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Manchester Mental Health NHS and Social Care Trust

# CaFI

## Culturally-adapted Family Intervention

African Caribbean people

**Therapist Training**

**9th March 2015**


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## Agenda

- Comfort break 2.30pm
- Overview of manual: part 6 2.45pm
  - Session 1-2: *Engagement & Assessment*
  - Session 3-4: *Shared Learning*
  - Session 5-6: *Communication*
  - Session 7-8: *Stress Management, Coping & Problem Solving*
  - Session 9-10: *Staying Well & Maintaining Gains*
- Supervision & supporting each other 3.45pm
- Questions & feedback 4.00pm
- Close 4.30pm

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## Agenda

- Welcome and introductions 1.00pm
- Overview of study 1.15pm
- Research protocol: feasibility study 1.30pm
- Delivering therapy in research versus clinical settings 1.45pm
- Overview of manual: parts 1-5 2.00pm
  - Part 1: Introduction to Historical, Cultural and Social Context
  - Part 2: Background to African Caribbean Mental Health in the UK
  - Part 3: Rationale and Development of CaFI
  - Part 4: Ethos of Delivery
  - Part 5: Practical Considerations

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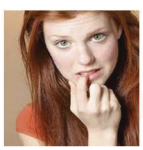
## How confident do you feel in delivering FI on a scale of 1-10?

**10 = very confident**



**1 = not confident at all**

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## Overview of study

# Background

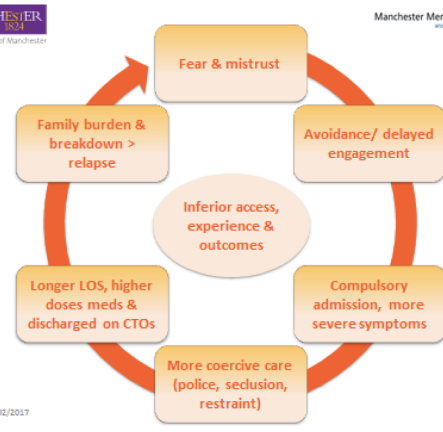
African Caribbeans in the UK experience the greatest inequalities in access, experiences and outcomes than any other ethnic group (Sainsbury Centre for Mental Health, 2006)

→ Rates of schizophrenia and psychosis up to nine time times higher in AC compared to WB groups (Fearon et al., 2006)

NICE guidelines (2009, 2014) recommend Family Intervention (FI) for schizophrenia

→ Engaging patients and families improves outcomes FI clinically and cost effective but patients rarely offered it

Lack of psychological therapies for African Caribbeans




28/02/2017

# Aims

1. Assess feasibility of culturally-adapting, implementing and evaluating an innovative approach to FI among African Caribbean patients with schizophrenia and their families across a range of clinical settings.

2. Test feasibility and acceptability of delivering FI via 'proxy families' where biological families are not available.

# Potential benefits of CaFI

- Improve access to **culturally appropriate psychological therapies**
- Improve **families' ability to support** recovery
- Improve **engagement** with mental health services
- Reduce **relapse & readmission** to hospital
- Improve **support networks** in communities

# Service user and carer involvement

- Research Advisory Group
  - Service users, carers, advocates
  - Regular meetings
  - Advise on recruitment and engagement strategies
  - Feedback on materials (e.g. Participant Information Sheet, posters, therapy manual)
  - Contribute to training & Conferences

# Service user and carer involvement

- Service user co-applicant
- Carer collaborator
- MRC START trial – PPI flyer
  - Does communicating PPI to potential participants improve recruitment and retention?
  - Developed PPI leaflet in collaboration with RAG
  - Randomise potential participants to PPI versus no PPI leaflet

## Objectives

- To test the feasibility of delivering culturally-adapted FI among African Caribbean patients in hospital and community settings.
- To test the feasibility of recruiting patients and biological and 'Family Support Members' and delivering the intervention via both.
- To identify outcome measures for future randomised studies and assess the feasibility of collecting them.
- To assess the acceptability of the intervention to key stakeholders – including patients, their families and mental health professionals.

## Project plan

- **Phase 1 (9m) Culturally-adapting the family intervention (CaFI)**: working with health professionals, carers, advocates and service users
- **Phase 2 (4m) Training**: for family therapists and family support members in delivery of CaFI & cultural competency
- **Phase 3 (21m) Feasibility study**: delivering and evaluating CaFI with 30 African Caribbean service users and families

## Timescale

Phase 3 Feasibility Study: *Delivering & Evaluating CaFI*

- Recruitment period: Apr 15 – Jan 16
  - 9 months
- Intervention period: Apr 15 – May 16
  - 12 months
- Data collection period: Apr 15 – Aug 16
  - 15 months, including 3 months follow up post-intervention

## Research protocol: feasibility study

## Recruitment service users

- Recruit 30 service users
  - African Caribbean descent (self-identify as 'Black-British', 'African Caribbean' or 'Mixed' African Caribbean but who have at least one African Caribbean parent or grandparent)
  - Diagnosis of schizophrenia or related diagnosis (ICD-10 F20: schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder or psychotic disorder not otherwise specified)
  - Receiving treatment psychiatric acute/rehabilitation inpatient wards, CMHTs (inc CTOs) at MHSCT
  - Over 18 years
  - English language
  - Capacity to consent and participate
  - Risk assessment – no high risk

## Recruitment families

- Family members
  - Relative of someone of African Caribbean descent with schizophrenia who is taking part in the study
  - Any ethnic group
  - Over 18 years
  - English language
  - Capacity to consent

## Data collection: outcome measures

- Primary outcome = uptake, retention and attrition of intervention
- Secondary outcome measures
  - Interviews/ questionnaires collected by RA at 3 time points:
    - Baseline, post-intervention, 3 months follow up
    - Therapists can have access to support assessments (e.g. KAPI)
- Service users
  - Positive & negative symptoms
  - Social & personal functioning
  - Perceived criticism
  - Working alliance – with key workers
  - Illness beliefs
  - Economic evaluation

*Therapeutic alliance – rated at session 3, administered by therapists

## Recruitment FSMs

- Family support members (FSMs)
  - Work alongside those with no contact with families.
- FSMs will be identified in two ways:
  - *Nominated*: nominate people they consider important or influential in their lives, people who they trust or anyone who provides emotional support (e.g. friends, local pastors or other 'trusted individuals' such as support, youth or community workers)
  - *Recruited*: 10 people specifically recruited to work with those patients who are unable to nominate

## Data collection: outcome measures

- Families/FSMs
  - Knowledge about psychosis
  - Economic evaluation
  - General emotional distress
  - Economic evaluation
- Key workers
  - Working alliance
  - Service engagement
- Therapists
  - Therapeutic alliance > rated by therapist at session 3
- Relapse rates
  - Hospital admission & change in patient management > case notes
  - Rated retrospectively by independent rater at end of study

## Recruitment families

- Family members
  - Relative of someone of African Caribbean descent with schizophrenia who is taking part in the study
  - Any ethnic group
  - Over 18 years
  - English language
  - Capacity to consent

## Data collection: acceptability

- Qualitative interviews post-intervention
  - Service users, family members, FSMs, therapists, key workers
  - Views about research and intervention:
    - taking part in research
    - content and delivery of sessions
    - usefulness, cultural-appropriateness and accessibility of intervention and materials
    - barriers/facilitators to implementation
    - training/supervision
    - personal benefits
    - delivery via FSMs and therapists
  - ➢ Administered by RA

## Data collection: acceptability

- Early withdrawal interviews
  - Reasons for withdrawal
  - ➢ Administered by RA
- Monitoring session feedback
  - Service users
  - Each family member/ FSM
  - ➢ Administered by therapists at the end of each session

❖ Therapists can take 'reflective notes' as deliver sessions
- ➢ Process of using CaFI manual issues/challenges/difficulties, positives/negatives
- ➢ Report to supervisor/research team if they wish

➡ *Feasibility study* = changes to manual based on feedback

## Exercise

What do you think is different about carrying out therapy as part of a research study compared to normal clinical practice?

What do you think is similar across both settings?

## Data collection: fidelity

- Adherence to the manual & delivery of intervention
- Independent review of 10% of sessions – clinical psychologist
- Cognitive Therapy Scale for Psychosis (Haddock et al., 2001)
  - 60 item checklist
    - agenda setting and adherence
    - checking understanding and providing feedback
    - interpersonal effectiveness (including ability to demonstrate warmth, caring and concern)
    - working collaboratively with patients and families
    - level of skill in delivery of intervention (ability to select and facilitate appropriate techniques)
- Adapted for CaFI – assess content and structure, and core therapist skills
- All sessions recorded with participant consent
- Therapists will be given audio recorders for duration of study
- Therapists will give recordings to Katherine in supervision
- Random selection of sessions from different therapist pairs & participants

## Differences

- Need to stick to manual and always discuss any barriers to this in supervision.
- Potentially less autonomy and flexibility in clinical decision making.
- With family consent, mandatory recording of sessions.
- Additional therapist measures e.g. feedback forms, alliance
- Fidelity checks as part of supervision with feedback on adherence to protocol.
- Supervision provided 'outside' of clinical team.
- Families will already have completed some assessments with RA prior to commencing therapy.
- Potential for families to confuse research with therapy.

## Delivering therapy in research versus clinical settings

## Similarities

- Delivered within Trust settings.
- Same structure: assessment, formulation, intervention and review.
- Importance of clinical supervision.
- Same risk issues and ways of assessing and dealing with these.
- Similar service users, families and presenting problems.
- Similar content of interventions.
- Same recording procedures for notes, including Amigos.

## Overview of manual: parts 1-5

## Part 1: Introduction to Historical, Cultural and Social Context

- Migration & African Caribbean family life
  - African-descended families traditionally extended
  - Caribbean people recreated traditional family structures - kinship networks
  - Migration to UK reduced access to supportive social relationships
  - Lack of knowledge of UK 'systems' & how to seek help
  - Hypervigilance & children taken into care > mistrust of authorities
  - Broken attachment, separation and loss = adverse psychological effects
  - However, majority of Caribbean-descended people living in UK are British born!
  - Stereotypical views can be unhelpful (e.g. matriarchal households, fathers leaving)

➢ View each family within their specific social context

## Part 1: Introduction to Historical, Cultural and Social Context

- UK African Caribbean families in wider socio-historical context
  - Power differentials between ethnic groups
  - Rooted in colonialism & slavery
  - Diversity of African Caribbean cultures

- Caribbean Islands – brief history
  - Common histories of colonialism, slavery & migration
  - Colonised by Spanish, French & British
  - Slave plantations – export tobacco, sugar, cotton, coffee, spices
  - Millions enslaved Africans transported to British colonies

➢ Diverse cultural origins shaped language, religions, music, cuisines & culture

## Part 2: Background to African Caribbean Mental Health UK

- Higher rates of schizophrenia and psychosis

e.g. AESOP: Fearon et al., (2006)

- Why the higher rates of schizophrenia?
  - Misattribution & misdiagnosis (e.g. lack cultural awareness, institutional racism)
  - Biological hypotheses (e.g. genetic predisposition, cannabis use)
  - Psychosocial hypotheses (e.g. social deprivation, parental separation before 16)

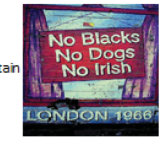
see Pinto et al. (2008) for lit review

- Negative experiences and pathways to care
  - Greatest inequalities in access, experiences and outcomes
  - Multiple help-seeking attempts, negative referral routes (police), higher rates seclusion & restraint, higher doses of meds, longer stays in hospital, higher rates of readmission, more likely discharged on CTOs, less likely offered psychological therapy

e.g. Morgan et al., (2004)

## Part 1: Introduction to Historical, Cultural and Social Context

- Post-war migration to the UK
  - Migration to 'mother country' – Second World War
  - During 1950s - ¼ million immigrants from Caribbean to Britain
  - Discrimination in accessing housing & employment
  - Adversity, exclusion & racism
  - Isolated from support of extended families
  - Emergence of pan-Caribbean solidarities (e.g. Black Majority Churches)




- African Caribbean population in the UK
  - By 2011, almost 3/4s of 1 million Caribbean descent born in Britain
  - Caribbean population in UK barely increased between 2001 and 2011 Census
  - 2011 Census, 4.1% Manchester population 'Black' ethnic group

(Office for National Statistics, 2001; 2011

## Part 2: Background to African Caribbean Mental Health UK

- Poor engagement with mental health services
  - Engagement with services characterised by fear, mistrust and avoidance
  - Vicious 'circle of fear'

Sainsbury Centre for Mental Health (2006)

- Impact on family relationships
  - Family burden and distress – long periods without professional help
  - Hostile home environments & family breakdown
  - Social isolation & readmission to hospital
  - Families often involved in calling police at crisis
  - Lack of knowledge about mental health problems and how to seek help
  - Deep-seated fear and mistrust of mental health services

## Part 3: Rationale and Development of CaFI

- Family Intervention
  - Recommended by NICE (2014)
  - Evidence clinically & cost effective - reductions in relapse

(Pharoah et al., 2010)

- Culturally-adapted Family Intervention
  - Adapted cognitive behavioural FI by Barrowclough & Tarrier (1992)
    - Psychoeducation and skills for stress management, coping & problem solving
    - Working in collaboration to tackle problems > alleviate stress, reduce relapse
  - Over the years, multiple models & interventions
  - Need to address cultural appropriateness
  - CaFI developed to meet needs of African Caribbean families in UK

## Part 4: Ethos of Delivery

Work in partnership with families to…

- Develop more helpful explanations for symptoms
- Facilitate better communication in the family
- Develop more effective coping and stress management strategies
- Improve problem-solving skills
- Promote recovery and relapse prevention
- Improve understanding of how 'the system' works and strategies for engaging and communicating with mental health services and partner agencies

## Part 3: Rationale and Development of CaFI

- Development of CaFI
  - Collaboration: 'experts by experience' (service users & families) and 'expert by profession' (academics & healthcare professionals)
  - Three main sources:
    - Literature review
    - Qualitative research – focus groups
    - Expert consensus conference

➢ Informed 'ethos of delivery' & session content

- Key issues to support culturally sensitive delivery
- Additional content of relevance to African Caribbean people
- Training therapists in 'cultural competent' practice

## Part 4: Ethos of Delivery

- Shared learning & recovery-based approach
  - Work with strengths
  - Family not to blame
  - Tailored to meet needs
  - Individualised formulations – understand problems & develop solutions
  - Collaborative
  - Learning three-way process
  - Recovery as self-acceptance & good quality of life
- Note on terminology
  - Non-stigmatising
  - Respect language & terminology accepted by family

## Part 4: Ethos of Delivery

- Aims of intervention

Support the family to…

1. Facilitate positive family relationships that enhance mental wellbeing for service users & their families
2. Enable families to optimise interactions with services to foster engagement – improving access, experiences & outcomes of mental health care

## Part 4: Ethos of Delivery

- Principles/ways of working with African Caribbean families
  1. Focus on individual values and beliefs versus 'African Caribbean culture'
  2. The needs of the family are understood holistically
  3. There is an awareness of the potential impact of diversity and difference and on the relationships between therapists, service users and their families
  4. The therapeutic relationship is one of collaboration, mutual respect and trust-building
  5. The confidentiality of the family is respected

## Part 5: Practical Considerations

- Who should deliver the intervention?
  - Pairs - FI trained therapist & co-therapist
  - Lead therapist plans & leads session
  - Lead therapist decides on therapist roles (e.g. tasks in session)
  - Co-therapist help to set up session & resources, make notes & observations, collecting feedback sheets, debriefing etc.
  - Option to divide time between different relatives (e.g. assessment interviews)
    - Last resort, discuss in supervision – family as a unit, time & resources
- Ethnic matching therapists
  - Lack of evidence improves outcomes
  - Shared understanding experiences – culture?
  - Build engagement and trust?
  - Not practical - low numbers of African Caribbean therapists
  - Other characteristics important – age, gender, social class, education, religion
  - Fear & stigma = preferences to work with people removed from community

➢ Workforce needs training in culturally-sensitive interventions!

## Part 5: Practical Considerations

- Maximising attendance
  - 10 sessions difficult for some families
  - Deal with potential barriers
  - Check access to transport, encourage sharing lifts etc.
  - With permission, send reminders via preferred mode contact
  - Repeated non-attendance should be addressed

- General structure & format of sessions
  - Be flexible & responsive to needs of family
  - Some structure required to ensure relevant material covered
  - Structure for sessions 1-2 *Engagement and Assessment:*
    - More flexible than other sessions
    - How have things been
    - Agenda for session
    - Feedback (*sheets) and setting plan for next session

## Part 5: Practical Considerations

- Referral pathways of families
  - RA responsible for recruitment
  - Support from Clinical Research Network – Clinical Studies Officers
  - 3 settings: acute, rehab, CMHTs
  - Community-level & self-referral – meet inclusion criteria & receive care at MHSCT

- Who should attend sessions?
  - Service users & family members – invite all who have regular contact
  - Need to be flexible
  - Some relatives may not be able to attend all sessions
  - Families can be encouraged to meet outside sessions – learning & engagement
  - Family Support Members – where no family available
    - Can nominate or select recruited person
    - RA matches family support member and facilitates meeting before first session
    - Boundaries & expectations agreed with input from lead therapist in initial sessions

## Part 5: Practical Considerations

General structure for all other sessions (3-10):

- Intro/overview = 20 mins
  - Welcome & general conversation
  - Summary of previous session & elicit reflections
  - Review and feedback of the between session tasks
  - Collaboratively agree agenda for current session

- Sessions content = 30 mins
  - Conduct main session content items/tasks – choice depends on formulation
  - Provide resources relating to session content (e.g. worksheets, handouts, leaflets)
  - Collaboratively set and agree tasks to complete before next session – identify barriers

- Finishing up = 10 mins
  - Elicit feedback from current session - anything difficult/unhelpful?
  - *** Session feedback sheet for every family member to complete in session**
  - Discuss briefly the outline next session and what want to achieve
  - Arrange next appointment (date, time, venue, attendees)

## Part 5: Practical Considerations

- Time scale of intervention
  - 10 hourly sessions
  - Pace depends on needs of family (e.g. weekly then fortnightly, monthly)
    - Completed within 20 weeks
  - Account for 1.5 hours of therapists' time (30 mins prep & debrief)
  - Additional time for supervision
  - Flexibility to maintain engagement

- Time & location of intervention
  - Depend upon needs of family
  - Depends where receiving care – wards, supported housing, family home, neutral space
  - Agree at start intervention
  - Flexible approach
  - Evening or weekend sessions – negotiated with research team & risk assessment
  - OOHs, Lone, Community & Safe Working Policies
  - Care management might change – contingency plans in place (e.g. venue, risk)

## Part 5: Practical Considerations

- Resources
  - 'Toolkit' or collection of resources feel comfortable using
  - Adapted to needs of family
  - Accessible, lay language, pictures etc.
  - Resource folder for families to keep handouts (e.g. worksheets, info leaflets)

- Note-taking
  - Record notes about session
    - Reminder what is covered
    - Meet Trust requirements
    - Record information for research – refinement of manual
  - Explain to family to reassure & confirm confidentiality

- Recording of sessions
  - Stated in PIS and permission in consent form
  - Remind families & check still okay
    - Improve understanding & help plan sessions
    - Discussed in supervision
    - Remain confidential & destroyed at end of study
    - Offer copy if they wish

## Part 5: Practical Considerations

- Risk assessment and monitoring:
  - Monitor risk of harm, self-neglect & relapse
  - Concerns re. medication – refer to care team (strategies in *Communication)*
  - Medication address during *Shared Learning*

- Feedback on sessions
  - Feedback forms completed at end of each session
  - Ongoing evaluation of intervention & its acceptability
  - Submit to researchers every two weeks
    - What mechanism in place to do this? Reminders needed? Fax/post/email?

- Prep work
  - Some understanding of family before meet them
  - Gather relevant info before session (e.g. case notes, key workers)
  - Supplement with info during assessment > formulation
  - Access to outcome assessments (baseline, 3 mths)

# Overview of manual: part 6

## Part 5: Practical Considerations

Additionalthingsto consider....

- Need to submit therapeutic alliance forms in session 3
  - Include in session 3 resource pack – write in manual
  - RA reminder
  - Forward to RA – email/fax/post?
- What contents should be in the therapy file?
  - Risk & referral form: receive prior to meeting family
  - MHSCT history sheets (signature & date)
  - Copies of outcome measures
  - Anything else?
- Recording appointments
  - Session number, date, time, who attended, venue/location, duration
  - RA input on retention database
    - Access to shared drive or paper forms to submit?
  - Therapists to record patient contact standard MHSCT policy - amigos

## Sessions 1 and 2

- **Engagement and assessment**
- Getting to know the family
- Discuss and clarify expectations, including confidentiality
- Developing a good alliance and trust
- Explain role of therapists
- Identify strengths and resources
- Identify priority problem areas
- Plan for future sessions

- Format
- Who attends?
- Whole family versus individual meetings.
- Importance of letting the family talk, including opportunity to off-load about negative experiences.

# Comfort break

## Sessions 1 and 2

- Family structure and roles
- Extended social networks.
- Female-headed, single-parent households.
- Hierarchies with different rules of communication for different members.
- Different views and cultural values in younger versus older generation.
- Importance of hospitality when carrying out home visits.

- Assessment process
- Family's understanding of psychosis and attitudes towards treatment/services.
- Quality of family relationships.
- Service user's problems/level of functioning and affect on family.
- How service user is affected by family relationships.
- Sources of stress or contention.
- Ways of coping – helpful or unhelpful.
- Strengths and resources.
- Role of religion and spirituality.
- Future aspirations.

## Sessions 1 and 2

- Formulation
- Developed from the first sessions onwards.
- Map or story about what factors lead to the development of problems and what keeps problems going.
- Explain how problems relate to each other and how family members impact on each other.
- Must include strengths and resources.
- Will evolve over time as new information comes to light.
- Formulations aren't presented to families but gradually shared in a way that enables the family to contribute their own understanding to.
- Formulations key focus in supervision and will be used to guide decisions throughout therapy.

## Sessions 3 and 4

- Sharing information
  - Should take into account what families know or belief already and what they want to know more about.
  - Avoid jargon and where possible use the family's own language.
  - All information based on accurate sources including emphasis on limits of current knowledge.
  - Could include information specific to African Caribbean people with psychosis.
  - Take into account reading level, different learning styles (e.g. visual, oral, verbal) and preferred mediums.
  - Material discussed in sessions can be supplemented by between session reading.

## Sessions 1 and 2

- SMARTER goals
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Timely
  - Evaluated
  - Rewarded

- Resource kit
  - Ice breaker exercise
  - Family and service user assessment topic guides
  - SMART goal setting

## Sessions 3 and 4

- Possible areas of focus
  - How the mental health system works
  - Available treatments
  - Stigma and challenging common myths
  - Role of substance misuse
  - Police involvement

- Resource kit
  - Information booklet 'Understanding schizophrenia and psychosis'
  - Word choice and mind maps
  - Stress-vulnerability model
  - Carer information booklets

## Sessions 3 and 4

- **Shared learning**
  - Therapists, relatives and service users learn from each other.
  - Information and beliefs about cause, symptoms and prognosis of psychosis.
  - Information and beliefs about the treatment of psychosis.

- Families explanatory models
  - People will have own explanations for service user's mental health problems.
  - These models will influence how problems are dealt with.
  - Different family members may have different models, leading to conflict.
  - Therapists should be aware of potentially unhelp beliefs and responses but avoiding challenging these 'head on'.

## Sessions 5 and 6

- **Communication**
  - Unhelpful patterns of communication common with high stress and burden.
  - But result in further stress and exacerbation of symptoms.
  - Families may also experience difficulties in communicating with services.
  - Improving communication within family provides good foundation for future sessions.
  - Therapists and therapy 'role model' for good communication.
  - Identify which communication skill(s) family wants to work on (e.g. active listening, expressing positive feelings, expressing negative feelings, being assertive).
  - Discuss rationale for skills, introduce and model skills, followed by role play and feedback.
  - Note and reinforce good communication throughout sessions.
  - Between session tasks to practise skills.

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## Sessions 5 and 6

- Resource kit
- Active listening worksheet
- Expressing positive feelings worksheet
- Expressing negative feelings worksheet
- Being assertive information leaflet
- Being assertive steps
- Communication skills record
- Communication checklist for families
- Communication checklist for service users

## Sessions 5 and 6

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- Active listening worksheet
- Expressing positive feelings worksheet
- Expressing negative feelings worksheet
- Being assertive information leaflet
- Being assertive steps
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- Communication checklist for families
- Communication checklist for service users

## Sessions 7 and 8

- Breaking vicious cycles
- Identify ways of improving service user's behaviour.
- Help relative to manage their own negative emotions, thoughts and behaviour triggered by the service user's behaviour.

- Goal setting and problem solving
- Focuses on improving service user's functioning through the family working together in a constructive and collaborative way.
- Identify difficulty.
- Translate problem into need: if person didn't have problem what would he/she be doing.
- Identify strengths: abilities, interests and resources.
- Generate ways of meeting needs.
- Set SMARTER goals and action plan.
- Plan for maintenance, generalisation and extension.
- Use of between session tasks.

## Sessions 7 and 8

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## Sessions 7 and 8

- **Stress management, coping and problem solving**
- Helps relatives and service users manage current stressors together through joint problem solving.
- Therapists should be aware of stress triggers, signs and coping responses within the family.
- Importance of 'normalising' common stressors and maladaptive coping responses.
- Importance of avoiding blame and rationale for aiming to reduce relative stress.
- Start by formulating stress response by drawing out vicious cycles: service user behaviour > relative interpretation> relative emotion > relative response > consequences for service user.
- Use formulation to identify ways of breaking vicious cycles.

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- Importance of avoiding blame and rationale for aiming to reduce relative stress.
- Start by formulating stress response by drawing out vicious cycles: service user behaviour > relative interpretation> relative emotion > relative response > consequences for service user.
- Use formulation to identify ways of breaking vicious cycles.

## Sessions 7 and 8

- Resource kit
- Identifying and recording stress triggers
- List of common stressors
- Stress avoidance rules
- Identifying coping strategies
- Relaxation and guided imagery
- Grounding breathing techniques
- Vicious cycle examples and cycles
- Helpful ways of responding to symptoms
- Thought diary
- Identifying and challenging thoughts
- Identifying and recording strengths
- Low self-esteem – questions for eliciting positives
- Problem solving and goal setting

## Sessions 9 and 10

- **Staying well and maintaining gains**
- Generate plan for staying well
- Consolidate learning.

- Relapse prevention
- Identifying early warning signs and 'relapse signature'.
- Identifying coping strategies to tackle early signs
- Getting the right support to tackle early signs.
- Developing an action plan for early signs.
- Crisis planning.

# Supervision & supporting each other

## Sessions 9 and 10

- Maintaining gains
- Work together with family to help them identify what they have learnt.
- Generate ideas for how new skills can be maintained.
- Identify any SMARTER goals the family could work on together following therapy.
- Use formulation to anticipate and deal with any potential difficulties in relation to ending therapy.
- Using goodbye letters.

## Supervision and support

- What are your previous experiences of clinical supervision?

- Proposed model
- Minimum fortnightly meetings of 1-1 ½ hour duration.
- Pairs of therapists.
- Individual sessions?
- Group sessions?
- Location: University of Manchester, Zochonis Building.
- Individual supervision contracts which outline practicalities and expectations.

## Sessions 9 and 10

- Resource kit
- Early warning signs and relapse prevention plan workbook.
- Relapse signature card sort exercise.
- List of potential relapse signs.
- Dealing with a crisis worksheet template.
- Recovery planning guide.
- Goodbye letter example.

## Supervision and support

- Proposed style
- Agenda setting
- Clear question(s)
- Review all cases
- Focus on particular cases/issues struggling with
- Listening to recordings in sessions.
- Monthly fidelity checks.
- Use of role plays

- Other ideas for supporting you and each other?

## Questions & feedback


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