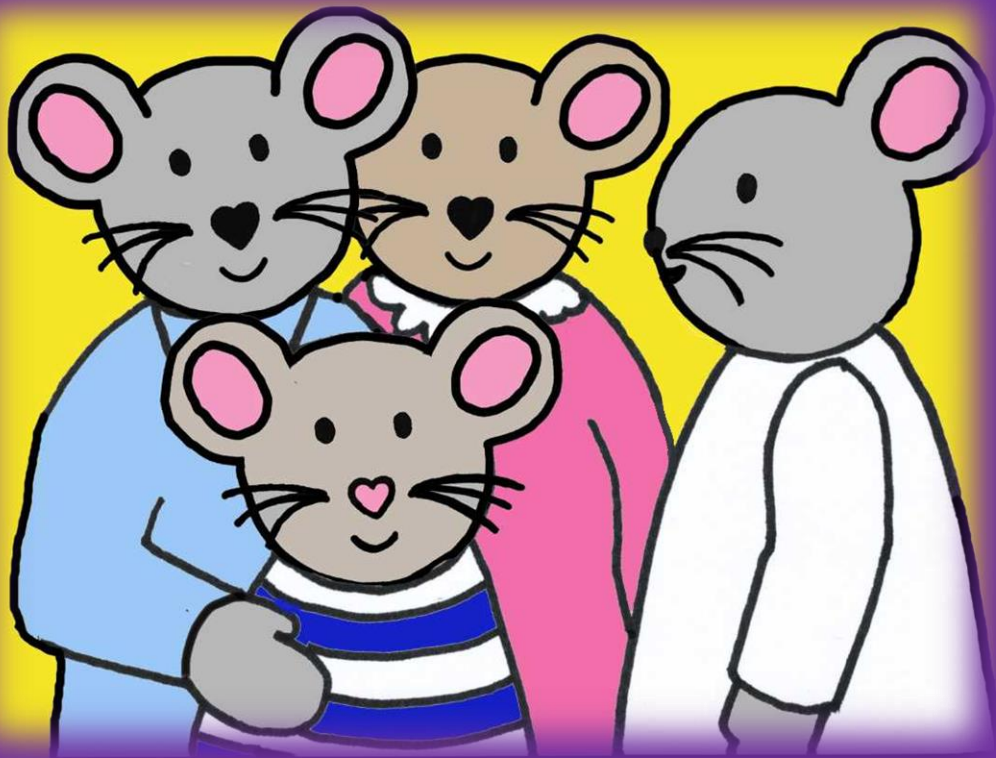


MATCH for MICE

A guide for study therapists



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¹ Creswell, C. and Willetts, L. (2012). *Overcoming Your Child's Fears and Worries*. London: Constable & Robinson.

² Baguley, C., Farrand, P., Hope, R., Leibowitz, J., Lovell, K., Lucock, M., et al. (2010). Good practice guidance on the use of self-help materials within IAPT services. In: *Improving Access to Psychological Therapies*. (ed. Nhs). Technical Report.

Introduction

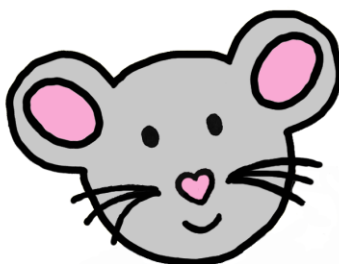
The aim of this treatment is to support children and young people with epilepsy, their parents and carers to implement strategies that they can use to work towards their own goals for managing difficulties with anxiety, low mood, behaviour problems or a combination of any of these. The treatment is delivered from within epilepsy services so that children with epilepsy get treatment for their mental health difficulties quickly in a way that is integrated with their physical health needs. Usually the treatment is delivered over the telephone unless the family are already coming into hospital or there is another reason to see the family face-to-face. The number of sessions needed will vary depending on the family's needs but the average number is expected to be 16 and each session is expected to last approximately 50 minutes although there will be variation according to clinical need. Between sessions, the family will work on strategies that have been discussed in the session and complete worksheets and questionnaires. This guide should be used alongside the materials in the manual and under supervision from an appropriately qualified health professional.

Evidence Base

We know that children and young people with epilepsy are at high risk of developing mental health problems, including emotional and behavioural difficulties. We also know that many of them do not receive adequate treatment for these difficulties. The Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) protocol³ has been demonstrated to reduce symptoms of behavioural and emotional difficulties in children and young people. It can be used to treat more than one difficulty at a time in a course of treatment (for example anxiety and behavioural problems, rather than just anxiety) and was developed through combining the components of evidence-based interventions into one manual.

The original MATCH-ADTC trials did not focus on children with epilepsy. This manual focuses on how to use MATCH-ADTC in the context of epilepsy. You will use modules that were developed specifically for children and young people with epilepsy and use epilepsy specific examples through the treatment. Many children with epilepsy may also have an intellectual disability or symptoms of Autism Spectrum Disorder. The same treatment strategies can be used to work with emotional or behavioural difficulties in these children although the pace of sessions may vary.

³ Chorpita, B. F., & Weisz, J. R. (2009). *MATCH-ADTC: Modular approach to therapy for children with anxiety, depression, trauma, or conduct problems*. Satellite Beach, FL: PracticeWise.



Philosophy of the treatment

We know that children with epilepsy and their families are regularly coping with challenges and stressful situations. Children may be taking many medications and have lots of medical appointments. For many, there could be uncertainty around treatment and prognosis. Epilepsy and seizures can be frightening for both the child and their family. We therefore **try to be as flexible with families as schedules allow**. For example, most sessions are delivered over the telephone to minimise travel time and we try to tie face-to-face appointments in with other hospital visits. Although the treatment was designed to be delivered over the telephone, it can be delivered over Skype/video conference or face to face if this is needed. If a child has just had a seizure, or there is another medical or family emergency, we will try to reschedule the appointment for another time the same week if possible. Many families prefer to have calls in the evening when work or school has finished. If this will fit in with your own work schedule then evening calls can work well and increase the chances that two parents can be present.



Many families have told us that they have felt blamed for their child's difficulties by services. This can be particularly difficult if the strategies that we suggest are parent-based. We know that up to 70% of children and young people with epilepsy may have emotional and behavioural difficulties and that this high rate is probably because **there are differences in the brains of children with epilepsy that put them at risk of developing both seizures and mental health difficulties and it is not parents (or young people's) fault**. Epilepsy and its treatment can also be stressful for children and their families and this stress can understandably affect their mental health. It is very important that this message is conveyed

at the assessment and throughout treatment. We may not know exactly why a child presents with particular difficulties, but **we do know what strategies can work to improve them.**

The child and parents are the true experts of the difficulties and often know what strategies work and do not work for them. **The purpose of the therapy is therefore to work together, collaboratively** with families, to find new strategies that may work, or to tweak existing ones. If a family has tried a strategy before and it hasn't been successful, you may work together with the parent to find a way to implement it in a way that fits around their life and circumstances. It is important to emphasize to the parent that he or she provides the perspective of a caring adult who knows the child much better than you ever will.

Practical issues

Supervision and consultation

You will be allocated a clinical supervisor at your site who will meet with you regularly to discuss your clinical cases. You will also receive fortnightly consultation sessions with the research team. If you have any difficulties with the treatment or any questions about this guide then please do contact your supervisor or the research team to discuss them. We are here to help you!

You should be prepared to give your supervisor and the research team the details of each patient (name, age, family circumstances), their main goals and a graph of their progress on weekly measures at each supervision. Consultation sessions and supervision should be a place to check-in with how things are going and get support/ideas to help with any problems you encounter. You will be asked to voice-record each call with patients so that the research team can make sure that all therapists are following the treatment protocol and to help resolve any issues. It is good practice to listen to your recordings and take clips of parts that went well and parts that were difficult/went less well to consultation and supervision so that the research team and your supervisor can give you ideas of what might help in the next session.

The route to treatment

Families will have either come into the study through a suggestion from a clinician, or through being recruited in their neurology clinic. They will have completed a Strengths and Difficulties Questionnaire and a Development and Wellbeing Assessment. In most cases, you will also have completed a face-to-face assessment with the family (see separate 'assessment' document). There is evidence that when conducting therapy remotely over the phone or internet, outcomes are better when the patient has met the therapist at least once before. The assessment should therefore be conducted face-to-face unless there are very exceptional circumstances. Such circumstances should be discussed with your supervisor and the research team. If a face-to-face assessment is not possible, or if the therapist changes during treatment, then it would be helpful to send some brief information and a photograph of yourself so that the family know who they are speaking with.

Timing of sessions

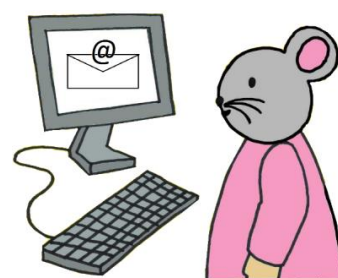
It is important to have contact with parents **weekly** where at all possible. It can be helpful to agree at least six further sessions at the first session as this encourages families to commit to the programme. If a family cancels a session, book a further session for as soon as possible afterwards so momentum is not lost. For telephone sessions, agree a set time to phone the parent, when they are confident that they will be able to talk for 50 minutes, uninterrupted.

Working over the telephone

Orientation to telephone-delivered therapy is important in establishing both engagement and collaborative working. Ensure that the person is free from interruption and has a pen and paper, copies of measures, and the resources that will be used during the call. You should make sure that you read the sessions in advance so that you can tell families what they need to bring/have available at the next session.

Access to emails

It is important to ensure that the parent/young person has access to a working email and provide them with your email in the first session. You should explain to the family that email access is essential as it is how you will communicate with each other between calls, and how the call materials and measures are sent. If they do not have access to an email currently, you should help with this process if possible to ensure an email is set up and functional. If email/internet access is not possible from home or a local library/GP surgery etc., then questionnaire measures can be completed over the phone either before or during the therapy sessions. Worksheets can be posted to families if necessary. As we want this therapy to increase access to treatment for an under-treated group, lack of internet access should *not* be a barrier to participation.



Who attends

The intervention and study cover a wide range of age ranges, abilities and presenting difficulties. Therefore, there is no strict rule on who should or shouldn't attend sessions. It is usually best for at least one member of the family to attend sessions consistently, however, so that they can follow the treatment progress (it is not ideal for one parent to attend one week and another the next).

In general, behavioural difficulties are usually treated via the parents alone and anxiety and depression may be treated through the child and parents. There is also good evidence that mental health problems such as anxiety can be treated via parents alone through teaching parents to be their child's therapist. An older, high functioning teenager with depression may prefer to have sessions without their parents. In general, we recommend that where possible, parents do attend sessions too, as they can support the young person to implement the strategies at home and support maintenance of the strategies after the treatment has finished. However, if a young person did not want this, then we would respect their wishes.

The treatment manual has been labelled with guides on whether the session is intended for parents only or the young person and parents, as follows:



= Parent session



= Family session

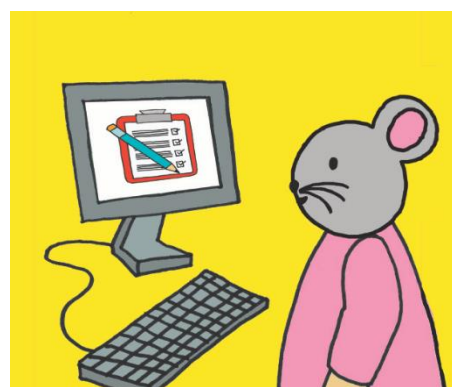
Therapist stance

One of the key aims of the programme is to increase the family's confidence in their ability to work towards their chosen goals. The philosophy of the programme is thus non-blaming and one that highlights positive skills and responses of the family, in order to build their confidence and empower them. In practical terms, this means never criticising a parent or child when they respond to the difficulties in an unhelpful way or when they do not engage fully in the programme. It is better to use these opportunities to reflect on other strategies that might be useful (unless of course their negative responses raise issues of child protection, in which case, the local child protection procedures should be followed). For engagement issues, it is best to find out why the family has not engaged and to help them overcome any obstacles that they highlight. Often these may be related to the difficulties the family faces in relation to the demands placed on them by the epilepsy, like medical or school appointments.

It is crucial to always look for anything positive that the parent has done and acknowledge this. As the programme progresses, it may be possible to begin to encourage the parent to think about what they might have done differently in certain situations, rather than solely focus on what they have done well. This should always be done in a collaborative (e.g. What else could you have done? What makes it difficult to praise your child?) rather than in an authoritative or didactic way (e.g. You didn't praise your child, why was that?).

Completing the homework tasks

In order for the family to be successful in working towards their treatment goals, it is imperative that they complete the homework tasks set. Occasionally, families find it hard to do so and, if this is the case, discuss what is stopping them from completing them. Explore whether there are any literacy difficulties as almost all the homework relies on the parent or child reading material and keeping written records. If the parent/child is not confident about their reading and writing skills, problem solve ways around this (e.g. can someone else help, can instructions be simplified). Sometimes parents or young people report that they do not have time to read the worksheets. Use potential difficulties with this as opportunities to rehearse strategies used within the programme (e.g. cognitive restructuring, problem-solving etc.).



Other issues that arise

During the course of the sessions, the family may raise other issues with which they would like help. These might include school difficulties, or social problems, such as housing issues. These issues must be acknowledged but, due to time limitations, should not take up whole sessions (see session structure below). During your discussion, you can encourage the parents to start to use the strategies included in the treatment to solve these problems or, if this is not appropriate, you may wish to advise the parent to seek advice from another source. Parents can also be referred to relevant resources in their resource list.

If further help is needed

It is important to emphasise that we do not always expect the goals to be met by the end of the programme. Significant change usually occurs during the programme but also in the 3 – 6 months following the end of the programme. Explain to the parent that a booster session will be conducted one month after the last session to see how the child is getting on and another 2 months after that (i.e. 3 months' after the last session).

If during the course of the programme the parent requests input for another problem (e.g. a school problem), explain that you will review this particular difficulty at the end of treatment and if necessary, refer the child to an appropriate professional at that point. It may not be helpful to refer a child for another treatment during the programme as this deflects from the focus of the current input, however there may be waiting lists for other services and this should ideally be discussed with your supervisor and with the research team during the consultation sessions. In the meantime, you can, once again, encourage the parents to apply the strategies covered in this programme to other types of problems and consult their list of resources.

Working over the telephone

Users of telephone-delivered interventions have expressed a need to know more about the background and credentials of the healthcare professional than in face- to-face therapy. These findings suggest that healthcare professionals should introduce themselves and give a detailed description of their qualifications and experience. Most therapists for the MICE trial will have met the family during a face-to-face assessment, but if this has not happened, then the therapist should ensure that they introduce themselves during the first session.



Elicit any immediate concerns from the person regarding using the telephone and encourage regular feedback from people during the first few sessions so that any concerns or fears can be discussed.

As you will not be able to use body language to demonstrate that you are listening, that you understand or that you are going to speak, you will need to use more verbal indications than you might otherwise in normal conversation.

Pauses in a telephone conversation often indicate misunderstanding, hesitation or not listening, therefore a clear explanation of pauses should be given to the person, for example: 'Throughout the call there may be a few pauses, these silences indicate that I am thinking, or writing something down and do not mean that I don't understand or have not heard you'. Whenever you find yourself nodding in agreement or understanding, you need to replace this with a verbal cue (such as aha, mmhmm, very true, etc.). Similarly, if you find yourself with a questioning look on your face you need to replace that with a verbal cue (e.g., I'm thinking about that).

Measures

Families will be asked to complete questionnaires before and after the intervention (DAWBA, SDQ, RCADS, PEDS-QL) and briefer questionnaires every week during the intervention ('Weekly Questionnaires'). We understand that there are a lot of questionnaires but it is very important that they are completed – both so that we can find out whether the treatment works for the research study, but also because they are a key part of success of psychological therapy.

The questionnaires before and after the intervention are being used to work out if the intervention helps and are the main outcomes that will be analysed at the end of the study. The research team will help families to complete them.

Weekly measures will be completed during the therapy. Research has shown that people who complete weekly measures have better outcomes than those who do not. They enable both you as the therapist and the family to track progress and see what is working and what isn't. They also help you to stick to clearly defined goals. It can be hard several weeks into therapy to accurately recall what things were like at the beginning of therapy and weekly questionnaires can give a more objective view of this. It is helpful to familiarise yourself with the weekly measures you will be using so you are prepared to answer any questions that the family may have. It is okay for you as the therapist to support the family to complete the weekly questionnaires and you can help the family complete them during the telephone call if necessary. You should make sure to look through the measures before each call and at every supervision and consultation session. We will discuss the systems being used to collect the questionnaire data at your site with you, but please ask your supervisor or the research team if you are unsure. The table below describes how questionnaire measures should and should not be used.

SOME DOS AND DON'TS OF USING CLINICAL OUTCOME TOOLS

<i>Do</i>	Make sure you have the forms you need ready before the session.
<i>Do</i>	Always explain why you are asking anyone to fill out a form.
<i>Do</i>	Look at the answers.
<i>Do</i>	Discuss the answers with service users.
<i>Do</i>	Share the information in supervision.
<i>Do</i>	Always use the information from the forms in conjunction with other clinical information.
<i>Don't</i>	Give out a questionnaire if you think the person doesn't understand why they are being asked to complete it.
<i>Don't</i>	Use any form if you don't understand why you are using it.
<i>Don't</i>	Insist on someone filling out forms if they are too distressed.
<i>Don't</i>	See the numbers generated from outcome tools as an absolute fact.
<i>Don't</i>	See your clinical judgement as an absolute fact.

Taken directly from the 'Guide to Using Outcomes and Feedback Tools with Children, Young People and Families'⁴

Regarding the weekly measures, the therapist should decide whether it is most appropriate for them to be given to the parent/carer, child or both. In general, if only the parent is involved in treatment, it may be most appropriate to give them to the parents to complete and vice versa if only the young person is involved in treatment. Where both are involved, the therapist should decide whether the parent or parent and young person should complete the measures. The child measures that are being used in the study are designed to be able to be completed by a relatively able 8-year-old; younger children or those with significant intellectual disabilities may have difficulty completing them and it may be most appropriate in this case for only parents to complete them. Some parents can take a long time to complete questionnaires because they deliberate over each answer; you should explain that their best guess/first thought is fine and that there are no right/wrong answers.

Use the measures to hear how the past week has been and to reflect on how things are changing. For example: "I'm curious that things look better/worse than last time, what has happened this week for you to give that rating?" "I wondered if we could think about what

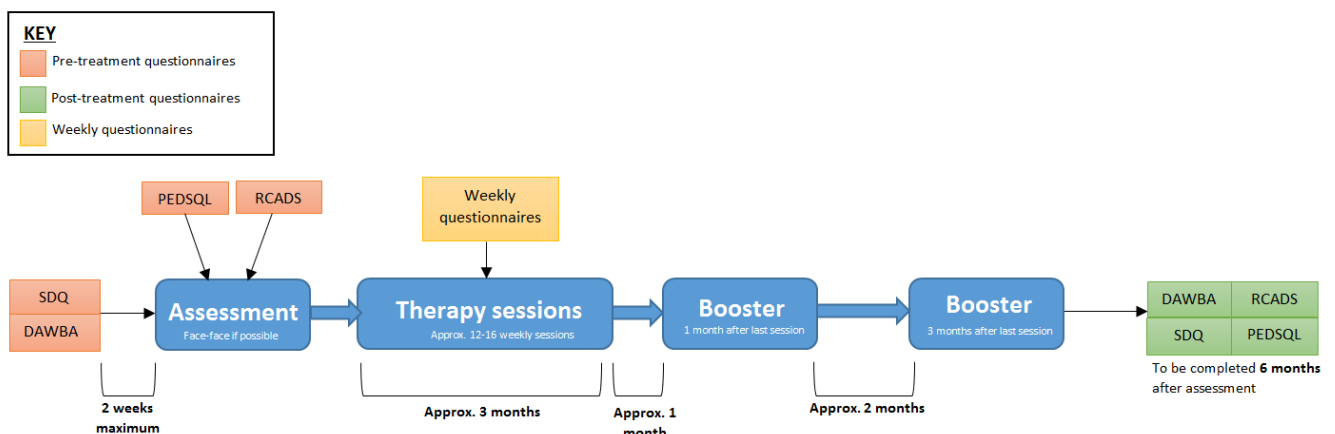
⁴ Law, D., & Wolpert, M. (2014). *Guide to Using Outcomes and Feedback Tools With Children, Young People and Families* (2 ed.). London: CAMHS Press.

is helping life feel better even though the anxiety is still as bad?" "It looks like our work so far has supported some improvements in your work with Oliver, but I can see that you are still struggling to manage the hitting. What do you think to the idea of our work shifting to focus more on your second therapy goal?"

Weekly measures are also discussed in supervision and in consultation sessions to inform treatment decisions and to help review and make sense of progress, stagnation or deterioration.

Session Timing

As this is a flexible programme and families will have different needs at the beginning of therapy, there is no set number of therapy sessions. However, there should be a **minimum of 10 sessions and a maximum of 22, delivered over a 6-month period, and including two booster sessions** (please see flowchart below). The average number of sessions needed in previous trials of the MATCH therapy was 16. Each session should be around **50 minutes long**. Usually, sessions are scheduled once per week. There is flexibility in the protocol and it can be helpful to schedule sessions more frequently than this, particularly in the beginning of therapy. Similarly, sessions may occur less frequently as therapy ends so that families have the opportunity to practice strategies on their own and develop their skills in problem solving difficulties as they arise without you. The final two sessions are booster sessions and take place one month and three months after the final session.



Session Content

The following pages outline what should be covered during each therapeutic session, including handouts and homework. The session plans in the main manual should be followed rigorously, although the material should not be presented word for word. Instead the therapist should be familiar with the material so that they are able to deliver it in a conversational style.

Session Structure

The structure of each session should be roughly as follows:

- i) Setting agenda (5 minutes)
- ii) Session by session monitoring/questionnaires and review of goals (5 minutes)
- iii) Reviewing homework (5 minutes)
- iv) Key concepts/content to be covered (20 minutes)
- v) Other issues highlighted by parents/young person (max. 5 minutes)
- vi) Setting homework (5 minutes)
- vii) Summarise (5 minutes)

Setting an agenda

Start with asking the parent and/or child how their week has been and if they have anything specific that they want to discuss. Reinforce that this topic will be important to discuss and that you will cover this during the session. Then tell them your plan for the session (outlined above). If there will not be time to go through everything in the session, discuss with the parent/child what they think is most important to cover and what can wait until next time.

Reviewing, measures and goals

Ask the parent/child how their week has been and how they think they are progressing towards their goals.



Goals

During the first session (Epilepsy Specific Module for Youth), you should review the goals set in the assessment and make sure that they are still important for the family. Refer to the 'Setting Goals for Treatment' handout (page 261 of the treatment manual). Be clear with families that they will rate the goals on a scale of 1-10, where 10 means the goal is completely met and 1 means no progress towards the goal.

Ensure that goals are 'SMART':

- ★ **SPECIFIC** - Be very clear in what you want to achieve. Consider breaking the goal down into smaller steps.
- ★ **MEASURABLE** - How will you know when you have achieved your goal? What will you be doing at that time? What will others notice you doing? What will be different? What will you have started or be doing regularly? What will you have stopped or be doing less of?
- ★ **ACHIEVABLE** - Ensure your goals are not too high. Don't set yourself up to fail! Consider setting smaller goals on your way to the big one. Celebrate your successes. If you don't

achieve what you set out to, then ask what you could do differently, what would make it more likely to succeed next time?

- ★ **REALISTIC & RESOURCED** - Is this achievable with the resources you have? Are there any other resources you need before you can, or to help you, achieve your goal? How can you access these resources? What problems might you have? What can you do to minimise those problems?

- ★ **TIME LIMITED** - Set a reasonable time limit to achieve your goal. Ideally it should be achievable within the course of treatment.

Some example SMART goals of families who have been through this treatment:

For a parent to be able to spend 5 minutes apart from their child (e.g. parent in the kitchen whilst child is in the living room)

To feel confident enough to manage X's behaviour to take her out to a public place on my own

To be able to walk down the stairs at school during break time

To be able to make choices without becoming overwhelmed (for example, to choose a meal from a menu in a restaurant)

To spend less than an hour per day comparing myself to other people

Monitoring

In the first session, families should be encouraged to monitor the particular difficulties associated with the identified goals throughout the therapy. They should detail the day/time, event/what happened, the parent or child's response and what worked/didn't work. Columns should be deleted/amended/added as appropriate, relevant to the needs of the particular family and the goals (for example, if a child has a lot of seizures, you may want to monitor seizure activity; if the goal is around anxiety then anxiety levels should be monitored). Monitoring enables you and the family to get a fuller picture of what is going on and what the particular difficulties are. It can also help to step back and notice patterns in the difficulties (for example does the child only get very anxious about something when they are very tired?) and the strategies that work best or less well. An example monitoring sheet is below and there are more in the therapy manual.

Monitoring does take time and it can be overwhelming for families. **As with the rest of the protocol, the key part is remembering to be flexible whilst sticking to the aims of the strategy.** If families prefer to write paragraphs in a notebook to photograph and send you, that is fine. Some families may find it easiest to just tick a box for which strategy they used, rather than giving lots of detail.

MATCH for MICE: A guide for study therapists

DATE	BEHAVIOUR <i>WHAT DID MY CHILD DO?</i>	RESPONSE <i>WHAT DID I DO?</i>	YES NO	OUTCOME <i>WHAT HAPPENED WHEN I DID THIS?</i>	WHAT WAS THEIR SEIZURE ACTIVITY LIKE AT THE TIME?
		Special time Praise Active ignoring Rewards Time out			

Review homework

Ask the family how the homework went and discuss any difficulties. It is key to review homework so that the family are clear that this part of the treatment is essential and that you consider it to be important.

If the family did not complete the homework, there was a misunderstanding of the task, or if the task needed tweaking to better fit the needs of the family, then you may spend most of the session repeating/reinforcing and problem solving the last homework and may not move onto new session content.

For example, when 'one to one time' is set in the first sessions for behavioural difficulties, many families have difficulties fitting the time into their schedule. It is better to problem solve ways around this (for example, reducing time on other tasks just for the duration of the treatment) and trying one to one time again rather than moving to praise, as this is an essential strategy when working with behavioural difficulties. This is okay as there is room in the protocol to allow this to happen. You should discuss this with your supervisor and in consultation sessions, however, and ensure that progress towards goals is maintained.

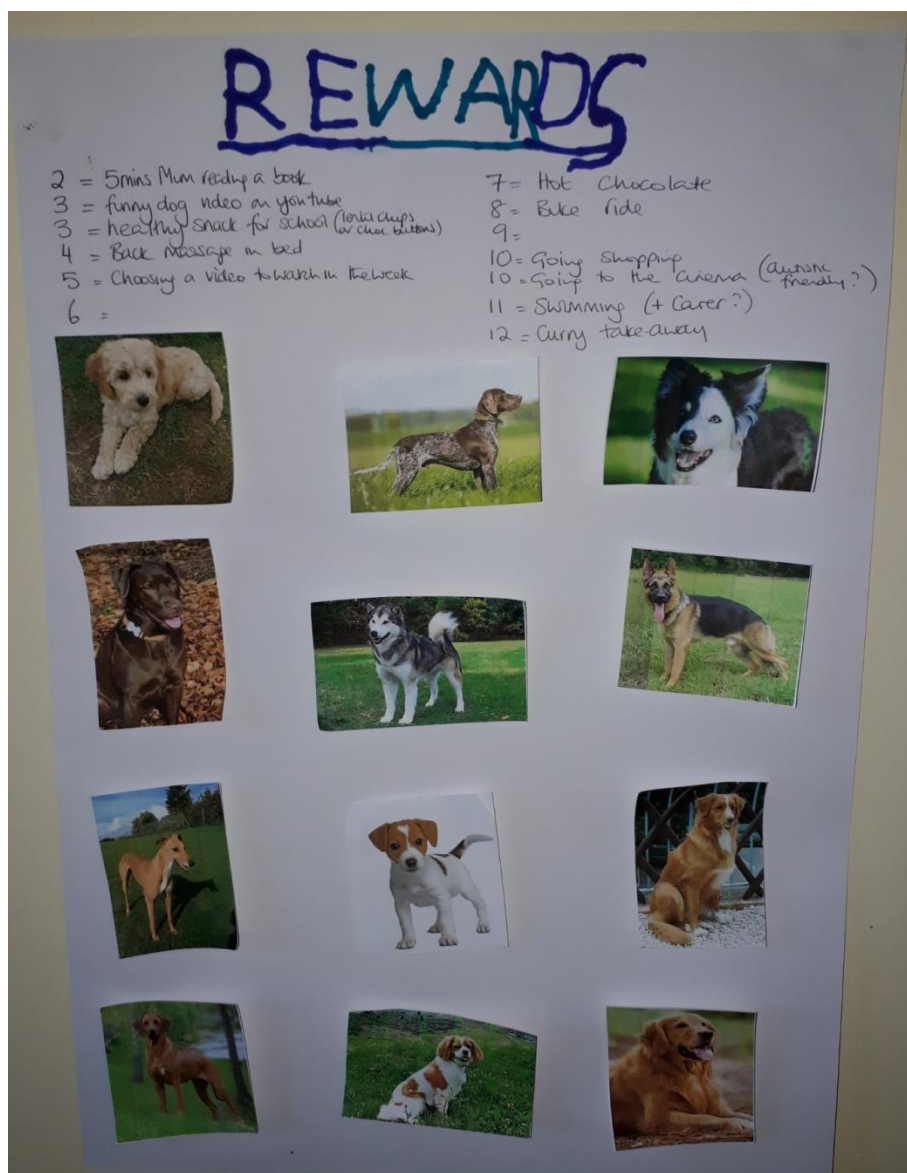


Key concepts

The session sheets in the manual cover all of the key points of the session. They include example scripts for explaining concepts, but these do not need to be followed word for word, and the therapist can choose to use other examples (for example ones raised by the

family). **However, the therapist should carry out every exercise with the family.** The content should be delivered flexibly, with the needs of the individual family at the centre. The family and therapist should work together to adapt the strategies to fit them. For example, reward charts can focus on the child's special interests, like the one below that a family designed themselves using the principles described in the homework sheet on rewards.

For many families, this may be the first time that they have spoken at length to anyone about their own/their child's emotional or behavioural difficulties. Sometimes, this might mean that the first sessions can take longer as the family may use this opportunity to explain the difficulties in detail. This is okay and it is most important that the families feel that they are being listened to and their concerns and thoughts are being taken seriously. This can help with rapport and provide useful information for the treatment. Do not worry if this means you don't get through all of the material in these first sessions – you will have time as later sessions usually move more quickly as the family has felt heard. You may want to split some of the early psycho-education sessions into two (or more) to make sure the key concepts are covered.



The first few sessions

Building rapport

Most therapists will have met the parent and child in the assessment. If, for any reason, you have not been able to meet with either the parent or child before the session (for example, if you have been working with parents on behaviour and then switch to working with the child and family on anxiety), then you should make sure that they feel comfortable talking to you. You may want to discuss a topic that isn't directly relevant to the therapy, such as favourite pets or TV programmes (hopefully you have an idea of their interests from previous sessions or the assessment). Some people prefer that you jump straight into talking about the work related to their goals. You can ask families what they/their child would prefer and trust your own clinical judgement regarding this.

Role plays

Throughout the manual, there are opportunities to role play strategies. As most therapy will be conducted over the phone, you may not be able to role play in exactly the way described. We have supplemented some of the role plays with video examples to help, however, role plays can be really good ways of explaining strategies and for families to practice them. Try not to skip them if at all possible. If you are on the phone, you might have to tell families what you are doing in the role play (for example, 'I'm tidying things away into this box'). If families are finding some concepts difficult to grasp, role play can be particularly helpful. You may even want to invite the family in for a face-to-face session so that you can role play with them if this is the case.

Summarise

After each key concept and at the end of the session ask the parent or young person to summarise the session and explain what they are going to focus on for the week/their homework. This helps to make sure that you are all on the same page regarding the plan and allows you the opportunity to clarify any misunderstanding.

After the session

Make sure that any notes are added to the patient's clinical records. You should send the family:

- ★ A typed summary of the session highlighting the key concepts, focus for the week and any homework tasks
- ★ The blank measures for the following week
- ★ The homework sheets for the week
- ★ A reminder of any materials that they may need for the next week's session

Letters

A letter should be sent to the GP, paediatrician and neurologist after the face-to-face assessment, after 6-10 sessions (mid treatment letter), after the end of therapy (end of treatment letter) and after each booster/follow-up session. Letter templates are available in your training booklet.

Tailoring for the child and family

Many children with epilepsy have additional needs, such as autism or intellectual disabilities. The same principle of flexibility applies in these cases. You want to deliver the main message of the session/strategy, in the way that the child/family is most likely to understand. This is true for all families and not just those with diagnosed additional needs.

The National Institute for Health and Care Excellence (NICE) guidelines agree that for children with an intellectual disability, therapy should be tailored to their preferences, level of understanding and strengths and needs. They also state that therapists should agree how the therapy will be delivered (for example, face-to-face or remotely by phone or computer), taking into account the person's communication needs and how suitable remote working is for them. This is important in the case of the MICE trial in which much of the intervention can be delivered over the phone. If you are working directly with a young person with an intellectual disability, they may find it easier to work over Skype or face-to-face, so that you can more easily demonstrate strategies.

The relevant guidance for working with children with autism is outlined in the box below. The research team will support you to decide how much and how many sessions should be adapted for your particular patient.

Recommendations for adapting CBT for children with ASD from NICE guidance (CG170 2013, p.22)

1. Greater use of written and visual information and structured worksheets
2. A more cognitively concrete and structured approach
3. Simplified cognitive activities, for example, multiple choice worksheets
4. Involving a parent or carer to support the implementation of the intervention, for example, involving them in therapy sessions
5. Maintaining attention by offering regular breaks
6. Incorporating the child or young person's special interests into therapy if possible

In general, a focus on concrete language and behavioural strategies is preferable. Similarly, for children with intellectual disabilities, you may want to discuss with the family how they express or describe emotions. You may want to use more visual worksheets and perhaps use visual representations of distress or wellbeing in monitoring (e.g. happy or sad faces), for example:

How did you feel practicing the first step of your fear ladder?



Working with schools

This therapy does not involve direct work with schools. However, some parents have found it useful to share the strategies/worksheets with their child's Teaching Assistant, A Special Educational Needs Coordinator (SENCO) or teacher and families should be encouraged to do so if appropriate.

Risk

Risk in work with children and families may take different forms, for example:

- Risk of harm to self or others (e.g. cutting, other forms of self-harm, suicidal thoughts or ideation, violence)
- Risk taking behaviour in young people, including use of drugs and alcohol
- Self-neglect (e.g. not eating)
- Risk of harm from others – physical abuse, sexual abuse, emotional abuse, neglect

All therapists should make sure that they have completed appropriate risk training before delivering this treatment (for example, the 'Assessing and Managing Risk' e-learning session through the minded website (<https://www.minded.org.uk>)).

Self-harm should be taken seriously. It is an identified risk factor of death by suicide and accidental death. The nature of self-harm (e.g. depth of cutting) does not predict underlying intent.

If you identify a risk issue, you should contact your clinical supervisor as soon as possible. For immediate risk, you may need to direct the family to emergency services, such as A&E. Risk management should follow your individual trust policy.

During the therapy trial, adverse events, including risk, need to be reported to the study team. The study team will discuss this with you in more detail.

Where can I get more information?

If you have a clinical question, the first person to contact should be your supervisor. If they are unsure, you can also contact the MICE team using the following details:

Professor Roz Shafran (Chief Investigator & Consultant Clinical Psychologist)
Dr. Anna Coughtrey (Clinical Psychologist)
Dr. Sophie Bennett (Clinical Psychologist)
Fahreen Walji (Research Assistant)
Alice Welch (Research Assistant)

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WC1N 1EH

MATCH for MICE: A guide for study therapists

Email: gos-tr.mice@nhs.net

Tel: 0207 905 2232

Please do not email confidential patient details without discussing with one of the research team first. These should only be sent via a secure email system, for example from an NHS.net email address to another NHS.net email address.

Parents are given a list of resources at the beginning of treatment. Therapists may also find resources from <https://www.minded.org.uk> - this has free evidence-based training on detecting and treating mental health problems in children for a wide range of professionals.

