Health professionals' experiences of behavioural family therapy for adults with intellectual disabilities: a thematic analysis

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Relevance Statement

This qualitative study explores the experiences of Community Learning Disability Nurses and Allied Health Professionals delivering Behavioural Family Therapy (BFT) to adults with intellectual disabilities. The complexity of implementing family interventions (FIs) into clinical practice is well known, and working with families of adults with intellectual disabilities may present further challenges. Furthermore, the practice of professions outside of psychology delivering evidence-based psychological therapies has become more prevalent over recent years, and examining the views of therapists would be of value.

Abstract

Introduction Studies have found family interventions (FIs) to be effective in reducing stress and relapse rates for a variety of mental health conditions. However, implementing FIs into clinical practice is challenging. Studies have suggested that levels of stress within some families of people with intellectual disabilities can be high. However, there is little reported about the use, and implementation of FIs, such as Behavioural Family Therapy (BFT), in adult intellectual disability services.

Purpose of study To explore the experiences of practitioners delivering BFT to adults with intellectual disabilities.

Method A qualitative methodology was employed, using semi-structured individual interviews with BFT therapists from Nursing and Allied Health Professional backgrounds (*n*=9). Data were analysed thematically.

Results Two overarching themes were identified: positivity and frustration.

Discussion Implementation of therapy was identified as being broadly successful but with some underlying challenges, notably wider organisational issues and some issues specific to working with adults with intellectual disabilities.

Implications for practice: The broadly positive experiences reported by participants provide encouragement for the delivery

of FIs, such as BFT, to adults with intellectual disabilities, by professions outwith psychology. However, there is a need to provide clarity on referral processes, adapt materials to be suitable for this client group and ensure that supportive management and supervision is available to therapists.

Keywords: family intervention, intellectual disability, psychological therapy, qualitative research

Accessible Summary

- **What is known on the subject?**
  - Behavioural Family Therapy (BFT) has been shown to help people with some severe mental health conditions, such as schizophrenia, by reducing relapse rates and stress within families.
  - It can be difficult to put family interventions, like BFT, into clinical practice.
  - Families where someone has an intellectual disability can experience more stress compared to those who don't, but we know very little about using BFT with families where a member has an intellectual disability.

- **What this paper adds to existing knowledge?**
  - We interviewed nine Community Learning Disability Nurses and Allied Health Professionals about their experiences delivering BFT to families where one member has an intellectual disability. We found that therapists' experiences of delivering BFT were broadly positive, although they found some aspects of their service frustrating.

- **Explain the importance of the paper's findings for a non-specialist audience**

- The study identifies the perceived benefits of BFT as a model to work with families, where a member has an intellectual disability
- The study highlights some of the challenges experienced by practitioners, notably issues with engagement and some issues specific to working with adults with an intellectual disability
- The findings suggest that it needs to be clear which families would benefit most from BFT, that interventions need to be adapted for people with intellectual disabiliites and that Community Learning Disability Nurses and Allied Health Professionals should have support from management to deliver these interventions.

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Introduction

Family Interventions (FIs) have been shown to be effective for supporting people with mental health problems, such as schizophrenia, by reducing stress within families, and hence positively influencing relapse rates (Kavanagh *et al.*1993, Fadden 1998, Pfammatter *et al.* 2006, Pharoah *et al.* 2006). FIs aim to support families to understand the illness, manage stress and cope better with supporting the person with mental health problems (Absalom-Hornby et al. 2011).

Although guidelines (e.g. NICE 2014) recommend the use of FIs for this population, implementation in routine clinical practice has proven problematic (Fadden 1998, Fadden & Heelis 2011). Barriers such as insufficient time (Absalom-Hornby *et al.* 2011), difficulties integrating family work with caseloads (Bailey *et al.* 2003), a lack of management and professional support (Smith & Velleman 2002), difficulties engaging with families (Kim & Salyers 2008, Lee *et al.* 2012) and inappropriate referrals (Smith & Velleman 2002) have been reported. Conversely, the development of clear pathways (Smith & Vellman 2002, Absalom-Hornby *et al.* 2011), strong organisational

commitment (Powell *et al.* 2013) and well-developed training and supervision (Fadden 2006, Absalom-Hornby *et al.* 2011) have been shown to enable implementation.

Behavioural Family Therapy (BFT) is a widely-used psycho-educational FI that supports families where a member has severe and enduring mental health problems by providing education, promoting positive communication and developing practical skills such as problem-solving (Jhadray *et al.* 2015, Fadden & Heelis, 2011). There is a large evidence base for BFT for those with schizophrenia and bipolar disorder (Pitschel-Walz et al., 2015), and BFT is regarded as a flexible model that can be applied equally to complex family situations, such as when a member has an eating disorder or within troubled families more generally (Fadden & Heelis 2011, Jhadray *et al.* 2015).

Levels of stress and perceived burden have been shown to be higher in families where one member has an intellectual disability and has behaviour that challenges (Hastings & Beck 2004, Baum 2006, Maes et al. 2003). Higher prevalence rates of mental ill health (Maes *et al.* 2003) and a greater number of life-cycle transitions (Hastings & Beck, 2004) may contribute to this. Moreover, levels of caregiver stress may persist, as individuals with an intellectual disability are more likely to live within the family home throughout adulthood. Hence, FIs may be suited to this population (Baum 2006, Fidell 2000, Goldberg et al 1995, Hastings & Beck, 2004).

The ethos of BFT is to address stress within the family system by improving communication and problem solving skills. Hence, as a result of associated high levels of family stress and the often more complex communication needs of individuals with intellectual disabilities, it may be beneficial for families where a member has an intellectual disability (Marshall & Ferris 2012). However, the evidence base for BFT with adults with an intellectual disability is, at present, limited to a single case study and an unpublished case series (Marshall & Ferris 2011, Marshall & Ferris 2012). Although there may be additional complexities in working with this client group, such as the need for modified communication and the often-longstanding nature of problems (Goldberg *et al.* 1995, Fidell 2000, Baum 2006), BFT appears to be ideally suited to this population, particularly since there is increased recognition of the role that families and carers play in supporting those with mental health difficulties (Baum 2006, Grant & Ramcharan 2001).

In order to increase access to psychological therapies, there has been a drive toward professions other than clinical psychology delivering these. Thus, the delivery of evidence-based systemic therapies, such as FIs, by Community Learning Disability Nurses and Allied Health Professionals (AHPs) has become more widespread. Within health teams for people with intellectual disabilities, multi-disciplinary working is a key element, thus professionals from a variety of backgrounds are

involved with individuals (National LD Professional Senate 2015). Hence, a multi-disciplinary approach to psychological therapies appears particularly apt.

The current study set out to explore the experiences' of Community Learning Disability Nurses and AHPs delivering BFT in services for adults with an intellectual disability. This was of interest for several reasons: firstly as BFT is regarded as a novel intervention for use with adults with an intellectual disability, with little reported about its efficacy; secondly, the challenges associated with implementing FIs into routine clinical practice is well documented, as are the concomitant complexities of delivering FIs to persons with an intellectual disability; and thirdly delivery of FIs by Community Learning Disability Nurses and AHP's was a relatively new practice for the adult intellectual disability services involved in this study.

Participants were drawn from therapists operating as part of a larger feasibility study that aimed to explore whether a controlled trial of BFT for people with intellectual disabilities would be possible (with regard to recruitment and retention numbers). The feasibility study recruited across a number of NHS Health Boards in Scotland, with inclusion criteria that participants were adults with an intellectual disability with additional mental health problems and/or challenging behaviour and were experiencing communication difficulties and/or high levels of family stress. Referrals for the wider feasibility study

were made from specialist community teams that included psychiatrists, psychologists, learning disability nurses, and allied health professionals.

Method

The consolidated criteria for reporting qualitative research (COREQ) were used to structure this thematic analysis.

Research team & reflexivity

For consistency, all interviews were conducted by K.L.: a female Research Assistant for the BFT feasibility study, and trained BFT therapist. K.L. was known to the participants as the Research Assistant for the study and organiser of BFT training but did not have a relationship with any of the interviewees. This was advantageous as participants may have felt able to be more open in their accounts, but equally as K.L. was known to participants as a person with an interest in the study, participants may have unwittingly reflected on their experiences in a more positive light. Authors J.H. & K.M. conducted the thematic analysis, both having had previous experience undertaking qualitative analysis during postgraduate studies (J.H.) and academic career (K.M.). Both authors were impartial to the implementation of BFT across participating Health Boards and were not trained BFT therapists. This was advantageous in reducing the risk of bias, although their lack of experience delivering BFT could have been a disadvantage in their

understanding and interpretation of participants' experiences. To account for this, findings and interpretations were discussed with author G.A., an experienced BFT therapist and trainer.

Study Design

Data were analysed using thematic analysis (TA), a method for identifying, describing and analysing patterns of meaning in data (Braun & Clarke 2013).

Ethical approval for the multi-site study was given by the East of Scotland Research Ethics Service, REC. Health professionals who were trained as BFT therapists (The Meriden Family Programme) were recruited from clinicians engaged in the wider feasibility study. All clinicians trained as a BFT therapist in any of the five participating Health Boards were eligible to take part in the study. Participants were recruited using purposive sampling via the lead investigators in each area, who invited eligible clinicians to take part by e-mail. Eligible participants were provided with an information sheet during recruitment (explaining the nature and purpose of the research) and asked to return a reply slip if interested in participating. Those who returned the reply slip were contacted by author K.L. to arrange an interview date.

Eleven responded and a total of 9 participants were interviewed. The demographic details for the sample (n=9) are provided in Table 1.

To ensure anonymity, participants' associated Health Boards are not specified; however, the sample included at least one participant from each participating health board, and included both urban and rural locations.

Table 1

Participants' demographic information

Data collection

Interview sessions began with a description of the research and informed consent was sought. In-depth, semi-structured interviews were conducted in person by author K.L. at a convenient time and place for the participant. Interview questions and prompts were designed based on Campbell (2004) and included open-ended questions that broadly explored factors such as: experiences delivering psychological therapies, the role of a BFT therapist, experiences working as a BFT therapist, working with families and colleagues and reflections on the delivery of BFT within their service. One interview (which has not been included in this analysis) was piloted, resulting in some questions being discarded. All interviews were audio-recorded and lasted between 17 and 38 minutes. Interviews were transcribed, rendered anonymous and checked for reliability. Analysis suggested that data had reached saturation point after nine interviews. Thus no further interviews were considered necessary.

Analysis

An inductive, bottom-up approach was used to extract themes through interpretation of meaning in the data set (Braun & Clarke 2013). Analysis followed a number of stages as described by Braun & Clarke (2013). Author J.H. undertook the initial familiarization stage through the process of transcription, reading and re-reading data, noting down initial ideas and observations. 'Complete coding' followed (coding of all data deemed relevant to the research question), which was collated in a systemic fashion. Patterns across the data set were then identified and candidate themes were developed. Relevant, coded extracts from the raw data were extracted and presented against initial themes to ensure themes represented and captured the meaning of the raw dataset. Themes were then re-assessed against the entire un-coded dataset. During analysis sessions to validate interpretations, candidate themes were discussed, reviewed and refined with author K.M. The steps taken and analytical process are shown in Table 2.

Table 2

Stages and analytical process (as recommended by Braun & Clarke 2013)

Findings

Table 3: Overarching themes and subthemes

Analysis found two distinct overarching themes: *positivity* and *frustrations*, and five subthemes, mapped in Table 3.

Overarching theme 1: Positivity

The first theme *positivity* reflects the overwhelmingly positive accounts participants gave about their experiences delivering BFT to families where a member had an intellectual disability. This was analysed and coded into two subthemes: working better, together and self-efficacy.

Subtheme 1: Working better, together

Participants described working together with families as beneficial for effecting change, and as a rewarding experience. Having a framework to work together with families was viewed as particularly useful for families at times of crisis, but the value of BFT was strongly advocated for any family with an adult with an intellectual disability, noting the additional stress families who care for someone with an intellectual disability endure, as well as the often complex communication needs. In this sense working together with families, where a member has an intellectual disability, was viewed as logical.

> Participant 9: '*One of the reasons why BFT was of interest to me because I could see …that … for learning disabilities, family support is huge, very often people live with their parents, or their siblings all of their life, so for*

> *me working with the family as a whole, was something that I thought could be very positive.'*

While challenges and frustrations were expressed, this was not found to affect participants' overall view of BFT as an effective intervention for working with families, where a member has an intellectual disability. Participants described the value of working together with families to positively affect change, such as improved communication, reduced stress and improved family dynamics.

> Participant 2: '*You can see that there's been huge improvements, they are communicating better, these things that were, to us maybe, were very small and trivial, were huge to them and they've dealt with it, they're talking more, they're doing more, and maybe setting goals, so that's been nice to see when they become more relaxed in the sessions...'*

The reported value of BFT extended to participants themselves, who described their experiences working together with families as enjoyable and rewarding. BFT was described as coming from a different place, with participants viewing their role more as a facilitator, working together with families to recognise and build on families' skills. In light of this, participants expressed satisfaction, indeed a sense of gratitude, in having been

equipped with a framework and skills to deliver an intervention that they perceived as distinct and valuable.

> Participant 7: *'It looks at the family and it gives you a framework to do that, so it's easy to implement. Obviously it looks at the family, which with hindsight [that] for years we've worked with individuals just seems incredibly crazy now, when really we're not going to affect change, unless you look at the family, because if they're living at home, it'll be far less effective if you're just tackling one person within that home environment.'*

Participants described the benefit of practicing as a BFT therapist for everyday clinical practice, noting that they gained key transferable clinical skills. It was identified that participants' positive perceptions of their personal and professional development contributed to their positive view of BFT, as well as a readiness to recommend BFT training to colleagues.

> Participant 1: *'There are large components that are relevant to daily practice, the conflict in families is something you see frequently, the skills, the problem solving, communication is something that we're addressing quite a lot within families, and staff teams and carers.'*

Subtheme 2: Self-efficacy

Self-efficacy was identified as stemming from participants' beliefs that they had obtained the requisite skills from training to practice as a BFT therapist, and that they had a strong foundation, in terms of the structure and framework of BFT, to draw upon. Overwhelmingly participants described the training as 'excellent', acclaiming its value in equipping them with the necessary skills and confidence to deliver BFT to families.

> Participant 9: *'I found the training really good. I think I quite like the structured approach and the fact that there is the guidance and the manual and the process to work though ... I felt the training really did prepare you for being a practitioner,'*

Furthermore, the level of support available was identified as fundamental to developing and maintaining self-efficacy, notably derived from working with colleagues, and group supervision. Participants described working with colleagues as absolutely necessary when working in more challenging family situations, and advantageous, in terms of learning, for less experienced therapists. Supervision was identified as forming the backbone of support, enabling participants to address and progress with challenging cases, as well as learn from others and refresh skills.

> Participant 4: *'It's [supervision] been very helpful coz you've been able to reflect on your current caseload as*

> *well as learn from others across the Service … and what they're finding positive and what they're finding negative about implementing BFT in their caseloads.'*

Overarching theme 2: Frustrations

Despite participants' acclaim for BFT, a strong undercurrent of frustration was identified, most palpable in participants' accounts of the challenges they faced in delivering BFT and in their reflections on the roll-out of BFT within adult intellectual disability services. Significantly, it was identified that frustration was closely associated with the high number of families they perceived to be 'dropping-out' from treatment.

Subtheme 3: Challenges

The process of engagement and commitment was depicted as one of the biggest hurdles to overcome when working with families, particularly at times of crisis. It was identified that participants felt somewhat powerless in this process, describing it as the hardest and least structured part, and expressing frustration with the consequences of non-engagement.

> Participant 3: *'We're having to do a lot of going in and making sure they're going to engage and you're like one step forward, two steps back … certainly the session we had with them where we did the first communication skills went really, really well and they both totally*

> *bought into it and we thought "oh this is it", so it was a bit annoying last week when we went out and [they said] "no we're not doing it anymore."'*

Frustration with the slow pace of treatment progression was described as resulting from challenges with engagement and commitment, in addition to the challenge of finding suitable times to fit in sessions with already busy family lives.

> Participant 7: *'I think one of the biggest challenges is getting a time that they're all available... a lot of the families that we work with, have a lot of things on…. so sometimes getting times that can suit them, can be a bit of a challenge.'*

Equally, the amount therapists' time required to deliver BFT, in terms of preparation, travel and delivery itself was described as problematic. However, it was identified that this only really became a source of frustration when families 'dropped out' from treatment, as participants expressed disillusionment with their perceived failure to complete BFT and the associated lost time.

> Participant 3: *'Well obviously the first couple of times families drop out, you feel a bit of a failure. You felt as if "Oh God, I went out there for weeks and weeks and weeks, yeah, they're a lot better, certainly the situation has got better for them but for me, I havenae [sic] completed that bit of work."'*

Subtheme 4: Reflections

Some participants described the delivery of BFT as falling short of their expectations, as it had not progressed as they had hoped.

> Participant 6: '*We've been actively... [trying] to identify cases but for whatever reasons they've just not, not quite materialised. So, I wouldn't say nothing's happened but it's just maybe not went in the direction that we had kind of hoped'.*

This was perceived as resulting from a lack of awareness and understanding from colleagues within the wider adult intellectual disability services about what BFT is, and for some, the seeming failure of BFT to be fully recognised as an effective treatment option.

> Participant 9: *'I think we probably need to sit down and have a real think as a service about what we're doing in the delivery and offering of BFT and really making the referral roots and stuff, really crystal clear ... [and] to allow us then to continue to raise the awareness, because I do feel that it's fallen to the wayside for lots and lots of reasons.'*

Participants described the parallel need to develop further resources specifically for individuals with intellectual disabilities to aid understanding of the therapy itself, and to

assist with delivery. While some participants expressed concern that the name itself 'Behavioural Family Therapy' was off-putting, it was identified that frustrations largely stemmed from a feeling that participants lacked the necessary resources to simply and accurately explain BFT to families and service users.

> Participant 1: *'I've felt we needed like an easy-read for the clients, to get them to understand what BFT really is.... they need more visual things to-to look at and I think we need DVDs [that] are based on people with learning disabilities rather than mental health.'*

Subtheme 5: Doubts

Doubts about BFT were identified on both a professional level and about the intervention itself. Notably, some participants expressed doubts about the long-term feasibility of delivering BFT in its current form, as low referral numbers resulted in participants feeling frustrated and less confident in their own abilities to deliver BFT.

> Participant 5: *'The only thing is when you have a wee gap in the middle from doing it, I feel as if I'm, back to being a beginner again... I would quite like to be in the position where I've done, two or three consecutively... you know in that way, if you don't use it, you lose it type stuff, that you'd feel a bit more confident, because I still*

think, "oh I've forgotten that bit" or "I need to go back to the folder."'

Participants also expressed doubts about the appropriateness of referrals; for example, whether BFT could successfully be delivered to couples where both have an intellectual disability, without additional support.

Participant 8: *'I'm just a bit unsure about how it's going to work with just two people who have an LD [sic], I don't know whether there should be somebody else, like another family member, [who] could support them, I just don't know if, it's going to work with the two of them'*

How and when referrals were made was also identified as a concern, with participants stating the need for further discussion and clarification of referral criteria, to avoid future frustration with inappropriate referrals.

Participant 9: *'I think some of those ones where people are referred just because nobody else really knows what to do and it may very well be that there is stress and distress but maybe perhaps it's [...] a last ditch attempt to offer something, so those for me are the referrals that we've had no success at all with.'*

Participants also expressed concerns about how BFT was viewed by colleagues in the wider service when substantial

numbers of families 'dropped-out' from treatment. While some participants described improvements for families who engaged with BFT, regardless of whether or not they completed the intervention, doubts were expressed about the strength of managerial support and flow of future referrals given the lower than expected reported 'successes'.

> Participant 5: *'I think people like to see, 'oh that's a piece of work done', you know, tick the box, so that family have been BFT-d, tick, there you have it, that's a success story, and I think, maybe our manager struggles a wee bit with that because there's not been many that have been completely finished.'*

Discussion

This was a relatively small qualitative study and findings are therefore not representative of experiences of BFT therapists more generally. However, this study sought to obtain a broad understanding of the experiences of Community Learning Disability Nurses and AHPs delivering BFT across several Health Boards across Scotland, and while there were some differences in participants' experiences, common themes were identified.

The main overarching theme identified was one of *positivity*, with participants describing their experiences delivering BFT as beneficial and valuable despite underlying frustrations. Overwhelmingly, participants expressed what they saw as the clear benefits of using BFT as a framework for working with families with an adult with an intellectual disability. This resonates with previous research that has advocated the use of FIs for families who are caring for persons with an intellectual disability because of associated elevated levels of family stress and psychological distress (Fidell 2000). Studies have long identified the inextricable link between the mental health of each member of the family on other members. Participants' descriptions of the positive changes for families undergoing BFT (e.g. improving communication and problem solving skills) echoes the wealth of research that has reported the benefit of FIs to decrease caregiver burden and reduce family stress (Jubb & Shanley 2002, Hatton & Emerson 2003).

Literature exploring implementation of FIs into clinical practice has emphasized the necessity of a supportive environment for newly qualified practitioners to develop confidence and facilitate delivery (Bailey *et al.* 2003, Fadden & Heelis 2011). This study identified that support, in particular training, supervisory support and co-working, was instrumental in developing self-efficacy in participants. According to Bandura's (1997) theory of self-efficacy, a strong sense of self-efficacy is

associated with increased confidence and motivation to carry out a task. It is therefore suggested that the supportive environment described above was instrumental in enabling the broadly successful implementation of BFT into participating adult intellectual disability services.

However, in common with previous studies, this study found implementing BFT was not without difficulties. Findings from this study suggest that difficulties experienced by participants delivering BFT in adult intellectual disability services were similar to the barriers identified in previous studies exploring implementation of FIs into general and community mental health settings (Absalom-Hornby *et al.* 2011, Eassom *et al.* 2014, Lee *et al.* 2012). For example, difficulties with engagement have been reported with other clinical populations (e.g. psychosis, alcohol and troubled families services). The number of families disengaging from BFT during the treatment process was identified as a key frustration but the reasons for this were largely unclear. Further work, exploring the experiences of those individuals and families in receipt of BFT, would be of particular value. In particular, examination of the reasons why families 'dropped-out' from treatment is a crucial aspect that requires examination. From the current study, there is a suggestion that inappropriate referrals may be relevant in some cases, highlighting the necessity to carefully promulgate clear referral criteria amongst the wider service. However, the

high attrition rate also brings into question the perceived relevance of BFT for these families. While BFT aims to address stress within the family system by promoting key skills, such as communication and problem solving abilities, alternative approaches that look to provide long-term family support could also be relevant for supporting this clinical population. For example, the integrated, whole systems approach of the Senses Framework (Nolan et al., 2006), which was developed to support older people and their families, by providing relationship-centred care may also be relevant for families, where a member has an intellectual disability.

The issue of time has been consistently reported as a barrier to implementing FIs, and while participants in this study also described the time-consuming nature of delivering BFT, in contrast to other studies, they did not report any significant difficulties with integrating BFT cases into current caseloads (Kavanagh 1993, Bailey *et al.* 2003). This may have been because participants only worked with a small number of BFT cases at one time, and expressed feeling supported by management, in terms of being allowed sufficient time to practice as a BFT therapist. However, in line with previous studies, the challenge of finding suitable times to work with busy families was described as a significant barrier (Bailey *et al.* 2003). Fadden (2006) emphasised the importance of addressing

issues such as out of hours working to facilitate the successful implementation of FIs.

Some difficulties with organisational issues were identified in this study, notably the lack of awareness and understanding about BFT within the wider service. A study by Smith and Vellman (2002), addressing barriers to implementing family work, stated the necessity of the whole team having sufficient understanding of the FI to feel confident discussing treatment options with families and referring appropriately. It is suggested that the lack of understanding and awareness about BFT amongst colleagues in the wider service may have been a factor in stagnating the progression of BFT in some services, as a result of infrequent and inappropriate referrals. Previous research examining difficulties implementing FIs has highlighted the requirement for successful change management to overcome barriers to implementation (Michie *et al.* 2007, NICE 2005). For example, organisations such as NICE (2005) have emphasised the need for healthcare providers to understand barriers to change, and to facilitate structural changes that allow for change in behaviours at an organisational and individual level; furthermore, Michie *et al.* (2007) point out the necessity for change at the level of multi-disciplinary teams, to permit successful implementation.

Lack of availability of suitable cases was identified as a factor affecting participants' confidence in practising as a BFT

therapist because of a perceived loss in skills. However, the number of families that participants worked with in this study (an average of 1.8 since training) was found to be similar to numbers reported in previous studies (e.g. Kavanagh *et al.* 1993 and Bailey *et al.* 2003 who reported staff worked with an average of 1.4 and 1.7 families since training). Fadden (1997) questioned whether a smaller, committed team would be a more cost-effective way of working with families, rather than training large numbers to work with only 1-2 families per year. Smaller teams of dedicated staff could also help foster stronger family intervention skills for those regularly practising.

Some challenges specific to working with adults with an intellectual disability were identified: notably the requirement for further development of visual resources to support individuals with an intellectual disability, and to address issues with engagement and the slow rate of treatment progression. While the flexibility of the BFT model is clear, in terms of its potential to be successfully applied in adult intellectual disability services, further systematic collection and observation of outcome data is needed to establish an evidence base for the use of BFT with adults with an intellectual disability. Furthermore, given the additional reported complexities of working with people with an intellectual disability (e.g. problematic nature of change, slow rate of treatment progression), systematic measuring, capturing and reviewing of

data is pertinent to ensure ongoing organisational and individual practitioner support for BFT.

Implications for practice

This study highlights the necessity for effective change management at all levels, to facilitate successful implementation of BFT into clinical practice. For example, promulgating clear information and referral criteria about the therapy across multi-disciplinary teams, and identifying how changes in organisational management (e.g. structure of family intervention teams and working hours) could help support successful implementation. Furthermore, this study has identified the requirement to adapt resources for people with intellectual disabilities, to address issues such as engagement and slow rate of treatment progression. Significantly, this study has shown that a strong supportive environment (good training, supervisory support and co-working) was instrumental in enabling practitioners, who were new to the practice of delivering psychological interventions, to effectively deliver BFT to families. This is encouraging for multi-disciplinary working, and the delivery of psychological interventions by professions outwith psychology.

Limitations

This study does not explore the experiences of families receiving BFT. An understanding of the perspectives of

families and service users would clearly be of great value, but was outwith the scope of this study. Future studies might seek to understand, in particular, the reasons for disengagement from the treatment process. This may guide the on-going development of BFT to ensure that it meets the needs of those service users and families who might benefit from this intervention.

Conclusion

It is encouraging that the experiences of Community Learning Disability Nurses and AHPs delivering BFT in adult intellectual disability services were broadly positive and that BFT is perceived as a valuable framework for working with adults with an intellectual disability, and their families. Findings suggest that enablers to implementing BFT resulted from the robust supportive environment provided to therapists (e.g. well developed training, managerial and supervisory support and co-working). However, sustaining success in implementing BFT in adult intellectual disability services requires further organisational support across the whole service (e.g. increasing awareness and understanding of BFT), as well as a deeper understanding of the specific challenges and requirements of delivering BFT to adults with an intellectual disability. Finally, to help establish an evidence base for the use of BFT with adults with an intellectual disability, further research should focus

upon gathering outcome data to establish the efficacy of this intervention with this client group.

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Table Legend:

Table 1:

Participants' demographic information

Table 1.doc

Table 2:

Stages and analytical process (as recommended by Braun & Clarke 2013)

Table 2.doc

Table 3:

Overarching themes and subthemes

Table 3.doc