signs of family conflict, from behaviours that everyone should be more concerned about and what family members and services would need to do if those arise.

ADAPTATIONS FOR REMOTE DELIVERY

Whilst many clinicians have long used phones or video links to work with family members unable to attend family intervention sessions, the Covid-19 pandemic has led to a rapid adaptation of clinical practice to enable remote delivery of sessions to the whole family/support network (e.g. Helps, 2020).

Prior to the pandemic, only the more structured integrated psychoeducational family intervention approaches had been delivered remotely (Joyce & Burbach, 2019). All approaches – including the least structured Open Dialogue approach – have now been adapted for digital delivery, and a number of useful guidelines have been produced (BPS, 2020; AFT, 2020; Matheson et al., 2020). What is clear from the evidence for digital psychotherapy generally is that the therapeutic relationship developed via a video screen, although somewhat different, can be as strong and effective as the traditional in-person relationship (Lopez et al., 2019; Simpson & Reid, 2014). Family workers reported that they found it harder to tune into nonverbal communication and the family's emotional climate but that they could elicit this through direct enquiry (Helps, 2020). This was also affected by the number of devices used by family members to join the session. Therapists also found that video sessions during Covid-19 increased transparency and positively affected the balance of power as everyone was at home.

'There is something about being invited in families' homes which I find humbling. And also, inviting them in our homes.'

'We encouraged family members to sit equidistant to the mic and camera to avoid inequitable access.'

There are three main adaptations which appear to be required for effective video delivery of family interventions (Burbach & Helps, 2021):

PRESENCE

When working online practitioners need to ensure that they make eye contact and appear fully engaged in the session. Good quality online therapy requires a sense of 'presence', which can be developed with feedback and practice. More animated facial expressions, voice inflection and gestures (e.g. thumbs up, thumbs down, a wave as a greeting) are helpful. To allow as much non-verbal communication to be captured as possible it is helpful for the therapist's head, neck, upper body and arms to be visible on screen when sitting back, which also allows forward movements at times of particularly heightened attention. This increased animation will often need to be combined with a somewhat slower rate of speech and slightly longer pauses between sentences to allow for any lag caused by slow connections. Clear short sentences can also help.

AGREEING BOUNDARIES/GROUND RULES

It is important to set clear boundaries for sessions: agree times for session, importance of arriving on time, and think with the family about what they may do after the session e.g. can they do something relaxing to give a bit of space before they go back to their day-to-day activities? It may be particularly important to do this with children and young people, and to make it clear that the sessions are not just an online chat. Clinical sessions must be conducted in a safe, private and confidential therapeutic space: both the therapist and clients should be in a room free of distractions and noises so they can engage fully – no multi-tasking, phone, TV/radio off, children/pets being looked after.

An issue which needs to be negotiated in family interventions is the number of devices that will be used. Having the family together using one device has some advantages and most closely approximates the traditional format, but it may pose challenges regarding sound quality (inevitably some family members will be sitting farther away from the microphone) and the picture (some family members may not be on the screen). Family members joining sessions from different locations on separate devices may be preferred by some, but this may result in a more formal 'videoconference meeting' atmosphere. This issue can be negotiated at the start of therapy and renegotiated to enable different therapeutic processes to occur – for example to rebalance the conversation between family members.

Agreement regarding 'ground rules' is useful for all family interventions, but is particularly important in remote working. A brief discussion early in therapy usually generates a collaboratively agreed list which includes listening respectfully rather than talking over each other, and in some cases includes how the family wishes to deal with strong emotional reactions (e.g. distress, anger) or an agreement to refrain from verbally abusing one another. It is also important to be clear about risk and safeguarding issues and the need to break confidentiality if someone is at risk of serious harm.

'I found it tricky when the family members who were in the room together (mother and two teenagers) shared comments among themselves that were inaudible and not directed to me. This happened a couple of times, mainly between brother and sister – who would sometimes speak to each other. In the room of course this would be less likely to happen, or if it did you could incorporate what they might have shared into the dialogue however I sometimes felt unsure/left out of what they were saying and had to encourage them to remain focused with the session.'

ORCHESTRATING

Whilst most of the above guidelines would also apply to other forms of psychological therapy, a key challenge in family interventions is to ensure that each person has a voice in the sessions, feels validated and develops a therapeutic alliance with the therapist. Although the same skills are required doing this remotely or in-person, the online task requires a somewhat more active ‘orchestrating’ of the session. Clinicians need to use more explicit verbal invitations regarding who might talk next, but very deliberate use of gestures can also be useful (e.g. to reinforce verbal requests to stop an unhelpful blaming conversation, or to emphasise a switch of focus to a different member of the family). In addition to explicit structuring of the session, the therapist will need to adjust the pacing of the session, moving the conversation through the agreed agenda and ensuring turn taking within the session. Whilst the more psychoeducational and behavioural skills focused models of family intervention may therefore appear to be particularly suited to online delivery, the less structured dialogical approaches also appear to be well suited to remote working. The ODESSI trial of Peer-Supported Open Dialogue in the UK has successfully been adapted to online delivery (Pilling & Clarke, 2020), generally holding sessions with two therapists joining from their own devices (video and phone links are being used). Remote delivery has not impeded their use of therapeutic reflections. However, once again this has required explicit preparation and explanation to ensure that network members listen to the reflecting conversation.

‘The lead practitioner allowed every family member a voice in the room, including the youngest member of the family who was more engaged than during the in-person sessions that took place in the months before. The conversation flowed, family took turns in speaking and the lead skillfully placed interruptions when monologues went on too long and punctuated important moments.’

Another issue that is important to consider when doing therapy via video-link is to make sure that you have a background free from confidential information and that your face is adequately lit and positioned on the screen. It is important to be aware of the glare from bright objects in your background. A plain, darker background with light directly on your face is recommended and may help where the connection is of lower quality. It may also be helpful if earbuds or headphones are used as this can improve sound quality.

ORGANISATIONAL ISSUES

- Individual practitioners need to have adequate technology to be able to do video calling.
- Organisations need to balance the ability for people to call each other with potential security risks of certain platforms.
- Organisations can prepare for further COVID spikes or other pandemics by ensuring that teams/individual practitioners are adequately trained and fluent on using technology so that therapeutic approaches can continue.

Both during lockdown and at other times, a clear message needs to be fed back to the organisation that work with families is essential to ensuring the continuity of services and decreasing the demand on other services (e.g. acute services).

Psychologists have an important role to play in tailoring family interventions to meet the diverse needs of a limitless number of different family presentations. Psychologists are well placed to think about the adaptations that may be required in atypical situations and to negotiate complex and delicate situations such as those involving risk.

RECOMMENDATIONS

1. Avoid making assumptions about who constitutes 'family' and who should be involved in the family intervention. Talk to the person first and then to those in supporting roles about who it would be most useful to invite. This might include people from a wider social network, such as friends or neighbours.
2. Be flexible in how sessions are offered in order to maximise the possibilities of attendance for all those identified as important to the process.
3. Be prepared for the possibility that attendance may change over time. Think with the family about the implications of changing attendance and how to maximise continuity in this context.
4. Be alert to occasions when it may be useful to arrange separate meetings with individuals or parts of the system. This may help to address issues that are difficult to share in front of other family members, or which may be risky to discuss in front of others, such as the person experiencing psychosis.
5. Family workers should ensure that their own safety is considered in accordance with organisational policies.
6. Offer individual sessions to family members who are sole carers, when the person declines an offer of family intervention.
7. Consider the particular needs of couples when one or both in the relationship experiences mental health difficulties, recognising the relevance of couple distress as a contributing factor to mental health.
8. Where families with children are referred, talk with the adults about how their child/ren might be involved in the work. Adapt the approach to be suitably child-friendly depending on the age of the child concerned.
9. Given that it is often not possible to include the whole family in every session of an intervention, agree with the family on ways to keep absent members in mind and include them through other means; either remotely accessing the session in real time, or sharing key information after the fact.
10. FI sessions can be delivered successfully via the internet using a secure videoconferencing platform. Increased therapist 'presence' and 'orchestration', as well as agreeing boundaries/ground rules will facilitate remote delivery of FI with little additional adaptation.

8. Training and supervision

Mair Thomas and Gráinne Fadden

KEY POINTS

- Robust training programmes and supervision structures are paramount in the delivery of quality family interventions.
- The first step in training and supervision of family interventions should be the development of robust organisational systems to support implementation.
- Provision of family interventions by clinical teams requires high levels of training and supervision in a range of models providing a range of options for working with families.
- There needs to be a hierarchy of training needs, with those with more training and experience supervising and supporting those with less experience.
- Practitioner psychologists who are trained in Family Interventions potentially have multiple roles in training and supervision.
- Working with families and networks should become a core part of practitioner psychology training.
- Doctoral courses should be training all clinical psychologists to work with families. Training accredited at a Foundation Level by the Association for Family Therapies is recommended for all doctorate psychology courses.
- Training must include working with families from different backgrounds, and consideration of how to adapt and use culturally appropriate interventions. Having practitioners representative of the communities we serve is important so work needs to be done to increase access to training
- Training should include the skills required to conduct sessions via video-conferencing.
- Family and Systemic psychotherapists, given their knowledge and experience in working with families, have an important role to play in training and supervision.

'As a team we are committed to delivering family interventions, and having almost everyone in the team trained helps with this.'

INTRODUCTION

Training and supervision are intricately linked and are essential for good practice in family intervention. They have been seen as key factors in determining the successful implementation of family interventions (Fadden, 1998; Eassom et al., 2016). Nevertheless, training alone does not lead to the delivery of family interventions in routine care, and there is variation in the delivery of training and supervision (Burbach, 2012). A clear strategy around implementation following training is essential for the development of family interventions in services and this must include supervision structures. .

IMPLEMENTATION OF TRAINING AND SUPERVISION

Establishing good structures around training and supervision will support the development of family interventions. Factors that have been identified to support successful implementation of training (Burbach, 2012) are:

- Ensure support for the programme of training and service development at all levels of the organisation, including the highest level of management and lead professionals.
- Agree a service development strategy that ensures an appropriate service context and the availability of sufficient resources to enable practice and supervision post-training (protected time; smaller caseloads; practical support for clinicians).
- Establish robust supervision structures to ensure post-training expert clinical supervision is available. It is essential there are adequate supervisors to provide regular supervision as well as support new practitioners in co-working/live supervision. Supervision must be programmed into job plans and protected.
- Use a team training approach or ensure that there is a local 'critical mass' of trained practitioners who can support one another.
- Involve families/carers in the training programme and in the design and governance of the service.
- Appoint local service leads/champions who are responsible for the development and maintenance of family intervention.

UK GOOD PRACTICE EXAMPLES OF FAMILY INTERVENTIONS TRAINING PROGRAMMES

- Northumberland, Tyne and Wear, an NHS mental health Trust, (NTW, 2016) has a strategy which aims to train all staff in house in Family Awareness Training, and specified numbers of staff in each team in Foundation and Intermediate Family Therapy training as well as Family Intervention for psychosis trainings. The strategy specifies the numbers of staff required to complete each level of training and supervision requirements.*
- The Meriden Programme (Fadden, 2006), which trains staff in Behavioural Family Therapy, operates a cascade training system aiming for a critical mass of trained staff.*
- Sussex Partnership NHS Foundation Trust aims for all staff to be trained in family inclusive practice. Several people from each team are trained in The University of Surrey/Sussex Partnership Family Interventions course, which integrates systemic and psycho-social interventions and is accredited by the Association for Family Therapy at a Foundation level. Supervised practice is integral to the course and care is taken as people graduate to ensure smooth transition to local FI supervision groups (Smart, 2017, Meddings et al., 2009).*
- In Humber Teaching NHS Foundation Trust, all staff are supported to develop competence in family inclusive practice, through attending a one day, and subsequent two day, in-house training workshop. This is delivered in partnership with a local Rethink group, to hear carer stories in the training. Recorded interviews with carers, using questions developed by the carer volunteers, are played during the training and staff are invited to reflect on these. Experiential exercises are also used to create empathic appreciation for family and carer perspectives. The principles of confidentiality and information sharing with families are discussed, with an opportunity to unpick practice dilemmas in relation to these. Role-play is used to develop skills and*

confidence in engaging in collaborative partnerships with families and carers. Foundation and Intermediate levels of systemic family therapy training are also available, facilitated by qualified family and systemic psychotherapists who lead on family therapy clinics. Supervision, coaching and ongoing support for staff, including modelling family inclusivity and collaboration, is provided by staff who have undertaken this training. The integration of family inclusive and systemic training, supervision and coaching aims to influence an organisational culture away from individualised models of care. The cascade approach to development is expected to maximise the attitude shift necessary to move towards family work becoming viewed as 'instead of' rather than 'in addition to' other interventions.

- e. Looking beyond the UK, in Finland there has been a particular focus on the Open Dialogue approach (Seikkula et al., 2001), described earlier in this document. Services have had success in training all staff in three-year family therapy, and the development of organisational structures to support family work as the routine form of service delivery.

FAMILY INTERVENTION TRAINING COMPETENCIES

Work undertaken at University College London (UCL) identified the competencies required for family interventions in psychosis. These competencies provide a framework for therapists to deliver family interventions for psychosis excluding family inclusive practice. They were developed through examination of published, evidence-based treatment manuals, compiling the important competencies. Given the evidence base has been formed around those family interventions which have been more researched, especially through RCTs, the competencies are based primarily on more structured approaches. These competencies are provided on the basis of the NHS England psychological interventions implementation programme. It is to be hoped that this programme will lead to an increase in those trained in family interventions in psychosis, and will support the delivery of a stepped care approach. Health Education England (HEE) is supporting the implementation programme through funding HEE approved Flp training courses. These courses all deliver training aligned to a standard national curriculum and are designed to ensure practitioners have the competence and confidence to deliver evidence based family interventions. This is an important breakthrough for the development of family interventions in psychosis in services and will hopefully lead to more families experiencing this helpful input.

As a result of the move to online work following Covid-19, new competencies will need to be added to training courses. Sherbersky et al. (2021) provide a useful overview of these issues for systemic therapy. The new framework of digital competencies, which has been initiated by the British Psychological Society, Division of Clinical Psychology, and supported by IAPT London and HEE, is also useful. An interactive version of the framework with detailed definition of competencies can be found at www.digitalhealthskills.com/digitalcompetencies.

'New skills, helping me have more confidence in interacting with family.' HTT practitioner following family work training

TRAINING CRITERIA FOR OTHER FAMILY INTERVENTIONS

STRUCTURED FAMILY INTERVENTIONS

Structured approaches tend to provide shorter training as these trainings enable clinicians to have specific conversations with families. Due to the national curriculum, all courses are at least 10 days

plus 12 months of supervision. Behavioural Family Therapy training is now therefore a 10-day training followed by monthly supervision. The CBT-FI approaches available have ranged from 10 days to 1 year. Both enable clinicians to support conversations in sharing information with families about diagnosis and discussing mental health experiences as well as supporting conversations about communication and family understanding of the problems. These trainings are available to people with little therapy experience. As previously mentioned, it is recommended non-therapists should always co-work with experienced family workers and have regular supervision and sought further training when possible.

INTEGRATED SYSTEMIC, PSYCHOEDUCATIONAL/COGNITIVE BEHAVIOURAL FAMILY INTERVENTIONS

There are various integrative courses now available in the UK. They are usually year-long courses with supervised practice integral to the course. They support training in structured interventions, within the context of systemic theory and techniques, in order to develop a dynamic and positive therapeutic relationship which is responsive to the context and particular system.

Practice example: The University of Exeter have delivered an Integrated FI model (Called Family Intervention for Psychosis) course to more than 120 staff across the South West region. The course is also now accredited as a Foundation in Family Therapy by AFT. They train geographically focused teams in integrated systemic, psychoeducational/cognitive behavioural approaches. ‘Very useful training either as an introduction to systemic thinking or a refresher. Even when not doing “formal” family work helps to keep a “systemic lens” on practice.’ (Burbach, 2006).

SYSTEMIC PRACTICE

Skills in systemic practice are developed through Intermediate level training in Family Therapy (Association for Family Therapy, 2015). This training builds on skills in systemically informed work with families developed in Foundation training in Family Therapy. Systemic practice includes skills in delivering systemic interventions and taking the lead interviewer role under supervision in family therapy. Systemic practice enables practitioners to use a wealth of creative tools to open up conversations with families to support change.

FAMILY AND SYSTEMIC PSYCHOTHERAPY

Building on Intermediate level training and prior professional training (including clinical psychology), this involves a further two years training – leading to full qualification as a family and systemic psychotherapist. Skills are developed in working with families, individuals, couples and others in close relationship as well as work in wider organisational settings. This may involve working with or consulting to groups, teams and management structures (Association for Family Therapy, 2015).

TRAINING AND SKILL MIX

Services may vary in the combination of skills they require, but the key principles are that they should aim for all members of a clinical team to be trained in core family inclusive practice (Eassom et al., 2014), and a significant number in a range of family intervention skills, as there can be difficulties when only a minority of team members have been trained in an intervention (Fadden, 1997). It is also recommended that there are staff trained in longer family intervention courses, and family and systemic psychotherapists available to support all family work including complex work, supervise and train staff. There is evidence that services with a greater number and range of staff trained in family work, do work more with families (Veitch & Thomas, 2013).

It is recognised that in developing skills to work therapeutically with families, duration of formal training can be as important as duration of supervised clinical practice, since many skills

are arguably acquired as much through practical experience as through teaching. However, a combination of both is recommended to support best practice. Some approaches, for example, MSc level family and systemic psychotherapy training, build supervised clinical practice into their core training. Enabling a team to gain and maintain these skills requires persistence and support from all levels of the organisation (Eassom et al., 2014), involvement of service users and family members in training has been identified as a key support to their implementation (Fadden, 2006).

Professionals with responsibility for gatekeeping access to family intervention training should ensure they proactively work to reduce barriers to training for all staff groups. Diversity within teams providing family interventions will increase the cultural capabilities of the workforce.

There is a responsibility to contribute towards the anti-racist task of creating a workforce that represents – and therefore serves – its ethnically diverse communities. In the current state of the psychology and psychotherapy workforce, families from ethnic minority communities are less likely to see someone from their own racial and/or ethnic background. The British Psychological Society (BPS) has published guidance around the challenge of recruiting more ethnically diverse psychological therapists (BPS, 2004, Maxie et al., 2006; Hays & Iwamasa, 2006; Hays, 2001) and this has most recently become a key priority area for Health Education England (2020). As well as recruiting more racially and ethnically diverse psychological therapists, the profession needs to pay attention to the way in which whiteness and structural racism may function to exclude ethnic minority psychologists and psychotherapists (Goodbody & Burns, 2011; Odusanya et al., 2017). This creates a responsibility for white family workers to be allies in supporting the creation of a context whereby ethnic minority psychological therapists can bring their personal-professional selves, genuinely inform psychological practice using their knowledge and lived experiences and progress within the field.

CONTINUING PROFESSIONAL DEVELOPMENT

Training does not stop after initial training, and all practitioners require ongoing continuing professional development. Good service examples of this include Sussex, where staff are required to attend a minimum of one day's CPD specific to family interventions in addition to their ongoing family interventions supervision. In addition, professional groups such as the Association for Family Therapy (2015) require practitioners to do specified amounts and types of Continuing Professional Development.

SUPERVISION

Supervision is of central and fundamental importance to safe and effective practice at all levels and contexts. There are some systems for formal training and accreditation of supervisors in psychological therapies (for example in Family Therapy, Association for Family Therapy, 2017) – but until recently most were essentially elective. Consequently, a competence framework for the supervision of psychological therapies has been drawn up (Roth & Pilling, 2015). This provides a detailed description of generic and specific supervision competencies. The supervision competencies required by each model varies in relation to the model and context.

TYPES OF SUPERVISION

Family work supervision can include group, live, individual one-to-one and retrospective supervision, as well as the supervision and analysis of recorded practice (Association of Family Therapy, 2017). It can also include 'drop in', ad hoc and supervision clinics, which can work well in inpatient settings. Supervision is most often provided by a more experienced and/or trained supervisor, but may be provided peer to peer.

In addition, supervisors require supervision of their own supervision. For example, systemic practitioners supervising family intervention practitioners might require space in their supervision group for this or separate time for supervision of supervision. There are a number of useful summaries of issues around psychological therapies supervision (Roth & Pilling, 2015) and relational therapies supervision (Lee & Nelson, 2014).

BARRIERS TO SUPERVISION

The following barriers have been identified (Eassom et al., 2016),

- Lack of organisational support for supervision in terms of strategic plans and solutions – including limited structured regime of supervision encouraging attendance and ongoing support and lack of forward thinking in terms of supporting advanced training to support supervision at all levels.
- Lack of access to adequate, modality specific supervision.
- Little encouragement of a range of supervision practices such as peer and whole team supervision.

TRAINING IN SUPERVISION

Levels of training and accreditation in supervision vary across interventions, from five-day integrated ‘Train the trainer and supervisor’ training, accredited by the Meriden Programme (Fadden, 2006), to an academic year of training accredited by a professional training body (Association for Family Therapy, 2017) or accredited supervision trainings across psychological modalities. Some services provide in-house supervision training.

IMPLEMENTATION OF SUPERVISION

Whatever the model, implementation of supervision needs to be linked to training and requires a structured regime of supervision and encouragement of attendance (Fadden, 2009). Supports can include:

- Preparation for supervision
- Supervision registers
- Supervision contracts
- Professional body requirements, for example requirements from the Association for Family Therapy for minimum supervision levels at each stage of training (Association for Family Therapy, 2017)
- Organisational governance requirements for supervision

All members of a clinical team should be regularly supervised, a ‘whole team approach’ being particularly helpful (Eassom et al., 2016). There are a number of good examples of descriptions of supervision supports (Fadden, 2009; Sussex Partnership Family and Systemic Therapy Practice Network, 2016); Burbach, 2012; NTW, 2016). Self reflexivity is an essential part of any supervision and should be included in training. Supervisees should be encouraged to reflect on their practice, what they bring of themselves to the work, how it affects them and how it impacts on the processes in the room (Krause, 2012; Gabb & Singh, 2015).

Research (Haggarty, 2016) has explored the lived experience of family workers in implementing family interventions, and found supervision was seen as fundamental to managing the challenges of the work. Group supervision acted as a motivator and a refresher. It allowed for growth and new ways of using the approach, as emphasised by Lesley:

'Supervision is immensely, immensely helpful ... we really must try to hold onto that opportunity to... have supervision around family work, experience what other colleagues are doing and how they're doing it, and how they overcome the challenges that come with it ... and innovative ways of using the approach'

Further reading can be found about the supervision of psychological therapies (Roth & Pilling, 2015), relational supervision (Lee & Nelson, 2014) and systemic supervision (Burck & Daniel, 2010).

Supervision from a family therapist who has more psychosis experience would help with the development of practice – however finding practitioners with both is difficult.

Clinical and counselling psychology training in itself is not sufficient to provide the competencies to deliver family intervention training and supervision at all levels. Doctorate courses vary in their commitment to training psychologists in family work. Work needs to be done to enable psychologists to come out of doctorate training with sufficient experience of working with families. Currently psychologists vary in their levels of training and experience in family interventions during and post professional training. This can influence potential training and supervision roles in relation to family interventions.

Psychologists can have a role in the provision of family intervention training and supervision, relevant to their level of training and experience, and in the implementation of training and supervision at multiple levels of organisational systems. To this end, clinical psychology training should equip all trainees with the skills to work with families and networks.

RECOMMENDATIONS

- Organisations aiming to provide best practice family interventions should have a clear strategy for the provision of training and supervision in family interventions. This should specify the numbers of staff to be trained in family intervention in each service and how they can be supported to implement their skills through supervision and CPD. Additionally the strategy should include training and supervision in family inclusive practice for all staff in contact with families plus training in a range of evidence based models for staff with prior professional training to ensure a range of family interventions are available to families using the services.
- Doctorate courses in clinical psychology need to support psychologists to be proficient in supporting families. It is therefore recommended that they provide training in family inclusive practice at induction, followed by additional training and access to clinical experience in family work. Courses should also encourage trainees to complete training in Structured Family Interventions to support the implementation of family interventions and be part of supervision and training programmes.
- Foundation level training in family and systemic psychotherapy accredited by the Association of Family Therapy should be considered by training courses.
- Psychologists involved in family interventions will need additional specialist training and adequate and appropriate supervision.
- Fully qualified family and systemic psychotherapists are well placed to be involved in providing supervision and consultancy.
- Service users and their families should be part of all teams providing family training to staff working with people who experience psychosis. Special consideration needs to be given to supporting experts by experience, through training and supervision, to use their lived experience in a way that is helpful to others.

9. Implementation

Gráinne Fadden

KEY POINTS

- Implementation of family work remains challenging in spite of the robust evidence base for its effectiveness and guidelines stipulating it should be delivered.
- Organisational factors such as leadership, management support, and availability of training and ongoing supervision are key to ensuring that services to families are delivered.
- Other barriers identified by clinicians include difficulties in integrating family interventions alongside the other demands on their time and lack of management support (Fadden, 2006). Clinicians newly trained in family interventions can lack confidence in applying skills, have difficulties in engaging families and lack the basic therapeutic skills that family intervention training hopes to build on (Burbach, 2012).
- Services should aim to provide a range of family interventions to meet the needs of families at different points in time.
- The involvement of families in a range of roles in services, including training, service planning and auditing supports the development of family-inclusive practice.
- Psychologists may usefully play a role in establishing and safeguarding family therapy resources, as well as helping ensure adequate support for those delivering family services, including multidisciplinary team members and trainees.

IMPLEMENTATION ISSUES

Implementation of family work in routine services remains one of the biggest challenges we face – in spite of evidence, policy and guidelines. In a systematic review of implementation, Ince et al., (2015) found that implementation rates for family intervention varied from 0 per cent to 53 per cent. A more stringent audit of files and case notes (Haddock et al., 2014) found rates of 1.6 per cent being offered family intervention, with 1.1 per cent being delivered. Systemic thinking is ideally placed to help with all aspects of implementation. This is necessary as it would appear that family interventions face more implementation challenges compared with other aspects of new healthcare programmes (Addington et al., 2012).

The difficulties with implementation have been identified through research in three categories; therapist variables, family variables and organisational context (Fadden, 1998; Kavanagh et al., 1993; Fadden, 1997). Four recent reviews provide excellent summaries of the relevant issues (Bucci et al., 2015; Ince et al., 2015; Eassom et al., 2014; Selick et al., 2017).

Organisational barriers were the most commonly reported in the review by Ince et al., 2015. These included issues such as lack of protected time for family work, workload pressures, staff shortages and negative management and team attitudes towards psychological therapies. Eassom et al. (2014) cite similar organisational attitudes such as family work being seen as secondary to the care of the service user without the link between these being recognised, as well as issues linked with resources and funding. Availability of training and supervision are also key, so if these are absent, implementation will not be successful.

Historical factors can also be relevant, e.g. services retaining a focus on the individual rather than on social networks. This can be reflected in a lack of welcoming spaces for families in service buildings, or in recording systems that do not have space for recording services offered to families.

For clinicians, there is clearly overlap with organisational issues in terms of access to training and supervision. Other barriers relate to attitudes and beliefs of staff, including lack of confidence in skills, and uncertainty about the value of the intervention for particular families (Ince et al., 2015). Some clinicians find it difficult to think systemically, preferring to work with individuals rather than facing the challenge of seeing multiple perspectives on difficulties presented.

Issues related to families – some family members or others in the individual's social network may be unsure about engaging in therapy. There may be issues about readiness, timing, intensity and content of the intervention (Selick et al., 2017), and there can be challenges linked with cultural appropriateness of the approach (Bucci et al., 2016). Some may not understand the benefits of their involvement. Others may feel let down by services and angry that they were not offered help sooner in the initial challenging stages of dealing with ill-health in a family member.

SUPPORTING IMPLEMENTATION

Proactive strategies are needed that take account of contextual factors as well as ways to overcome barriers (Bauer et al., 2015; Saeed et al., 2015). Given that barriers arise at organisational, clinician and recipient level, the solutions also need to address these three main areas. The overarching principles of valuing families as equal partners and having a focus on recovery apply to all of these.

ORGANISATIONAL LEVEL

An overarching goal is to develop a shared culture that is positive towards families, where family work is prioritised and where families are seen as partners in care (Froggatt et al., 2007; Stanbridge et al., 2007). A recovery-focused approach that emphasises the service user's social context will help with this.

The role of leadership and management, both senior and middle, is crucial to implementation. Eassom et al. (2014) identified this as the strongest facilitator of implementation. The role that management can play has been described in detail (Fadden, 2006, 2009; Fadden & Heelis, 2011; Burbach, 2012).

The idea of having family work champions has been around for some time (Smith & Velleman, 2002). This is different from management, as champions can be at different levels in the organisation. Training and supervision are both essential for implementation and are addressed in the chapter on training. In implementing family work, it is important to be aware of change management principles and how to deal with resistance to new ideas.

In this document, the different options available for working with families are promoted (see Chapter 2 above). For those starting to implement family work, it may be worth thinking what it is feasible to offer of the different ways of working. It is crucial when looking at the range of possible family approaches that families are involved in this process so that decisions are made based on what meets their needs, rather than on service expediency or clinician preference. These guidelines advocate for structural organisational change to support family work at all levels.

RECOMMENDATIONS

- Develop a strategy, policies and procedures that clearly include families as well as service users.
- Ensure there are carer and family member governors on the board of the organisation.
- Involve families in the recruitment of staff.
- Ensure there is a place in documentation to record input to families whether at an individual or group level.
- Welcome families to events held in the organisation.
- Have a mechanism in place for getting feedback from families on their views on the service.
- Write the delivery of family interventions into policy, business plans and job descriptions.
- Ensure that training is funded and available for clinicians and managers.
- Facilitate protected time to deliver family work and to attend supervision. This involves agreeing how crises in other aspects of the clinician's work will be dealt with so that they are not drawn away from planned sessions with families.
- Support flexible working as family work sometimes needs to be delivered outside of 9–5 working hours.
- Have a family work champion on each team and ward who reminds people about issues related to families, keeps family issues on the agenda, and communicates family-relevant information to different groups in the organisation.

People often ask how to get started in getting family work established in a service. Here is an example of how you might go about it:

- Establish a Family Work Steering Group. This group should not be very large, and should have representation from senior management, operational management as well as service user and family member representatives.
- Identify a senior management link person – it is really important to have a 'sponsor' at management level. It is also important to use arguments that matter to managers, e.g. improved quality, cost savings, delivering evidence-based practice, fewer complaints and less bad publicity.
- Develop a family work strategy or family/carer pathway such as that developed by South London and Maudsley NHS Foundation Trust (<https://www.slam.nhs.uk/media/18933/slam-family-and-carers-strategy-2021.pdf>) or work within the framework of other initiatives such as the Triangle of Care (Worthington et al., 2013). Work needs to be carried out to promote the strategy and empower staff to make it a reality.
- Draw up a detailed implementation plan which outlines clearly the responsibilities of those at different levels in the organisation in relation to the delivery of family work, and targets with dates when they will be reviewed.
- Have a system of recording family work and measuring outcomes (See Chapter 10). It is a disincentive if the services delivered to families are not recognised, and it helps to change the culture of individual care if contacts with family members are recorded.
- Have an audit system so that delivery of family work and how it is received by families is measured. It is helpful to get commissioners on board so that they can set the delivery of family work as one of their targets.

CLINICIAN LEVEL

Clearly having well trained and supervised staff in sufficient numbers with protected time is crucial to the successful implementation of family work. Issues related to training and supervision are addressed in more detail in Chapter 8.

RECOMMENDATIONS

- Arrange for staff to be trained and for supervision to be available.
- Address attitudes and beliefs as well as skills (Prytys et al., 2011).
- Facilitate staff having time to deliver family work and attend supervision.
- Facilitate co-working. Clinicians often feel anxious about starting family work following receipt of training. It can help when they work with a colleague, preferably someone experienced in delivering family work.
- Pay particular attention to developing skills in engaging families, as clinicians often find this challenging (James et al., 2006). The Meriden Family Programme have found that a clinician being joined by a family member who has benefitted from family work can help to engage other families. This is good practice regardless of the model of family intervention, but is seldom implemented. The presence of paid Family/carer peer workers in teams should make it easier to provide this useful input to sessions (see section on Family/carer peer workers in Chapter 2 above).
- Offer family work at the initial meeting with the service user so that this becomes the norm. This is common practice in early intervention in psychosis services.
- Make it clear that families should be included in care planning unless there is a specific reason why this cannot happen.

CONFIDENTIALITY ISSUES AS A MAJOR CHALLENGE

One of the biggest challenges to engaging with families is clinicians' concerns about confidentiality conflicts between service user and family. It is identified in surveys with families as one of their main concerns and as a key obstacle to them being included in their relative's care (Pinfold et al., 2007; Rapaport et al., 2006), and so deserves special mention. Much of this clinician anxiety is unfounded and it is useful for teams to discuss their anxieties as part of their training, and to use the guidance that is available for overcoming their concerns (Gold et al., 2009; Slade et al., 2007). However all staff need to be supported to understand issues around confidentiality, acknowledge carer confidentiality as well as service user confidentiality and not allow confidentiality to get in the way of supporting families' emotional needs and including their input into care planning.

EXAMPLE

In Birmingham and Solihull Mental Health Foundation NHS Trust, the challenge of addressing confidentiality concerns is met by organising training days co-delivered by family workers, service users, family members and staff from the legal department. Clinicians often confuse issues relating to information governance and those linked with sharing information with families. Having someone from the legal department as part of the training team is crucial as it reassures staff when they are guided through what can and what should not be shared in what circumstances.

Hearing from both service users and family members about the benefits of the family being involved provides those attending with a more balanced view as prior to the training they tend to see only the conflicts that confidentiality issues gave rise to.

FAMILY/SERVICE USER LEVEL

Selick et al. (2016), in a review primarily of group approaches to family work have highlighted a number of factors that can influence whether families accept an offer of family work linked with timing and readiness. Some family members may not believe that this is relevant to them or may have competing work and home commitments (Petrakis et al., 2014). It is crucial therefore to have a number of different options available to families and to offer support at different points in time (Burbach et al., 2010). Families should always have the option to opt in – one ‘no’ doesn’t mean that they never want to engage in our services. Circumstances change and we must keep the door open. It is also important to have a flexible approach to the delivery of family work to suit the individual family, and to be aware of cultural factors that may impact on the acceptability of what is being offered (see Chapter 4 for further information).

RECOMMENDATIONS

- Provide different opportunities for families to get involved in services.
- Ensure that payment systems are in place so that family members are reimbursed for the work they do.
- Have a range of options available to families to meet their differing needs.
- Develop family peer support systems.
- Have clear guidance on confidentiality and provide training and consultation for staff around issues of confidentiality in families.

EXAMPLE – ONE FAMILY’S EXPERIENCE

‘When family work was suggested, I was sceptical at first as I felt it was my daughter’s problem and that they (service) should be helping her. The two family workers explained why they thought my wife and I and our son should be involved, and I could see their point as there were constant arguments at home.

I was impressed from the start at how positive the two workers were that things could change. This gave my wife and I hope and we thought we’d give it a try anyway. They were really flexible about things like how often we met and where. They came to our home which was great because it meant that our daughter was more likely to attend – at that stage she didn’t like going out anywhere. They agreed we could meet 3-weekly because my wife and I were busy with work, and our son was in his final year at school and was studying.

The biggest thing that changed was that we started talking to each other again without shouting. We even started to laugh again which we hadn’t done for a long time. When we finished the sessions we continued to meet every 4 months or so which was very reassuring.’

10. Measuring outcomes for families

Maria Griffiths

KEY POINTS

- Outcome measures are an important way of illustrating change over time, for the benefit of family members, practitioners and service managers.
- Measures can be a useful means to make comparisons between services and to inform service development.
- Measuring outcomes for families can be complex due to multiple and varying outcomes so the choice of an appropriate measure needs to pay attention to a range of considerations, some of which may be locally determined.
- Consider the cultural context of each family when selecting, administering and interpreting outcome measures.
- Outcome data will be most useful if it is routinely and consistently collected and collated, so feasibility is an essential component.
- Idiosyncratic measures and qualitative feedback can be valuable additions to standardised outcome measures.

INTRODUCTION

Outcome measurement has been defined as: *'the assessment, during or after having received services, of behaviour, states or adjustment, which are significantly related to the reasons for the person having sought care'* (p.5, Sperlinger, 2002). The Division of Clinical Psychology (DCP) has identified evaluation of psychological interventions as an integral part of the work: *'The ability to devise, modify and use evaluation procedures to improve clinical outcomes and to handle complex and difficult data are key competencies for any clinical psychologist.'* (p.6, DCP, 2010)

There are many reasons for measuring outcomes in routine practice, which can be thought about in three main areas, summarised by Sperlinger (2002). The first is clinical utility. Measures help us to consider whether family members are responding to the service that is being offered and whether any of these changes are clinically significant. Secondly, measures enable comparisons to be made, such as between practitioners or between services. Finally we can use outcome measures to facilitate service developments through communicating information to managers and practitioners about areas for quality improvement, as well as to commissioners to support decision-making about resource allocation. This last point is particularly important given what we know about some of the difficulties in protecting resources for the delivery of family work (Onwumere et al., 2016).

In the broadest context, guidance from the Department of Health has increasingly focused on health outcomes rather than targets, through the collection of a range of routine outcome measures (Department of Health, 2013). These have in common the ultimate aim of improving service quality and largely fall into the categories of patient-rated outcome measures (PROMs), clinician-rated outcome measures (CROMs) and patient-rated experience measures (PREMs) (Lewis & Killaspy, 2014). Given that perception of outcome often differs according to whose perspective is sought, it may be desirable to consider using all three types in addition to process

measures such as the proportion of families offered FI (Lewis & Killaspy, 2014). It should also be noted that many recommended PROMs, such as DIALOG (Priebe et al., 2012), are used to evaluate outcomes from a whole service episode and are unlikely to be specific or sensitive enough to identify changes from a psychological intervention although some (DIALOG included) do ask about partner/family satisfaction. Even if such measures are required by a service, FI practitioners should plan to use a more specific outcome measure to evaluate their family work.

In summary, outcome measurement comprises a range of tools to enable us to reflect on our clinical work and facilitate continued improvement of the service (Sperlinger, 2002) and the implementation of FI initiatives. To do this well requires careful selection of appropriate measures and means of using them in practice.

ISSUES IN THE MEASUREMENT OF OUTCOMES FOR FAMILIES

MULTIPLE OUTCOMES

There are many complex and interacting variables to consider in the use of outcome measures, many of which are relevant for individual work as well as for families. For example, there are multiple influences in a person's life and separating these out to measure the potential impact of an intervention is challenging (Berger, 1996). Similarly, there are multiple outcomes, which may differ between individuals using the same service and which may be idiosyncratic or hard to capture. For example, people can highly value interventions that have not led to observable change.

In addition, there is the complexity that comes with measuring outcomes for several individuals in a family who are likely to have all experienced the same events slightly differently and may have diverse views about what has changed, if anything, as a result of the intervention. Our interest in the experience of those in the care context, as well as the person experiencing psychosis, generates two interdependent sets of outcome. The multiplicity of influences and consequences is inevitably increased.

CHOICE OF MEASURE

It is important to make a decision about the nature of the change that is of most interest. For example, FI emerged from an evidence base focused on the prevention of relapse and hospital admission (Bustillo et al., 2001) but over time has developed in recognition that valued outcomes concern more than just 'symptomatic' change for the person. Meaningful outcomes could occur in any of the following areas, and more:

- Whole family function (e.g. relationship changes such as connectedness, mutual support and communication style)
- Caregiver experiences (e.g. carer burden, distress and wellbeing, relationship to services)
- Service user experiences (e.g. relapse, distress, wellbeing, social and occupational function)
- Service experience or satisfaction (e.g. for a specific intervention, or a whole team)
- Economic outcomes (e.g. therapist hours, cost effectiveness ratios)

Choosing the appropriate measures will therefore depend on identifying the prioritised functions of the data being collected, combined with a respectful approach to what will feel useful and acceptable to the family members, as well as feasible for practitioners.

In addition, care should be taken to minimise the effects of cultural specificity in the choice and interpretation of outcomes data, attending to such things as cross-cultural validation of tools and the use of language. Many outcome measures have not been validated for different cultures

though it is clear that peoples' experiences can have very different meanings and interpretations in non-Western cultures (Bhui et al., 2003). Qureshi et al. (2011) noted the effect of various cultural influences on the interpretation of mental health assessment instruments. For many families using secondary mental health services, English is not their first language, so a written assessment tool may be challenging for some. Given that conceptual equivalence between languages is often poor, it is rarely straightforward to translate measures (Bhui et al., 2003). Idiosyncratic measures, developed collaboratively with individual families, to assess outcomes on the basis of what is most important to them, can be a useful adjunct here.

USE OF MEASURES IN PRACTICE

Practitioners are more likely to use measures which are easy to understand and which have clear utility, for example if they receive regular feedback based on their completion of measures (Trauer et al., 2009). Practitioners may nevertheless be reluctant to give outcome measures due to concerns about this reflecting a service agenda rather than the family's agenda. Additionally, it can feel like an interruption to what can, at times, feel like a fragile engagement process. One practitioner expressed the following thoughts:

'I find it difficult to find the right moment to ask families to complete measures as the time runs out quickly in a session and then it feels like we're prioritising my agenda over theirs'

On the whole, research does not seem to support this position, with some evidence suggesting that outcomes assessment can be wholly acceptable – or even helpful – to the person experiencing psychosis, and their family members (Fornells-Ambrojo et al., 2017).

Family member: 'I was so relieved that when I saw all the things I had been experiencing written down on the sheet. I thought that if they were written there, it means that other people must feel them too and that it's not just me, so I didn't feel so much on my own anymore'

In addition there is evidence to suggest that collecting and using feedback from clients contributes positively to the therapeutic relationship (Ellis et al., 2018). Nevertheless people on the receiving end of outcome measures could struggle to see the value of the exercise, or worry about how their responses could be perceived. It is important that decisions about the use of measures are explained and negotiated, with families also able to offer their views about how best to capture any changes for their own situation.

Family member: 'There is value in both the qualitative and quantitative aspects. The support we received helped the entire family, improved our relationships and understanding of the condition our family member experiences. I can appreciate that it is difficult to measure this and a qualitative approach may be appropriate. However, I believe that there is a clear way of quantifying benefit and it should be used to demonstrate the benefit of the service in financial terms and in how periods of hospitalisation or crisis diversion have impacted on outcomes for the patient and in savings for the service.'

Psychologists should be able to advise on how to incorporate outcome measures in a way that feels helpful, rather than intrusive, to families. This will depend on the measure and its purpose. Some will best be given in sessions in order to inform discussions about how things are progressing, whilst others might be better given by someone other than the therapists, for example satisfaction questionnaires at the end of the intervention.

Practice example: A family service paid for a carer, with past personal experience of FI, to meet with families at the end of their interventions, to obtain their views about what had helped and

made a difference, or what they might have liked to be done differently. Families were able to give more honest feedback to someone from a similar position to their own.

There are marked advantages to routinely giving a short measure at the end of each session as this will allow some meaningful data collection to occur – and to illustrate progress – even if families disengage. In the absence of a routine approach such as this, much of the data collected from families will be incomplete and therefore of little value. The frequency of use will then in turn influence the choice of measure in order to minimise time taken.

Consideration should also be given to practical issues such as how completed assessment measures are stored for family members when they do not have a record of their own. Electronic records are not often designed to record and store family data when they are not the identified client. Some systems have worked around this through the development of specific carer records which are electronically linked to the service user's record. Whatever approach is taken to this should be consistent with local policy and negotiated explicitly with family members.

An advantage of digital FI is that routine outcome measures can be incorporated within the clinical approach. For example, the Healios FI programme uses a range of validated clinical outcome measures including SCORE-15. Some measures such as the RCADS, which is used as a pre- and post-intervention measure, are administered in the virtual waiting room; other measures such as GAD7 and PHQ9 are administered electronically within sessions as session-by-session measures, and Session Rating Scales are administered at the end of each session.

MEASURES FREQUENTLY USED IN ROUTINE PROVISION OF FAMILY INTERVENTION

The following list comprises examples of measures in common use at the time of writing, partly informed by the work of the IAPT-SMI demonstration sites (e.g. Fornells-Ambrojo et al., 2017) and developments in EI services subsequent to the national reporting on 'Access and Waiting Time Standards' (NHS England, 2015). The Early Intervention in Psychosis Network, which audits EI teams against various benchmarks, requires the use of DIALOG, HoNOS/HoNOSCA and QPR. Outside of EIS however, there are no currently agreed standards for the use of measures in FI, and decisions are likely to be influenced by local factors.

- Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) (Bass et al., 2016) – for all.
- Clinical Outcomes in Routine Evaluation (CORE-10) – for service users and sometimes for relatives (Barkham et al., 2013).
- Depression Anxiety and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995) – for all.
- Illness Perception Questionnaire – carer version (IPQ) (Barrowclough et al., 2001) – for relatives.
- Systemic CORE (SCORE-15) (Stratton et al., 2010) – for all.
- Experience of Caregiving Inventory (ECI) (Szmukler et al., 1996) – for relatives.
- Outcome Rating Scale and Session Rating Scale (Miller et al., 2003; Miller & Duncan, 2004) – for all.

In the pursuit of more objective measures, the significance of collecting idiosyncratic and sometimes highly subjective data should not be neglected. There is a real value in highlighting to families any changes that have been noticed in such things as the amount and quality of time spent together, number of anxious phone-calls made to a team and so on. Similarly families may benefit from telling their story about what it was like to receive help together, so qualitative questionnaires or interviews at the end of an intervention can be worthwhile. With

families' consent, these offer opportunities to supplement hard data – shared with managers and commissioners – with individual quotes that often have higher impact. This can be very validating for families.

Practice example: Croydon Family Intervention and Support Service used a feedback questionnaire with space for qualitative comments, which included an opportunity for family members to indicate their consent for anonymised quotes to be shared. One relative fed back that this encouraged them to give more feedback as they believed it had the potential for them to be heard beyond the immediate service. The same service also offered families the opportunity to be filmed talking about their experiences of family intervention and any outcomes, at the end of the work. Take up for this was high.

Psychologists have a central role to play in supporting the development of robust and well thought out approaches to the measurement of outcome in FI. Psychologists are well placed to advise on the most meaningful areas to measure and with whom, the intended function and audience of the data, acceptability for the client group and feasibility for the practitioners involved. Psychologists also have a role to play in clarifying the rationale for the chosen measures to all those involved, in order to support routine completion and maximise utility of the data.

Psychologists often lead on the collating and reporting of FI outcomes in order to ensure that the data is presented in ways that respect the complexities outlined above, whilst making key information accessible to those who need it.

RECOMMENDATIONS

1. Choose one short measure – that is consistent with any other local reporting requirements or standard practice – and use it routinely and consistently.
2. Supplement a short, routine measure with any additional measure (standardised or idiosyncratic) that you think will have clinical utility for a particular family.
3. Consider the cultural context of the family you are seeing and any associated limitations of the standard measure. Ask families about what will be the most meaningful way to judge outcomes for them.
4. Explain the rationale for using measures to families and draw on their responses to inform the progress of your work together and reflect on any changes.
5. Explain the rationale for using measures to colleagues and make sure that feedback is shared and discussed regularly to demonstrate the value of collecting data.
6. Think with colleagues about how data can be shared more widely (e.g. with senior managers and commissioners) in order to support local arguments for increased access to FI.

11. Conclusions and aspirations

Jo Allen and Steven Livingstone

Working with families and networks is essential for good practice in services. All mental health professionals have a role in supporting family inclusive practice and increasing availability and quality of family interventions.

This document is intended to provide helpful guidance on the different ways of supporting families and the range of approaches available. Family interventions have been shown to reduce relapse and hospitalisation and support improved outcomes for all family members. Family and networks should be included in decision-making and care planning to best support outcomes for the service user. It is essential to support families and carers to manage at this difficult time through carer support.

NICE guidelines and the UCL competencies give support for the areas of need in family interventions. These can however be delivered in various ways, through structured interventions or through using a systemic approach. All family interventions follow common processes such as attending to the therapeutic relationship, contracting of goals in the work and supporting change through conversations around understanding experiences, improving communication and supporting recovery. Differences are often around the approach to these conversations and tools used. The different training and support routes affect the different practices.

When deciding on which intervention or approach to take forwards, consideration needs to be taken to the existing skills in the workforce and the training and supervision provision within the organisation. What is most important is providing support for families which is appropriate and delivered by competent practitioners. Choice for families and practitioners should be supported. Some families prefer a psychoeducational approach and structured communication skills learning. Others value open-ended questions, attention to the wider context and a focus on trans-generational issues, as more often used in systemic practice. Additionally, practitioners should be encouraged to pursue which approach makes sense to them, as there is evidence that therapist conviction in the approach is an important indicator of progress in therapy. Ultimately, the different ways of working and different approaches described in this document all offer something helpful to families. Commitment to offering different approaches should be sought, and choice should be available to families in the approach they take up.

All families are different and attention to difference should be central to family interventions. A wide view of family should always be taken, asking service users and families who should be included in any intervention. Work needs to be undertaken to audit and improve access and take-up of family intervention in diverse communities. Family interventions training must equip practitioners to work with diversity and to practice in an anti-racist and anti-oppressive manner. Practitioners should commit to ongoing self-reflexivity and curiosity about their own and families' socio-historical context and develop competencies in bringing this into their work with families.

Supporting families throughout their journey in services is important, and practitioners should offer family interventions multiple times in each service. Families might require different things at different times in their journey and different conversations and support might be necessary depending on the situation. Attention needs to be given to the trauma experienced in crisis, the shock and trauma of first episodes and the burn-out after multiple years of caring, which can lead to loss of hope and feelings of grief. Different family members may want to be included

at different times, hence flexibility in supporting work with different groups of family members is important.

A clear implementation strategy with support at all levels of the organisation is important to providing sustained delivery of family inclusive practice and family interventions. Training and supervision should always be included in these plans. A strategy should highlight the importance of critical numbers of clinicians trained in family intervention and support for clinicians to have the time to not just attend training but also to deliver interventions and attend on-going supervision. Different approaches should be supported and differing lengths of training to support the development of expertise in services. All staff should be trained in family-inclusive practice. Training needs to follow guidelines and be supported by co-working and supervision by experienced family intervention practitioners. Psychologists, along with other professionals, have a role to play in the development of family interventions in services, particularly in supervision and training. Support is required in organisations and professional groups to help them achieve this, and doctorate psychology training should equip all trainees with the skills to work with families and networks.

This guidance is specifically focused on family interventions for psychosis. The recommendations apply equally however to many if not all mental health difficulties. It is hoped that family interventions will become readily available for all families regardless of diagnosis.

We hope that in the future no family should go through supporting a loved one in their journey through mental health services without being included in their care and being offered family interventions as well as their own individualised support.

REFERENCES

- Aaltonen, J., Seikkula, J. & Lehtinen, K. (2011). The comprehensive open-dialogue approach in Western Lapland: I. The incidence of non-affective psychosis and prodromal states. *Psychosis*, 3, 179–191.
- Addington, D.E., McKenzie, E., Wang, J. et al. (2012). Development of a core set of performance measures for evaluating schizophrenia treatment services. *Psychiatric Services*, 63(6), 584–591.
- Addington, J., Coldham, E.L., Jones, B. & Ko, T. (2003). The first episode of psychosis: the experience of relatives. *Acta Psychiatrica Scandinavica*, 108(4), 285–289. <https://doi.org/10.1034/j.1600-0447.2003.00153.x>
- Afuape, T. (2011). *Power, resistance and liberation in therapy with survivors of trauma: To have our hearts broken*. Hove: Routledge.
- Ahsan, Sanah. (2020). Holding up the mirror: Deconstructing Whiteness in clinical psychology. *The Journal of Critical Psychology, Counselling and Psychotherapy*, 20(3), 45–55.
- Alanen, Y.O. (2009). Towards a more humanistic psychiatry: Development of need-adapted treatment of schizophrenia group psychoses. *Psychosis*, 1:2, 156–166. doi:10.1080/17522430902795667
- Allen, J., Burbach, F. & Reibstein, J. (2012). 'A different world': Individuals experience of an integrated family intervention for psychosis. *Psychology and Psychotherapy: Theory, Research and Practice*, 86(2), 212–228.
- Andersen, T. (1991). *The reflecting team: Dialogues and dialogues about the dialogues* (pp.98–126). New York: Norton.
- Andersen, T. (1995). Reflecting processes; Acts of informing and forming: You can borrow my eyes, but you must not take them away from me! In S. Friedman, S.(Ed.) *The reflective team in action: Collaborative practice in family therapy* (pp.11–37). New York: Guilford Publication.
- Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy*. New York: Basic Books.
- Anderson, H. & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. Gergen (Eds.) *Therapy as social construction* (pp.25–39) London: Sage.
- Anderson, K.K., Flora, N., Archie, S. et al. (2014). Race, ethnicity, and the duration of untreated psychosis: A systematic review. *Soc Psychiatry Psychiatr Epidemiol*, 49, 1161–1174.
- Angermeyer, M.C., Bull, N., Bernert, S., Dietrich, S. & Kopf, A. (2006). Burnout of caregivers: A comparison between partners of psychiatric patients and nurses. *Archives of Psychiatric Nursing*, 20(4), 158–165.
- Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11–23. <https://doi.org/10.1037/h0095655>
- Askey, R., Holmshaw, J., Gamble, C. & Gray, R. (2009). What do carers of people with psychosis need from mental health services? Exploring the views of carers, service users and professionals. *Journal of Family Therapy*, 31(3), 310–331. doi:10.1111/j.1467-6427.2009.00470.x
- Association for Family Therapy (2015). *The Blue Book. Training Standards and Course Accreditation*, 4th edition.
- Association for Family Therapy (2017). *The Red Book. Training standards and requirements for systemic supervisors and supervision training courses*, 3rd Edition.
- Bailey, R., Burbach, F. & Lea, S. (2003). The ability of staff trained in family interventions to implement the approach in routine clinical practice. *Journal of Mental Health*, 12(2), 131–141.
- Barkham M., Bewick B.M., Mullin T. et al. (2013). The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. *Counselling & Psychotherapy Research*, 13, 3–13. doi.org/10.1080/14733145.2012.729069
- Barrowclough, C. (2003). Family intervention for substance misuse in psychosis. *Substance Misuse in Psychosis: Approaches to Treatment and Service Delivery*, 227–243.
- Barrowclough, C. & Tarrier, N. (1997). *Families of schizophrenic patients: Cognitive behavioural intervention*. Nelson Thornes.
- Barrowclough, C., Haddock, G., Fitzsimmons, M. & Johnson, R. (2006). Treatment development for psychosis and co-occurring substance misuse: A descriptive review. *Journal of Mental Health*, 15(6), 619–632.
- Barrowclough, C., Haddock, G., Tarrier, N., Moring, J. & Lewis, S. (2000). Cognitive Behavioral Intervention for Individuals with Severe Mental Illness who have a Substance Misuse Problem. *Psychiatric Rehabilitation Skills*, 4(2), 216–233.
- Barrowclough, C., Lobban, F., Hatton, C. & Quinn, J. (2001) An investigation of models of illness in carers of schizophrenia patients using the Illness Perception Questionnaire. *British Journal of Clinical Psychology*, 40(4), 371–385. doi:10.1348/014466501163869
- Barton, K. & Jackson, C. (2008). Reducing symptoms of trauma among carers of people with psychosis: Pilot study examining the impact of writing about caregiving experiences. *Australia and New Zealand Journal of Psychiatry*, 42(8), 693–701. <https://doi.org/10.1080/00048670802203434>
- Bass, M., Dawkin, M., Muncer, S., Vigurs, S. & Bostock, J. (2016) Validation of Warwick -Edinburgh Mental Well-Being Scale (WEMWBS) in a population of people using secondary care mental health services. *Journal of Mental Health*. 25, 4, 323 – 329. doi:10.3109/09638237.2015.1124401
- Batten, D. et al. (2020) 'Initial family meetings in adult mental health', *Context*, 168, pp.2–5.
- Bauer, E., Kleine-Budde, K., Stegbauer, C. et al. (2016). Structures and processes necessary for providing effective home treatment to severely mentally ill persons: a naturalistic study. *BMC Psychiatry*. doi:10.1186/s12888-016-0945-z.
- Bauer, M.S., Damschroder, L., Hagedorn, H., Smith, J. & Kilbourne, A.M. (2015). An introduction to implementation science for the non-specialist. *BMC Psychol*, 3(1),32. doi:10.1186/s40359-015-0089-9
- Bell, V., Dunne, H., Zacharia, T., Brooker, K. & Shergill, S. (2018). A symptom-based approach to treatment of psychosis in autism spectrum disorder. *BJPsych open*, 4(1), 1–4.
- Berger, M. (1996). Outcomes and effectiveness in clinical psychology practice. *DCP Occasional Paper 1*.
- Berry, K. & Haddock, G. (2008). The implementation of the NICE guidelines for schizophrenia: barriers to the implementation of psychological interventions and recommendations for the future. *Psychology and Psychotherapy*, 81(4), 419–36.
- Bertolino, B. & O'Hanlon, W.H. (2002). Collaborative, competency-based counselling and therapy. Prentice Hall.
- Bertrando, P., Beltz, J., Bressi, C. et al. (1992). Expressed emotion and schizophrenia in Italy: A study of an urban population. *British Journal of Psychiatry*, 161, 223–229.

- Bertrando, P. (2006). The evolution of family interventions for schizophrenia. A tribute to Gianfranco Cecchin. *Journal of Family Therapy*, 28(1), 4–22.
- Bertrando, P. & Gilli, G. (2010). Theories of change and the practice of systemic supervision. In C. Burck and G. Daniel (Eds.) *Mirrors and reflections: Processes of systemic supervision* (pp.3–26). London: Routledge.
- Bhugra, D. & McKenzie, K. (2003). Expressed emotion across cultures. *Advances in Psychiatric Treatment*, 9(5), 342–348. <https://doi.org/10.1192/apt.9.5.342>
- Bhui, K., Mohamud, S., Warfa, N., Craig, T. & Stansfeld, S. (2003). Cultural adaptation of mental health measures: Improving the quality of clinical practice and research. *British Journal of Psychiatry*, 183, 184–186. doi:10.1192/bjp.183.3.184
- Bhui, K., Ullrich, S., Kallis, C. & Coid, J. (2015). Criminal justice pathways to psychiatric care for psychosis. *The British Journal of Psychiatry: The Journal of Mental Science*, 207(6), 523–9.
- Bhui K., Nazroo J., Francis J. et al. (2018). *The impact of racism on mental health*. Available at: <https://synergiccollaborativecentre.co.uk/wp-content/uploads/2017/11/The-impact-of-racism-on-mental-health-briefing-paper-1.pdf> [Accessed 16/01/21]
- Bird, V., Premkumar, P., Kendall, T. & Whittington, C. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: systematic review. *British Journal of Psychiatry*, 197(5), 350–356. <https://doi.org/10.1192/bjp.bp.109.074526>
- Bowman, S., Alvarez-Jimenez, M., Wade, D., Howie, L., & McGorry, P. (2017). The positive and negative experiences of caregiving for siblings of young people with first episode psychosis. *Frontiers in Psychology*, 8, 730. doi:10.3389/fpsyg.2017.00730
- Bownas, J. & Fredman, G. (2016). *Working with embodiment in supervision. A systemic approach*. London: Routledge.
- Boye, B. & Malt, U.F. (2002). Stress response symptoms in relatives of acutely admitted psychotic patients: A pilot study. *Nordic Journal of Psychiatry*, 56(4), 253–260.
- Boydell, K., Hodgins, M., Pignatiello, A. et al. (2014). Using technology to deliver mental health services to children and youth: A scoping review. *Journal of Canadian Academic Child Adolescent Psychiatry*, 23(2), 87–99.
- Bradley, G., Couchman, G., Perlesz, A. et al. (2006) Multiple-family group treatment for English- and Vietnamese-Speaking families living with schizophrenia. *Psychiatric Services*, 57(4), 521–530.
- Breitborde, N.J.K., Lopez, S.R., Wickens, T.D., Jenkins, J.H. & Karno, M. (2007). Toward specifying the nature of the relationship between expressed emotion and schizophrenic relapse: The utility of curvilinear models. *International Journal of Methods in Psychiatric Research*, 16(1), 1–10.
- Brennan, A., Warren, N., Peterson, V. et al. (2016). Collaboration in crisis: Carer perspectives on police and mental health professional's responses to mental health crises. *International Journal of Mental Health Nursing*, 25(5), 452–461.
- British Psychological Society (2017). *Working with interpreters: Guidelines for psychologists*. Available at <https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Working%20with%20interpreters%20-%20guidelines%20for%20psychologists.pdf> [Accessed 16/01/21]
- Brown, M. (2020). Psychoses of the female body: the need for more psychosocial engagement. *Psychosis*. doi:10.1080/17522439.2020.1856175
- Bucci, S., Berry, K., Barrowclough, C. & Haddock, G. (2015). Family interventions in psychosis: A review of the evidence and barriers to implementation. *Australian Psychologist*, 51, 62–68.
- Burbach, F. (2012). Family interventions: Fundamental considerations when developing routine and formal family intervention services. In X. Anastassiou-Hadjicharalambous (Ed.) *Psychosis: Causes, diagnoses and treatment*. Nova Science Publishers, Inc.
- Burbach, F. & Helps, S. (2021). Delivering family therapy and systemic interventions using digital platforms. In H. Wilson (Ed.) *Delivering mental health therapies using digital platforms*. London: Jessica Kingsley.
- Burbach, F. & Stanbridge, R. (2006). Somerset's family interventions in psychosis service; an update. *Journal of Family Therapy*, 28, 39–57.
- Burbach, F., Fadden, G. & Smith, J. (2010). Family interventions for first-episode psychosis. In P. French, J. Smith, D. Shiers, M. Reed & M. Rayne (Eds.) *Promoting recovery in early psychosis*. Oxford: Wiley-Blackwell.
- Burbach, F.R. (2012). Family interventions: Fundamental considerations when developing routine and formal family interventions services. Chapter 10. In X. Anastassiou-Hadjicharalambous (Ed.) *Psychosis: Causes, diagnosis and treatment*. Nova Science Publishers.
- Burbach, F.R. (2013). Towards a systemic understanding of family emotional atmosphere and outcome after psychosis. Chapter 9. In A. Gumley, A. Gillham, K. Taylor & M. Schwannauer (Eds.) *Psychosis and emotion: the role of emotions in understanding psychosis, therapy and recovery*. London: Routledge.
- Burbach, F.R. (2015). The development of efficient family intervention services – a whole systems approach. *Clinical Psychology Forum*, 271 Special Issue: Lean, 36–41.
- Burbach, F.R. (2016a). Brief family interventions in psychosis – a collaborative, resource-oriented approach to working with families and wider support networks. Chapter 8. In B. Pradhan, N. Pinninti & S. Rathod (Eds.) *Brief interventions for psychosis: a clinical compendium*. Springer
- Burbach, F.R. (2016b). Co-work: Working in pairs enables effective whole family sessions. Chapter 20. In M. Diggins (Ed.) *Parental mental health and child welfare work volume 1: A Pavilion Annual*.
- Burbach, F.R. (2018). Family therapy and schizophrenia: a brief theoretical overview and a framework for clinical practice. *BJPsych Advances* (accepted).
- Burbach, F.R. & Stanbridge, R.I. (1998). A family intervention in psychosis service integrating the systemic and family management approaches. *Journal of Family Therapy*, 20(3), 311–325.
- Burbach, F.R. & Stanbridge, R.I. (2006). Somerset's family interventions in psychosis service: An update. *Journal of Family Therapy*, 20, 311–325.
- Burbach, F.R. (2012). Family Interventions: Fundamental considerations when developing routine and formal family interventions services. In X. Anastassiou-Hadjicharalambous (Ed) *Psychosis: Causes, diagnosis and treatment*. Nova Science Publishers Inc.
- Burnham, J. (2012). Developments in Social GRRRAACCEEESSS: Visible-invisible and voiced-unvoiced. Chapter 7. In I.-B. Krause (Ed.) *Culture and reflexivity in systemic psychotherapy: Mutual perspectives*. London: Karnac.
- Burnham, J.B. (1993). Approach, method, technique: Making distinctions and creating connections. *Human Systems: Journal of Systemic Consultation and Management*, 3, 3–26.

- Burnham, J. (2018). Relational reflexivity: A tool for socially constructing therapeutic relationships. In *The Space Between* (pp.1–17). London: Routledge.
- Bustillo, J., Lauriello, J., Horan, W. & Keith, S. (2001). The psychosocial treatment of schizophrenia: an update. *The American Journal of Psychiatry*, 158(2), 163–175. doi:10.1176/appi.ajp.158.2.163
- Butler, C. (2015). Intersectionality in family therapy training: inviting students to embrace the complexities of lived experience. *Journal of Family Therapy*, 37, 583–589.
- Butler, C., Sheils, E., Lask, J. et al. (2018). Measuring competence in systemic practice: Development of the 'Systemic Family Practice – Systemic Competency Scale' (SPS). *Journal of Family Therapy*. doi.org/10.1111/1467-6427.12251
- Butzlaff, R.L. & Hooley, J.M. (1998). Expressed emotion and psychiatric relapse: A meta-analysis. *Archives of General Psychiatry*, 55(6), 547–552.
- Campbell, L., Hanlon, M.C., Poon, A.W.C. et al. (2012). The experiences of Australian parents with psychosis: The second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry*, 46(9), 890–900.
- Care Act (2014). Available at: <https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>
- Carr, A. (2009). *What works in psychotherapy*. London: Routledge.
- Carrà, G., Montomoli, C., Clerici, M. & Lorenzo Cazzullo, C.L. (2007). Family interventions for schizophrenia in Italy: Randomized controlled trial. *European Archives of Psychiatry and Clinical Neuroscience*, 257, 23–30.
- Carter, K. (2011). Family liaison in an adult acute inpatient ward. *Mental Health Practice*, 14(8), 24–27.
- Cecchin, G. (1987). Hypothesising, circularity and neutrality revisited: An invitation to curiosity. *Family Process*, 26(4), 405–413
- Chien, W.T. & Chan, S.W. (2004). One-year follow-up of a multiple-family-group intervention for Chinese families of patients with schizophrenia. *Psychiatric Services*, 55(11), 1276–1284.
- Chuttoo, L., Griffiths, M. & Allen, J. (2019). Using clinical records to evaluate family intervention for psychosis in routine practice. *Journal of Psychiatric Intensive Care*, 15(2), 57–65.
- Claxton, M., Onwumere, J. & Fornells-Ambrojo, M. (2017). Do family interventions improve outcomes in early psychosis? A systematic review and meta-analysis. *Frontiers in Psychology*, 8, 371.
- Cleary, M., Hunt, G.E., Matheson, S. & Walter, G. (2008). The association between substance use and the needs of patients with psychiatric disorder, levels of anxiety, and caregiving burden. *Archives of Psychiatric Nursing*, 22(6), 375–385.
- Cohen, A.N., Glynn, S.M., Murray-Swank, A.B. et al. (2008). The family forum: Directions for the implementation of family psychoeducation for severe mental illness. *Psychiatric Services*, 59, 40–48.
- Cohen, M. (2012). The experiences of Australian parents with psychosis: The second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry*, 46(9), 890–900. doi:10.1177/0004867412455108
- Combs, G. (2019). White privilege: what's a white therapist to do? *Journal of Family Therapy*, 45(1), 65–75.
- Comer, J.S., Furr, J.M., Miguel, E.M. et al. (2017). Remotely delivering real-time parent training to the home: An initial randomized trial of Internet-delivered parent-child interaction therapy (I-PCIT). *Journal of Consulting and Clinical Psychology*, 85(9), 909.
- Commander, M. & Rooprai, D. (2008). Survey of long-stay patients on acute psychiatric wards. *The Psychiatrist*, 32(10), 380–383. doi:10.1192/pb.bp.107.018507
- Cook, W.L. (2005). The SRM approach to family assessment: An introduction and case example. *European Journal of Psychological Assessment*, 21(4), 216–225. doi:10.1027/1015-5759.21.4.216
- Copello, A. & Orford, J. (2002). Addiction and the family: Is it time for services to take notice of the evidence? *Addiction* 97(11), 1361–3.
- Copello, A., Templeton, L., Orford, J. & Velleman, R. (2010). The 5-Step method: Principles and practice. *Drugs: Education, Prevention and Policy*, 17(sup1), 86–99.
- Cornelis, J., Barakat, A., Dekker, J. et al. (2018). Intensive home treatment for patients in acute psychiatric crisis situations: a multicentre randomised controlled trial. *BMC Psychiatry*. <http://doi.org/10.1186/s12888-018-1632-z>.
- Corstens, D., Longden, E. & May, R. (2008). Talking with voices.
- Crenshaw, K. (1989). "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics,". *University of Chicago Legal Forum: Vol. 1989, Article 8*.
- Crisp, N., Smith, G. & Nicholson, K. (Eds.) (2016). *Old problems, new solutions – improving acute psychiatric care for adults in England*. The Commission on Acute Adult Psychiatric Care.
- Cronin, I., Judson, A., Ekdawi, I. et al. (2021). Holding onto the 'mystery' within online family and systemic therapy. *Journal of Family Therapy*. <https://doi.org/10.1111/1467-6427.12330>
- Dadds, M. R., Thai, C., Mendoza Diaz, A., Broderick, J., Moul, C., Tully, L. A., ... & Cane, L. (2019). Therapist-assisted online treatment for child conduct problems in rural and urban families: Two randomized controlled trials. *Journal of consulting and clinical psychology*, 87(8), 706.
- Dausch, B. M., Miklowitz, D. J., Nagamoto, H. T., Adler, L. E., & Shore, J. H. (2009). Family-focused therapy via videoconferencing. *Journal of Telemedicine and Telecare*, 15(4), 211–214.
- Dallos, R. & Draper, R. (2010). *An introduction to family therapy: Systemic theory and practice*. McGraw-Hill Education (UK).
- De Shazer, S. (1985). *Keys to solution in brief therapy*. Norton.
- De Witte, N., Crunelle, C., Sabbe, B., Moggi, F. & Dom G. (2014) Treatment for outpatients with comorbid schizophrenia and substance use disorders: a review. *Eur Addict Res*, 20(3), 105–14. doi:10.1159/000355267. Epub 2013 Oct 31. Review.
- Department of Health (2013). *Public Health Outcomes Framework for England 2013–2016*. Department of Health.
- Dieterich, M., Irving, C.B., Park, B. & Marshall M. (2010). Intensive case management for severe mental illness. *Cochrane Database Syst Rev*, 10, CD007906.
- Divac & Heaphy, G. (2005). Space for GRRACCES: training for cultural competence in supervision. *Journal of Family Therapy*, 27, 280–284.
- Division of Clinical Psychology (2010). *The core purpose and philosophy of the profession*. Leicester: British Psychological Society.
- Division of Clinical Psychology (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift*. DCP Position Statement. Leicester: British Psychological Society.
- Division of Clinical Psychology (2015). *Guidelines on language in relation to functional psychiatric diagnosis*. Leicester: British Psychological Society.

- Dyregrov A. (1989). Caring for helpers in disaster situations: Psychological debriefing. *Disaster Management*, 2, 25–30.
- Eassom, E., Giacco, D., Dirik, A. & Priebe, S. (2014). Implementing family involvement in the treatment of patients with psychosis: a systematic review of facilitating and hindering factors. *BMJ Open*, 4(10). doi:10.1136/bmjopen-2014-006108.
- Eassom, E. Giacco, D., Dirik, A. & Priebe, S. (2016). Implementing family involvement in the treatment of patients with psychosis: a systematic review of facilitating and hindering factors. *BMJ Open*, January 21, 2016.
- Edge, D. & Grey, P. (2018). An assets-based approach to co-producing a culturally adapted family Intervention (CaFI) with African Caribbeans diagnosed with schizophrenia and their families. *Ethnicity & Disease*, 28(Suppl 2), 485.
- Edge, D., Degan, A., Cotterill, S. et al. (2016). Culturally-adapted Family Intervention (CaFI) for African-Caribbeans diagnosed with schizophrenia and their families: a feasibility study protocol of implementation and acceptability. *Pilot and Feasibility Studies* 2, 39.
- Ekdawi, I., Gibbons, G., Bennett, E. & Hughes, G. (2000). *Whose reality is it anyway? Putting social constructionist practice into everyday clinical practice*. Pavilion Publishing (Brighton) Ltd.
- Ellis, A., Simiola, V., Brown, L., Courtois, C. & Cook, J. (2018). The role of evidence-based relationships on treatment outcome for adults with trauma: A systematic review. *Journal of Trauma and Dissociation*, 19(2), 185–213. doi:10.1080/15299732.2017.1329771
- Engur, B. (2017). Parents with psychosis: Impact on parenting & parent-child relationship – A systematic review. *Global Journal of Addiction & Rehabilitation Medicine*, 1(2) doi:10.19080/GJARM.2017.01.555558
- Evans-Jones, C., Peters, E. & Barker, C. (2009). The therapeutic relationship in CBT for psychosis: Client, therapist and therapy factors. *Behavioural and Cognitive Psychotherapy*, 37, 527–540.
- Fadden, G. & Heelis, R. (2011). The Meriden West Midlands Family Programme: Lessons learned over ten years. *Journal of Mental Health*, 20(1), 79–88.
- Fadden, G. (1997). Implementation of family interventions in routine clinical practice following staff training programmes: A major cause for concern. *Journal of Mental Health*, 6, 599–613.
- Fadden, G. (1998). 'Family Intervention'. In C. Brooker & J. Repper (Eds.) *Serious mental health problems in the community*. London: Balliere Tindall Limited.
- Fadden, G. (1998). Research update: psychoeducational family interventions. *Journal of Family Therapy*, 6, 599–612.
- Fadden, G. (2006). Training and disseminating family interventions for schizophrenia; Developing family intervention skills with multidisciplinary groups. *Journal of Family Therapy*, 28, 23–38.
- Fadden, G. (2009). Overcoming barriers to staff offering interventions in the NHS. In F. Lobban & C. Barrowclough (Eds.) *A casebook of family interventions for psychosis* (pp.309–335). Chichester: Wiley and Sons.
- Fadden, G. (2015). Family interventions. In F. Holloway, H. Killaspey, S. Kalidindi & G. Roberts. *Enabling recovery: The principles and practice of rehabilitation psychiatry* (2nd edn, pp.153–170). London: Gaskell.
- Falicov, C. (1995). Training to think culturally: A multidimensional comparative framework. *Family Process*, 34, 373–88.
- Falloon, I.R.H., Boyd, J.L. & McGill, C.W. (1984). *Family care of schizophrenia*. New York: Guildford Press.
- Falloon, I.R.H., Boyd, J.L., McGill, C.W et al. (1982). Family management in the prevention of exacerbations of schizophrenia: A controlled study. *New England Journal of Medicine*, 306, 1437–1440.
- Falloon, I.R.H., Fadden, G., Mueser, K. et al. (2004). Family Work Manual. Birmingham: Meriden Family Programme. Family intervention for psychosis to families with children. Unpublished thesis. Canterbury Christ Church University. *Family Therapy*. 38(1) 145–168. doi:10.1111/j.1752-0606.2011.00249.x
- Faulkner, A. & Thomas, P. (2002). User-led research and evidence-based medicine. *British Journal of Psychiatry*, 180, 1–3.
- Fearon, P., Kirkbride, J.B., Morgan, C. et al. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: Results from the MRC AESOP Study. *Psychol Medicine*, 36(11), 1541–1550. <https://doi.org/10.1017/S0033291706008774>
- Fornells-Ambrójo, M., Johns, L., Onwumere, J. et al. (2017). Experiences of outcome monitoring in service users with psychosis: Findings from an improving access to psychological therapies for people with severe mental illness (IAPT-SMI) demonstration site. *British Journal of Clinical Psychology*, 56(3), 253–272. doi:10.1111/bjc.12136
- Fredman, G. (2016). Using supervision to prepare our bodies for the therapeutic relationship. In J. Bownas & G. Fredman (Eds.) *Working with embodiment in supervision: A systemic approach*. London: Routledge.
- Fredman, G. (2010). Introduction: Being with older people – a systemic approach. In G. Fredman, E. Anderson & J. Stott (Eds.) *Being with older people: A systemic approach* (pp.1–29). Karnac Books Ltd.
- Fredman, G. & Rapaport, P. (2010). How do we begin? Working with older people and their significant systems. In G. Fredman, E. Anderson & J. Stott (Eds.) *Being with older people: A systemic approach* (pp.1–29). Karnac Books Ltd.
- Freeman, D., Reeve, S., Robinson, A. et al. (2017). Virtual reality in the assessment, understanding, and treatment of mental health disorders. *Psychological Medicine*, 47(14), 2393–2400.
- Friedlander, M.L., Escudero, V., Heatherington, L. & Diamond, G.M. (2011). Alliance in couple and family therapy. *Psychotherapy*, 48(1), 25.
- Froggatt, D., Fadden, G., Johnson, D.L., Leggatt, M. & Shankar, R. (Eds.) (2007). *Families as partners in care: A guidebook for implementing family work*. Toronto: World Fellowship for Schizophrenia and Allied Disorders.
- Furlong, M.A. (2001). Constraints on family-sensitive mental health practices. *Journal of Family Studies*, 7, 217–231.
- Gabb, J. & Singh, R. (2015). Reflections on the challenges of understanding racial, cultural and sexual differences in couple relationship research. *Journal of Family Therapy*, 37(2), 210–227.
- Garety, P.A., Kuipers, E., Fowler, D., Freeman, D. & Bebbington, P.E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine*, 31, 189–195.
- Gilbert, H. (2015). *Mental health under pressure*. London: The King's Fund.
- Gleeson, J., Lederman, R., Koval, P. et al. (2017). Moderated online social therapy: A model for reducing stress in carers of young people diagnosed with mental health disorders. *Frontiers in Psychology*, 8, 485. doi:10.3389/fpsyg.2017.00485
- Glynn, S.M., Cohen, A.N., Dixon, L.B. & Niv, N. (2006). The potential impact of the recovery movement on family interventions for schizophrenia: Opportunities and obstacles. *Schizophrenia Bulletin*, 32(3), 451–463. doi:10.1093/schbul/sbj066
- Gold, M., Philip, J., McIver, S. & Komesaroff, P. A. (2009). Between a rock and a hard place: Exploring the conflict between respecting the privacy of patients and informing their carers. *Internal Medicine Journal*, 39(9), 582–587.

- Gracio, J., Goncalves-Pereira, M. & Leff, J. (2015). What do we know about family interventions for psychosis at the process level? A systematic review. *Family Process*, 21, 1–12.
- Graham, H., Copello, A., Birchwood, M. & Mueser, K. (Eds.) (2003). Substance misuse in psychosis: Approaches to treatment and service delivery. (and, with Orford, J., McGovern, D. Atkinson, E., Maslin, J., Preece, M., Tobin, D. & Georgiou, G., 2004. *Cognitive-Behavioural Integrated Treatment (C-BIT): A treatment manual for substance misuse in people with severe mental health problems*). Chichester: John Wiley & Sons Ltd.
- Greenberg, L.S. & Goldman, R.N. (2008). *Emotion-focused couples therapy: The dynamics of emotion. Love and Power*. APA.
- Griffiths, M., Allen, J., Patel, K. & Bell, V. (2020). Promoting family inclusive practice in home treatment teams. *The Journal of Mental Health Training, Education and Practice*.
- Grover, S., Nehra, R. & Thakur, A. (2017). Bipolar affective disorder and its impact on various aspects of marital relationship. *Industrial Psychiatry Journal*, 26(2), 114.
- Haddock, G., Eisner, E., Boone, C. et al. (2014). An investigation of the implementation of NICE- recommended CBT interventions for people with schizophrenia. *Journal of Mental Health*, 23, 162–165.
- Haggarty, D. (2016). *Exploring the delivery of family interventions to people facing recent-onset psychotic symptoms: The experience of navigating the family system*. Unpublished doctoral thesis: University of Leicester.
- Haley, C., O'Callaghan, E., Hill, S. et al. (2011). Telepsychiatry and carer education for schizophrenia. *European Psychiatry*, 26(5), 302–304.
- Hardy, A. (2017). Pathways from trauma to psychotic experiences: A theoretically informed model of posttraumatic stress in psychosis. *Frontiers in Psychology*, 8, 697. doi:10.3389/fpsyg.2017.00697
- Hardy, K.V. & Laszloffy, T.A. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy*, 21(3), 227–237.
- Hartman, A. (1995). Diagrammatic assessment of family relationships. *Families in Society*, 76(2), 111–122.
- Hays, P.A. & Iwamasa, G.Y. (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. American Psychological Association.
- Hedges, F. (2005). Circular questions. In F. Hedges *An introduction to systemic therapy with Individuals: A social constructionist approach* (pp.83–99). Palgrave Macmillan.
- Heffernan, S., Neil, S., Thomas, Y. & Weatherhead, S. (2016). Religion in the recovery journey of individuals with experience of psychosis. *Psychosis*, 8(4), 346–356.
- Helps, S.L. (2020). Doing remote systemic psychotherapy during a pandemic: Responses from a speedy Quality Improvement Project. *Murmurations: Journal of Transformative Systemic Practice*, 3(1).
- Helps, S. & LeCoyte Grinney, M. (2021). Synchronous digital couple and family psychotherapy: A meta-narrative review. *Journal of Family Therapy*. <https://doi.org/10.1111/1467-6427.12333>
- Holmberg, Å., Jensen, P. & Ulland, D. (2017). To make room or not to make room: Clients' narratives about exclusion and inclusion of spirituality in family therapy practice. *The Australian and New Zealand Journal of Family Therapy*, 38(1), 15–26.
- Hopfenbeck, M. (2015). Peer-supported open dialogue. *Context*, 138, 29–31.
- Horsfall, J., Cleary, M., Hunt, G.E. & Walter, G. (2009). Psychosocial treatments for people with co-occurring severe mental illnesses and substance use disorders (dual diagnosis): A review of empirical evidence. *Harvard Review of Psychiatry*, 17(1), 24–34.
- Hudak, J. & Giammattei, S.V. (2014). Doing family: Decentering heteronormativity in “marriage” and “family” therapy. In T. Nelson & H. Winaver (Eds.) *AFTA Springer briefs in family therapy. Critical topics in family therapy: AFTA Monograph Series highlights* (pp.105–115). Springer Science + Business Media.
- Ince, P., Haddock, G. & Tai, S. (2015). A systematic review of the implementation of recommended psychological interventions for schizophrenia: Rates, barriers, and improvement strategies. *Psychology and Psychotherapy: Theory, Research and Practice*, doi:10.1111/PAPT.12084.
- Ivanović, M., Vuletić, Z. & Bebbington, P. (1994). Expressed emotion in the families of patients with schizophrenia and its influence on the course of illness. *Social Psychiatry & Psychiatric Epidemiology*, 29, 61–65.
- James, C., Cushway, D. & Fadden, G. (2006). What works in engagement of families in behavioural family therapy? A positive model for the therapist perspective. *Journal of Mental Health*, 28, 23–38.
- Johnstone, L. (1999). Do families cause ‘schizophrenia’? Revisiting a taboo subject. In C. Newnes, G. Holmes, G. & C. Dunn (Eds.) *This is madness*. Herefordshire: PCCS Books.
- Jongsma H.E. et al. (2020). Social disadvantage, linguistic distance, ethnic minority status and first-episode psychosis: results from the EU-GEI case-control study. *Psychological Medicine*, 1–13.
- Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *Power-Threat-Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to psychiatric diagnosis*. Leicester: British Psychological Society.
- Joint Commissioning Panel for Mental Health (2016). <https://www.networks.nhs.uk/nhs-networks/regional-mental-health-commissioning-networks-portal/documents/joint%20commissioning%20panel%20for%20mental%20health%20briefing%20-%20Feb%202012.pdf>
- Jones, E. (1993). *Family systems therapy: Developments in the Milan-Systemic therapies*. John Wiley and Sons Ltd.
- Kavanagh, D.J., Piatkowska, O., Clarke, D. et al. (1993). Application of cognitive-behavioural family intervention for schizophrenia in multi-disciplinary teams: what can the matter be? *Australian Psychologist*, 28, 181–188.
- Kirkbride, J.B., Errazuriz, A., Croudace, T.J. et al. (2012). Incidence of schizophrenia and other psychoses in England, 1950–2009: A systematic review and meta-analyses. *PLoS One*, 7(3).
- Kissil, K., Nino, A. & Davey, M. (2013). Doing therapy in a foreign land: When the therapist is “Not From Here”. *American Journal of Family Therapy*, 41, 134–147.
- Kohlhoff, J., Cibralic, S., Horswood, D. et al. (2020). Feasibility and acceptability of internet-delivered parent-child interaction therapy for rural Australian families: a qualitative investigation. *Rural and Remote Health*, 20(1), 5306.
- Kowalski, C., Attoe, C., Ekdawi, I., Parry, C., Phillips, S. & Cross, S. (2018). Interprofessional simulation training to promote working with families and networks in mental health services. *Academic Psychiatry*, 42(5), 605–612.
- Knudson, B. & Coyle, A. (2002). Parents' experiences of caring for sons and daughters with schizophrenia: A qualitative analysis of coping. *European Journal of Psychotherapy*, 5, 169–183.

- Krause, I-B. (2012). *Culture and reflexivity in systemic psychotherapy. Systemic Thinking and Practice Series*. London: Karnac.
- Krumm, S., Checchia, C., Badura-Lotter, G., Kilian, R., & Becker, T. (2014). The attitudes of mental health professionals towards patients' desire for children. *BMC Medical Ethics*, 15, 18.
- Kuipers, L., Leff, J. & Lam, D. (2002). *Family work for schizophrenia: A practical guide*. London: Gaskell.
- Kuipers, E. (2006). Family interventions in schizophrenia: Evidence for efficacy and proposed mechanisms of change. *Journal of Family Therapy*, 28, 73–80.
- Kuipers, E., Bebbington, P., Dunn, G. et al. (2006). Influence of carer expressed emotion and affect on relapse in non-affective psychosis. *British Journal of Psychiatry*, 188, 173–179.
- Lambert, M.J. & Barley, D. E. (2001) Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 357–361.
- Large, M.M. & Niessen, O. (2010). Violence in first-episode psychosis: A systematic review and meta-analysis. *Schizophrenia Research*, 125(2), 209–220. doi:10.1016/j.schres.2010.11.026
- Lebow, J.L., Chambers, A.L, Christensen, A. & Johnson, S.M. (2012) Research on the treatment of couple distress. *Journal of Marital and Family Therapy Vol. 38, No. 1*, 145–168. doi:10.1111/j.1752-0606.2011.00249.x
- Lee, R.E. & Nelson, T.S. (2014). *The contemporary relational supervisor*. London: Routledge.
- Legislation Government. (2014). Care Act 2014. UK: Crown Copyright. <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>
- Lewis, G. & Killaspy, H. (2014). Getting the measure of outcomes in clinical practice. *Advances in Psychiatric Treatment*, 20(3), 165–171. doi:10.1192/apt.bp.113.011809
- Lobban, F. & Barrowclough, C. (2016). An interpersonal CBT framework for involving relatives in interventions for psychosis: Evidence base and clinical implications. *Cognitive Therapy and Research*, 1–18.
- Lobban, F. & Barrowclough, C. (2016). An interpersonal CBT framework for involving relatives in interventions for psychosis: Evidence base and clinical implications. *Cognitive Therapy and Research*, 40(2), 198–215.
- Longwill, A. (2015). *Clinical Psychology Workforce Project*. Division of Clinical Psychology UK. Leicester: British Psychological Society. <https://www.bps.org.uk/sites/www.bps.org.uk/files/Page%20-%20Files/Clinical%20Psychology%20Workforce%20Report%20%282015%29.pdf>
- Lopez, A., Schwenk, S., Schneck, C.D., Griffin, R.J. & Mishkind, M.C. (2019). Technology-based mental health treatment and the impact on the therapeutic alliance. *Current Psychiatry Reports*, 21(8), 76.
- Lovibond, S. & Lovibond, P. (1995). Manual for the depression anxiety stress scales. *Psychology Foundation Monograph*. Sydney, Australia: School of Psychology, University of New South Wales.
- Lowenstein, L. (Ed.) (2010). *Creative family therapy techniques: Play, art and expressive activities to engage children in family sessions*. Toronto: Champion Press.
- Lynggaard, H., Donati, S., Pearce, P. & Sklavounos, D. (2001). A difference that made a difference: Introducing systemic ideas and practice into a multidisciplinary learning disability service. *Clinical Psychology*, 3, 12–15.
- McCann, E. (2003). Exploring sexual and relationship possibilities for people with psychosis – a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 10, 640–649.
- MacInnes, D. (2000). Relatives and informal caregivers. In C. Chaloner & M. Coffey (Eds.) *Forensic mental health nursing: Current approaches* (pp.208–31). Oxford: Blackwell Science.
- Mansell, C. & Fadden, G. (2009). Meeting the needs of families on inpatient units. In F. Lobban, C. Barrowclough (Eds.) *A casebook of family interventions for psychosis* (pp.259–284). Chichester: Wiley.
- Martin, R.M., Ridley, S.C. & Gillieatt, S.J. (2017). Family inclusion in mental health services: reality or rhetoric? *Social Psychiatry*, 63, 480–487.
- Matheson, B.E., Bohon, C. & Lock, J. (2020). Family-based treatment via videoconference: Clinical recommendations for treatment providers during COVID-19 and beyond. *International Journal of Eating Disorders*.
- Maxie, A.C., Arnold, D.H. & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy? *Psychotherapy: Theory, Research, Practice, Training*, 43(1), 85.
- McAndrew, S., Chambers, M., Nolan, F., Thomas, B. & Watts, P. (2014). Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, 23, 212–220.
- McDonnell, M.G., Short, R.A., Hazel, N.A., Berry, C.M. & Dyck, D.G. (2006). Multiple-family group treatment of outpatients with schizophrenia: Impact on service utilization. *Family Process*, 45(3), 359–373.
- McFarlane, W.R., Lukens, E.P., Link, B. et al. (1995) . Multiple-family groups and psychoeducation in the treatment of schizophrenia. *Arch Gen Psychiatry*, 52, 679–87.
- Meddings, S., Easton, P., Dorey, T. & Gordon, I. (2009). *Family Interventions for psychosis*. Sussex Partnership NHS Foundation trust.
- Mermon A., Taylor K., Mohebaty L.M et al. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England. *BMJ Open* 2016.
- Miller, S.D., Duncan, B.L., Brown, J., Sparks, J. & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, 2, 91–10.
- Miller, S.D. & Duncan, B.L. (2004). *The outcome and session rating scales: Administration and scoring manuals*. Chicago: Author.
- Mistry, H., Levack, W.M.M. & Johnson, S. (2015) Enabling people, not completing tasks: patient perspectives on relationships and staff morale in mental health wards in England. *BMC Psychiatry*, 15, 307–316.
- Mitchell, J. (1988). Stress: The history and future of critical incident stress debriefings. *Journal of Emergency Medical Services*, 7–52.
- Montejo, A.L., Montejo, L. & Navarro-Cremades, F. (2015). Sexual side-effects of antidepressant and antipsychotic drugs. *Current Opinion in Psychiatry*, 28(6), 418–23. doi:10.1097/YCO.0000000000000198
- Moran, P. (2017). Selecting self-report outcome measures for use in family and systemic therapy. *Journal of Family Therapy*, 39(1), 41–56. doi:10.1111/1467-6427.12082
- Morant, N., Lloyd-Evans, B., Lamb, D. et al. (2017). Crisis resolution and home treatment: Stakeholders' view on critical ingredients and implementation in England. *BMC Psychiatry*. doi:10.1186/s12888-017-1421-0.

- Morgan, A. (2002). Beginning to use a narrative approach in therapy. *The International Journal of Narrative Therapy and Community Work*, No. 1.
- Mottaghipour, Y. & Bickerton, A. (2005). The pyramid of family care: A framework for family involvement with adult mental health services. *Australian e-Journal for the Advancement of Mental Health*, 4(3), 210–217.
- Mueser, K.T. & Fox, L. (2002). A family intervention program for dual disorders. *Community Mental Health Journal*, 38(3), 253–270.
- Mueser, K. & Gingerich, S. (2006). *The complete family guide to schizophrenia*. New York: The Guilford Press.
- Nadirshaw, Z. & Goddard, S. (1999). *Rethinking clinical psychology: A race against time for minority ethnic communities in mental health settings*. London: Department of Health.
- National Health Service England. (2014). *Five Year Forward View*. <http://www.england.nhs.uk/ourwork/futurehns/#doc>.
- National Institute for Health and Care Excellence (NICE). (2014). *Psychosis and Schizophrenia in Adults: Treatment and Management*. National Institute for Health and Care Excellence, London.
- National Institute for Health and Care Excellence (NICE) (2016a). *Autism spectrum disorder in adults: diagnosis and management. Clinical guideline [CG142]*. National Institute for Health and Care Excellence, London.
- National Institute for Health and Care Excellence (NICE) (2016b). *Mental health problems in people with learning disabilities: prevention, assessment and management Clinical guideline [NG54]*. National Institute for Health and Care Excellence, London.
- Ncube, N. (2006). The Tree of Life Project: Using narrative ideas in work with vulnerable children in Southern Africa. *The International Journal of Narrative Therapy and Community Work*, 1, 3–16.
- Newman, S., Simonds, L.M. & Billings, J. (2011). A narrative analysis investigating the impact of first episode psychosis on siblings' identity. *Psychosis*, 3(3), 216–225. doi:10.1080/17522439.2010.542588
- NHS Benchmarking Network. (2016). *Secure Care analysis & benchmarking Medium secure services*. NHS Benchmarking Network, Manchester.
- NHS England (2015). *Guidance to support the introduction of access and waiting time standards for mental health services*.
- NHS England (2016). *Implementing the early intervention in psychosis access and waiting time standard: Guidance*. London: NHS England.
- NICE (2011). *Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (CG120)*. London: National Institute for Health and Care Excellence. Updated 2016.
- NICE (2014). *Psychosis and schizophrenia in adults: treatment and management. NICE Clinical Guideline 178*.
- NICE (2016). *Coexisting severe mental illness and substance misuse: community health and social care services (NG58)*. London: National Institute for Health and Care Excellence.
- Noite, L. (2007). White is a colour too: engaging actively with the risks, challenges and rewards of cross-cultural family therapy training and practice. *Journal of Family Therapy* 29(4), 378–388.
- Nordström, A. & Kullgren, G. (2003). Victim relations and victim gender in violent crimes committed by offenders with schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 38(6), 326–30.
- Northumberland, Tyne and Wear, NHS Trust (2016). *Working with families a strategy for developing family therapy across the trust*. Northumberland Tyne and Wear NHS Foundation Trust.
- Office for National Statistics (2019). *Childbearing for women born in different years, England and Wales: 2018*. Retrieved 14 September 2020 from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/childbearingforwomenbornindifferentyearsenglandandwales/2018#women-are-having-smaller-families-than-previous-generations-but-two-children-families-remain-the-most-common-family-size>
- O'Hanlon, B., Hayes, L., Perlesz, A. & Harvey, C. (2018). Understanding the complex family experiences of behavioural family therapy. *Journal of Family Therapy*, 40, 45–62.
- Olasoji, M., Maude, P. & McCauley, K. (2017). Not sick enough: Experiences of carers of people with mental illness negotiating care for their relatives with mental health services. *Journal of Psychiatric Mental Health Nursing*, 24, 403–411.
- Olson, M., Seikkula, J. & Ziedonis, D. (2014). The key elements of dialogic practice in open dialogue: Fidelity criteria. *The University of Massachusetts Medical School*, 8, 2017.
- Onumere, J., Grice, S. & Kuipers, E. (2016). Delivering cognitive-behavioural family interventions for schizophrenia. *Australian Psychologist*, 51, 52–61.
- Onumere, J., Gursharan, L., Schulz, J. et al. (2015). Burnout in early course psychosis caregivers: The role of illness beliefs and coping styles. *Early Intervention in Psychiatry*, Retrieved from <http://hdl.handle.net/2299/17568>
- Onumere, J., Zheng, Z. & Kuipers, E. (2018). *Informal caregiving relationships in psychosis: Reviewing the impact of patient violence on caregivers*. doi:10.3389/fpsyg.2018.01530
- Open dialogue UK (2018). Open dialogue – full training programme (<http://opendialogueapproach.co.uk/>)
- Orford, J., Copello, A., Velleman, R. & Templeton, L. (2010). Family members affected by a close relative's addiction: The stress-strain-coping-support model. *Drugs: Education, Prevention and Policy*, 17(sup1), 36–43.
- Osborne, J., Colman, M. et al. (2017). The Kent and Medway NHS and Social Care Partnership Trust Peer Supported Open Dialogue service: Perspectives from the team. *Context*, 152, pp.28–32.
- Petrakis, M., Bloom, H. & Oxley, J. (2014). Family perceptions of benefits and barriers to first episode psychosis carer group participation. *Social Work in Mental Health*, 12(2), 99–116.
- Pfammatter, M., Junghan, U. & Brenner, H. (2006). Efficacy of psychological therapy in schizophrenia: Conclusions from meta-analyses. *Schizophrenia Bulletin*, 32, 64–80.
- Pharoah, F., Mari, J., Rathbone, J. & Wong, W. (2010). Family intervention for schizophrenia. *The Cochrane Database of Systematic Reviews*, (12), CD000088.
- Pilling, S. Roth, A.D. & Stratton, P. (2011). *The competencies required to deliver effective systemic therapies*. (<http://www.ucl.uk/CORE/>).
- Pilling, S. & Clarke, K. (2020) *ODESSI Trial – Experience of a trial of a f2f intervention moving to digital delivery (perspective of clinicians, service users/families, researchers)*. NIHR MindTech MIC National Symposium 2020, virtual event 3.12.20
- Pinfold, V., Rapaport, J. & Bellringer, S. (2007). Developing partnerships with carers through good practice in information sharing. *Mental Health Review Journal*, 12(2), 7–14.

- Pitschel-Walz, G., Leucht, S., Bäuml J., Kissling, W. & Engel, R.R. (2001). The effect of family interventions on relapse and rehospitalization in schizophrenia – a meta-analysis. *Schizophrenia bulletin* 27, no. 1, 73–92.
- Priebe, S., Golden, E., McCabe, R., & Reininghaus, U. (2012). Patient-reported outcome data generated in a clinical intervention in community mental health care- psychometric properties. *Bmc Psychiatry*, 12(1), 113.
- Priebe, S., Omer, S., Giacco, D. et al. (2014). Resource-oriented therapeutic models in psychiatry: Conceptual review. *British Journal of Psychiatry*, 204, 256–61.
- Prytys, M., Garety, P.A., Jolley, S., Onwumere, J. & Craig, T. (2011). Implementing the NICE guideline for schizophrenia recommendations for psychological therapies: A qualitative analysis of the attitudes of CMHT staff. *Clinical Psychology and Psychotherapy*, 18, 48–59.
- Qassem, T., Bebbington, P., Spiers, N. et al. (2015). Prevalence of psychosis in black ethnic minorities in Britain: Analysis based on three national surveys. *Social Psychiatry and Psychiatric Epidemiology*, 50(7), 1057–1064. <https://doi.org/10.1007/s00127-014-0960-7>
- Qureshi, A., Collazos, F., Revollo, H.W. & Casas, M. (2011). Culturally sensitive assessment of depression from a psychometric perspective. *European Psychiatry*, 26, 1. doi:10.1016/S0924-9338(11)73843-3
- Radcliffe, J.J.L., Adeshokan, E.O., Thompson, P.C. & Bakowski, A.J. (2012). Meeting the needs of families and carers on acute psychiatric wards: A nurse-led service. *Journal of Psychiatric and Mental Health Nursing*, 19, 751–757.
- Rapaport, J., Bellringer, S., Pinfold, V. & Huxley, P. (2006). Carers and confidentiality in mental health: Considering the role of the carer's assessment: a study of service users', carers' and practitioners' views. *Health and Social Care in the Community*, 14(4), 357–365.
- Razzaque, R. & Stockmann, T. (2016). An introduction to peer-supported open dialogue in mental healthcare. *BJPsych Advances*, 22(5), 348–356.
- Razzaque, R. (2019). *Dialogical psychiatry: A handbook for the teaching and practice of open dialogue*. UK: Omni House Press.
- Read, J. & Gumley, A. (2008). Can attachment theory help explain the relationship between childhood adversity and psychosis? *New Directions in Psychotherapy and Relational Psychoanalysis*, Vol. 2, 1–35.
- Read, J., Os, J., Morrison, A.P. & Ross, C.A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112(5), 330–350. doi:10.1111/j.1600-0447.2005.00634.x
- Recovery in the Bin (2015). RITB – 20 Key Principles. Recovery in The Bin: 20 Key Principles. *Asylum Magazine*. <https://asylummagazine.org/2015/10/recovery-in-the-bin/>
- Reibstein, J. & Sherbersky, H. (2012). Behavioural and empathic elements of systemic couple therapy: The Exeter Model and a case study of depression. *Journal of Family Therapy*, 34(3), 271–283.
- Reibstein, J. & Singh, R. (2018). The Intercultural Exeter Model. *Psychotherapy Review. Special section on Couples and Families*, 56–71.
- Reibstein, J. & Singh, R. (2021). *The Intercultural Exeter Model*. London: Wiley.
- Revier, C.J., Reininghaus, U., Dutta, R. et al. (2015). Ten-Year Outcomes of First-Episode Psychoses in the MRC ÆSOP-10 Study. *Journal of Nervous & Mental Disease*, 203, 379–386.
- Rober, P. (2005). The therapist's self in dialogical family therapy: Some ideas about not-knowing and the therapist's inner conversation. *Family Process*, 44(4), 477–495.
- Robson, J. & Gingell, K. (2012). Improving care for families where children and parents have concurrent mental health problems. *Child and Adolescent Mental Health*, 17(3), 166–172. doi:10.1111/j.1475-3588.2011.00630.x
- Roddy, S., Onwumere, J. & Kuipers, E. (2015). A pilot investigation of a brief, needs-led caregiver focused intervention in psychosis. *Journal of Family Therapy*, 37(4), 529–545. doi:10.1111/1467-6427.12054
- Rolin, S.A., Marino, L.A., Pope, L.G. et al. (2018). Recent violence and legal involvement among young adults with early psychosis enrolled in coordinated specialty care. *Early Intervention in Psychiatry*. doi:10.1111/eip.12675
- Roth, A. D. and Pilling, S. (2012). A competence framework for psychological interventions with people with psychosis and bipolar disorder. Research Department of Clinical, Educational and Health Psychology, UCL.
- Roth, A.D. & Pilling, S. (2015). A competence framework for the supervision of psychological therapies (<http://www.ucl.uk/CORE/>)
- Royal College of Psychiatrists (2020) *National Clinical Audit of Psychosis – National Report for the Early Intervention in Psychosis Audit 2019/2020*. London: Healthcare Quality Improvement Partnership.
- Saeed., S.A., Bloch, R.M. & Silver, S. (2015). Role of leadership in narrowing the gap between science and practice: Improving treatment outcomes at the systems level. *The Psychiatric Quarterly*, 86(3), 311–323.
- Scaife, J. (2001). *Supervision in the mental health professions: A practitioners guide*. Hove: Brunner-Routledge
- Scazufca, M. & Kuipers, E. (1997). Impact on women who care for those with schizophrenia. *Psychiatric Bulletin*, 21(8), 469–471. doi:10.1192/pb.21.8.469
- Schizophrenia in Adults: The NICE Guideline on Treatment and Management (updated edn) (National Clinical Guideline Number 178)*.
- Seikkula, J., Aaltonen, J., Alakare, B. et al. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, 16, 214–228.
- Seikkula, J. (2011). Becoming dialogical: Psychotherapy or a “Way of Life”. *The Australian and New Zealand Journal of Family Therapy*, 32, 179–193.
- Seikkula, J. (2012). Open Dialogue: Clients voices as resources. *Two Day Workshop, 29–30 November 2012, Sheffield, England*.
- Seikkula, J. & Trimble, D. (2005). Healing elements of therapeutic conversation: Dialogue as an embodiment of love. *Family Process*, 44(4), 461–475.
- Seikkula, J., Alakare, B. & Aaltonen, J. (2011). The comprehensive open-dialogue approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis*, 3, 192–204.
- Seikkula, J., Alakare, B. & Aaltonen, J. (2001). Open dialogue in psychosis 1; An introduction and case illustration. *Journal of Constructivist Psychology*, 14, 247–265.
- Selick, A., Durbin, J., Vu, N. et al. (2017). Barriers and facilitators to implementing family support and education in early psychosis intervention programmes: A systematic review. *Early Intervention in Psychiatry*. doi:10.1111/eip.12400.

- Selten, J.P., van der Ven, E. & Termorshuizen, F. (2020). Migration and psychosis: A meta-analysis of incidence studies. *Psychological Medicine*, 50(2), 303–313.
- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G. (1978). *Paradox and counterparadox: A new model in the therapy of the family in schizophrenic transaction*. New York: Jason Aronson.
- Selvini-Palazzoli, M., Boscolo, L., Cecchin, G. et al. (1980). Hypothesising-circularity-neutrality: Three guidelines for the conductor of the session. *Family Process*, 19(1), 3–12.
- Simpson, S.G. & Reid, C.L. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *Australian Journal of Rural Health*, 22(6), 280–299.
- Sherbersky, H., Ziminski, J. & Pote, H. (2021). The journey towards digital systemic competence: Thoughts on training, supervision and competence evaluation. *Journal of Family Therapy*. <https://doi.org/10.1111/1467-6427.12328>
- Shotter, J. (2004). *On the edge of social constructionism: "Witness-thinking" versus "aboutness-thinking"*. London: KCC Foundation publications.
- Sin, J., Gillard, S., Spain, D., Cornelius, V., Chen, T. & Henderson, C. (2017). Effectiveness of psychoeducational interventions for family carers of people with psychosis: A systematic review and meta-analysis. *Clinical Psychology Review*, 56, 13–24. <https://doi.org/10.1016/j.cpr.2017.05.002>
- Sin, J., Livingstone, S., Gamble, K. & Griffiths, M. (2013). Family intervention for psychosis: Impact of training on clinicians' attitudes, knowledge and behaviour. *Psychosis: Psychological, Social and Integrative Approaches*. doi:10.1080/17522439.2013.806569
- Sin, J., Moone, N. & Harris, P. (2008). Siblings of individuals with first-episode psychosis. *Journal of Psychosocial Nursing and Mental Health Services*, 46(6), 33–40. doi:10.3928/02793695-20080601-11.
- Singh, R. (2009). Constructing 'the family' across culture. *Journal of Family Therapy*, 31(4), 359–383.
- Singh, R. & Dutta, S. (2010). *Race and culture: Tools, techniques and trainings. A Manual for professionals*. Oxon: Routledge.
- Slade, M., Pinfold, V., Rapaport, J. et al. (2007). Best practice when service users do not consent to sharing information with carers. *British Journal of Psychiatry*, 190, 148–155.
- Smart, T. (2017). Family interventions for adults: A learning journey for students and tutors. *Context*, 150, pp.6–10.
- Smeerdijk, M., Keet, R., de Haan, L. et al. (2014). Feasibility of teaching motivational interviewing to parents of young adults with recent-onset schizophrenia and co-occurring cannabis use. *Journal of Substance Abuse Treatment*, 46(3), 340–345.
- Smith, G. & Velleman, R. (2002). Maintaining a family work service for psychosis service by recognising and addressing the barriers to implementation. *Journal of Mental Health*, 11, 471–179.
- Smith, J. (2009). Personal communication.
- Spain, D., Sin, J., Paliokosta, E. et al. (2017). Family therapy for autism spectrum disorders. *The Cochrane Database of Systematic Reviews*, 5(5), CD011894. <https://doi.org/10.1002/14651858.CD011894.pub2>
- Sperlinger, D. (2002). *Outcome Assessment in Routine Clinical Practice in Psychosocial Services. Paper 1*. The British Psychological Society, DCP.
- Stanbridge, R.I. & Burbach, F.R. (2007). Developing family inclusive mainstream mental health services. *Journal of Family Therapy*, 29, 21–43.
- Stratton, P. (2016). *The evidence base of family therapy and systemic practice*. Association for Family Therapy, UK.
- Stratton, P., Bland, J. Janes, E. & Lask, J. (2010) Developing an indicator of family function and a practicable outcome measure for systemic family and couple therapy: the SCORE. *Journal of Family Therapy*, 32(3), 232–258. doi:10.1111/j.1467-6427.2010.00507.x
- Stratton, P., Lask, J., Bland, J. et al. (2014). Detecting therapeutic improvement early in therapy: validation of the SCORE-15 index of family functioning and change. *Journal of Family Therapy*, 36(1), 3–19.
- Sussex Partnership Family and Systemic Therapy Practice Network (2016). Practice Networks work programme. Sussex Partnership.
- Szmukler, G.I., Burgess, P., Hermann, H. et al. (1996). Caring for relatives with serious mental illness: The development of the experience of caregiving inventory. *Social Psychiatry and Psychiatric Epidemiology*, 31, 137–148.
- Taylor, R., Mellotte, H., Griffiths, M., Compton, A. & Valsraj, K. (2016). Carers matter: promoting the inclusion of families within acute inpatient settings. *Journal of Psychiatric Intensive Care*. <http://doi:10.20299/jpi.2016.014>.
- Tasker, Fiona and Malley, M. and Costa, P.A. (2018). Family Mapping Exercises (FMEs) for adults and children in LGBTQ-parented families. In J. Whitman & C. Boyd (Eds.) *The therapist's notebook for sexual and gender identity diverse clients: Homework, handouts, and activities for use in counseling, training, and psychotherapy*. New York: Harrington Park Press.
- The Institute of Narrative Therapy (2018). Training and Supervision (<http://www.theinstituteofnarrativetherapy.com>)
- The Schizophrenia Commission (2012). *The abandoned illness: a report from the Schizophrenia Commission*. Rethink Mental Illness, London.
- Thompson, O., Griffiths, M., Allen, J. & Jones, F. (2019). A Delphi survey to explore best practice for practitioners offering family intervention for psychosis to families with children. *Journal of Family Therapy*.
- Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask circular, strategic or reflexive questions? *Family Process*, vol 27, No. 1, 1–16.
- Totsuka, Y. (2014). 'Which aspects of social GRRRAACCEEESSS grab you most?' The social GRRRAACCEEESSS exercise for a supervision group to promote therapists' self-reflexivity. *Journal of Family Therapy*, 36, 86–106.
- Trauer, T., Callaly, T. & Herrman, H. (2009). Attitudes of mental health staff to routine outcome measurement. *Journal of Mental Health*, 18(4), 288–297. doi:10.1080/09638230701879177
- Tribe, R. & Morrissey, J. (2004). Good practice issues in working with interpreters in mental health. *Intervention*, 2(2), 129–142.
- Tribe, R.H., Freeman, A.M., Livingstone, S., Stott, J.C. & Pilling, S. (2019). Open dialogue in the UK: qualitative study. *BJPsych Open*, 5(4).
- Tsami, L., Lerman, D. & Topper-Korkmaz, O. (2019). Effectiveness and acceptability of parent training via telehealth among families around the world. *Journal of Applied Behavior Analysis*, 52(4), 1113–1129.
- UK Government (2018) *Modernising the Mental Health Act: Increasing choice, reducing compulsion*. Final report of the Independent Review of the Mental Health Act 1983 Available at <https://assets>.

- publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf [Accessed 16/01/21]
- Ungar, M. (2006). Practicing as a postmodern supervisor. *Journal of Marital and Family Therapy*, 32, 59–71.
- Veitch, P. & Thomas, M. (2013). Families: Key to our work in stepped care. Are we trained? Are we working with them? An audit. 2012/13. Northumberland, Tyne and Wear NHS Foundation Trust.
- Wardale (2007). *Keeping the Family in Mind Resource Pack* (2nd edn). Barnardos: UK.
- Watt, G. & Brittle, R. (2008). The influence of attachment on relationships in caring for people with learning disability. *Learning Disability Practice*, 11(2).
- Watts, J. (2008). Doing care, doing schizophrenia: How the notion of the carer affects family-talk about psychotic distress. In *Analysing Psychiatric Discourse symposium. Qualitative Research in Mental Health II conference. 9 – 12 June 2008, Tampere, Finland.*
- Weintraub, M.J., Hall, D.L., Carbonella, J.Y., Weisman de Mamani, A. & Hooley, J.M. (2017). Integrity of literature on expressed emotion and relapse in patients with schizophrenia verified by ap-curve analysis. *Family Process*, 56(2), 436–444.
- While, D., Bickley, H., Roscoe, A., Windfuhr, K., Rahman, S., Shaw, J., et al. (2012). Implementation of mental health service recommendations in England and Wales and suicide rates, 1997–2006: A cross-sectional and before-and-after observational study. *Lancet*, 379, 1005–1012.
- White, M. (1988). The externalizing of the problem and the re-authoring of lives and relationships. *Dulwich Centre Newsletter*, summer.
- White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. WW Norton & Company.
- Williams, B. & Morris, L. (2015). Importance of co-working in family interventions. *Mental Health Practice (2014+)*, 19(2), 14.
- Williams, P.E., Turpin, G. & Hardy, G. (2006). Clinical psychology service provision and ethnic diversity within the UK: A review of the literature. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 13(5), 324–338.
- World Health Organization (2004). *Mental health policy, plans and programs*. Geneva: WHO.
- Worthington, A., Rooney, P. & Hannan, P. (2013). *The triangle of care: Carers included: A guide to best practice in mental health Care in England*. Carers Trust.
- Wrape, E.R. & McGinn, M.M. (2019). Clinical and ethical considerations for delivering couple and family therapy via telehealth. *Journal of Marital and Family Therapy*, 45(2), 296–308.

Appendix A: Training & supervision in family work

TYPE OF TRAINING	ENTRY REQUIREMENTS	TIME	OUTCOMES
FAMILY INCLUSIVE PRACTICE			
Family inclusive practice carer support Training	Staff with regular contact, routine and formal, with families	2–4 days	Awareness of family issues and increased confidence in talking to families
FAMILY INTERVENTIONS			
Psychoeducational & Formulation Behavioural Family Therapy	Staff with commitment to working with families	10 days followed by monthly supervision	Information & skills in behavioural family therapy
Training the Trainers	Initial Training in Behavioural Family Therapy	5 days	Skills in training & supervision BFTT
Caring for Carers	Staff working with people in a carer role	3–4 days	Skills & resources to roll out carers information
Information sharing with family & friends	Staff with commitment to working with families	1 day	Knowledge & skills around confidentiality

TYPE OF TRAINING	ENTRY REQUIREMENTS	TIME	OUTCOMES
Integrated Systemic & Psychoeducational/ cognitive behavioural approaches	Relevant health or social care professional training or equivalent Membership of team undertaking training	1 year	Foundation Level training in Family Therapy and CBT
Multi Family Group Work for Psychosis Training	Relevant health or social care professional training or equivalent	3 days	Ability to work with multi-family group
FAMILY THERAPIES			
Dialogical			
Foundation Level Programme	Mental health teams & peers, professionals, organisations	1 year, 5 blocks, 4 days	Foundation abilities in dialogical approach
Full 3 year training programme	Working at least 2 years as a mental health professional & opportunity to work with colleague & meet with families	Theory days = 26 Supervision days = 22 Form of ongoing – 12 plus 3 peer group days per year	Practice as a Dialogical Therapist

FAMILY INTERVENTIONS IN PSYCHOSIS

TYPE OF TRAINING	ENTRY REQUIREMENTS	TIME	OUTCOMES
FAMILY THERAPIES (CONTINUED)			
Systemic Family Therapy			
Foundation	Relevant professional training in mental health or social care discipline or equivalent	60 hours study minimum over one academic year	Systemic knowledge and skills
Intermediate	Foundation Level Training	60 hours study + 60 hours systemic practice over 9–12 months	Systemic Practitioner at Intermediate Level
Qualifying	Relevant professional qualification or equivalent First degree or evidence can study at degree level Foundation & Intermediate qualification Working in health or social care, statutory or voluntary organisation able to meet requirements of clinical hours DBS current clearance	Face-to-face clinical work with clients seen with live supervision in a supervision group: 40 hours Clinical Practice within a supervision group: 300 hours Clinical practice hours in own organisation/ agency/workplace (health and/or social care setting): 200 hours Direct teaching hours and Personal and Professional Development: 180 hours. Of this direct teaching time 25 hours must be dedicated to PPD Independent study time: 1175 hours	Practice as a Systemic & Family Psychotherapist

TYPE OF TRAINING	ENTRY REQUIREMENTS	TIME	OUTCOMES
SUPERVISION			
Behavioural Family Therapy	Behavioural Family Therapy trained	Trained BFT Therapist	Supervisor to BFT trained staff
Integrating Systemic Psychoeducational/ cognitive behavioural approaches	Integrated systemic psychoeducational/ cognitive behavioural trained		Supervisor to teams trained in integrated approaches
Multi Family Group Work	Multi family group work trained		Supervisor to multi family group clinicians
Family Therapy	Qualified Family Therapist	Experienced Family Therapists who have been on the UK CP Register for at least 2 years can undertake 1 year training 80 hrs systemic supervision practice 90 taught hours Over 1-3 years	Supervisor to Family Therapists at all levels
Dialogical Therapy	Qualified Dialogical Therapist		

FAMILY INTERVENTIONS IN PSYCHOSIS

Appendix B: Approach method technique framework

The different types of family-orientated practice are summarised below using the Approach-Method-Technique framework (Burnham, 1993). This framework allows the similarities and differences in stance and practice to be articulated. Approach describes the underlying assumptions and theory that inform practice; Method refers to the way practice is organised; and Technique captures the specific activities that comprise practice.

	APPROACH	METHOD	TECHNIQUES
Family inclusive practice	<p>Family-friendly, sensitive and inclusive practice</p> <p>Problems are systemic and need a family approach including families in all work and decisions</p> <p>Families to have their perspectives understood/valued by service</p>	<p>Multiple distinct opportunities for families to engage with services</p> <ul style="list-style-type: none"> • Staff supported by training to provide a whole family approach to care • Engaging with carer advisors to understand needs of families • Service support/allow time for <ul style="list-style-type: none"> – Individual family meetings: initial assessments /reviews /CPA meetings/ regular contact with care coordinators – Groups with other families: Carers' groups/Family & Friends Groups 	<p>Welcoming family members/friends to the service through providing space, resources, time to them</p> <p>Meeting with and listening to families and bringing them into decisions and information sharing</p> <p>Bringing in the family's perspective into case discussions</p> <p>Working through difficult situations with families in supervision</p>

	APPROACH	METHOD	TECHNIQUES
Support and information for significant others	Create culture where family perspective and input is valued and working with family members is seen as standard practice (Carers Matter)	Develop multiple pathways for offering support and allowing families to support each other <ul style="list-style-type: none"> • Meetings/therapy for individual carers • Carers' groups/Family & Friends Groups 	Meeting with and truly listening to experience of named 'carers' and families Facilitating carers/significant others to share stories/knowledge Facilitating groups and individual sessions Sharing information about the service and possible interventions Sharing information from professionals' experience and research (e.g. professional understandings of voices) and valuing the knowledge carers bring Providing one-to-one interventions aimed at improving wellbeing in family members Offering supervision to explore feelings of staff around family dynamics, dealing with distress in families
Peer support	Create culture where people with lived experience/perspective/ input is valued	Develop structures that support the individual in role as peer mentor	Provide training about the ethos of the work (e.g. recovery values), and specific skills (working with individuals and families) preferably co-produced with those with lived experience Set up peer support strategy with clear roles for peer support workers e.g. who and when peers engage with families Offer supervision (individual/team)

FAMILY INTERVENTIONS IN PSYCHOSIS

	APPROACH	METHOD	TECHNIQUES
<p>Structured family interventions and integrated approaches</p>	<p>The family is a potential asset and resource</p> <p>Families' strengths can be identified and built upon</p> <p>Families are not regarded as responsible for the difficulties</p> <p>Families have the capacity to shape an individual's unusual experiences and distress</p> <p>Providing information and skills training supports improved outcomes for families and service users</p>	<p>Usually see families in their homes</p> <p>Individual assessment sessions with each family member</p> <p>Bring the whole family together to do therapeutic work</p> <p>Information sharing and skills learning</p>	<p>Varies between the different models of structured intervention</p> <p>Underlying principles are consistent: psychoeducation, problem-solving approaches and communication skills are shared with the family to help them to find more adaptive ways to interact together</p>

	APPROACH	METHOD	TECHNIQUES
Systemic approaches	<p>Significance of relationships and power in the development and maintenance of difficulties</p> <p>Language, discourse and experience frames the situation, including multiple versions of 'reality' and the strengths of the family</p>	<p>Usually involve working with multiple people within an individual's family and social network</p> <p>Can happen in formal contexts like a clinic setting with a one-way mirror, and less formal settings such as in people's homes</p> <p>Reflecting Teams/Reflecting Conversations (Andersen, 1995)</p>	<p>Use of systemic skills to formulate the problem</p> <p>Act therapeutically to introduce change at the level of individual experience and/or relational patterns, such as circular questioning or externalising conversations, use of sculpting and creative exercises to support thinking and conversations</p>



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