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An Investigation of ‘Restrictive Practices’ within Services for Adults with an Intellectual Disability: Perspectives of Professionals and those involved with their care.

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Ollscoil Teicneolaíochta na Mumhan
Munster Technological University

An Investigation of 'Restrictive Practices' within Services for Adults with an Intellectual Disability: Perspectives of Professionals involved with intellectual disability care.

MA by Research Department of Applied Social Studies

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Under the Supervision of
Professor Margaret Linehan & Ms Sandra Conroy

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Declaration of Originality

I, *Rebecca Donovan*, hereby declare that this research study titled *An Investigation of 'Restrictive Practices' within Services for Adults with an Intellectual Disability: Perspectives of Professionals involved with intellectual disability care,* submitted to the Department of Applied Social Studies, Munster Technological University, in partial fulfilment of the requirements for the award of Masters by Research is my own work. Any work that is not my own has been acknowledged and referenced accordingly.

Student Signature:

[redacted]

Date: 09/05/2022

[redacted]

Signature of Supervisors:

[redacted]

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Firstly, I would like to thank the interviewees for their participation and contribution to this research study. I would also like to thank the interviewees for their adaptability and co-operation during such unprecedented times throughout the Covid-19 pandemic.

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To my friends, thank you for being there when I needed you, supporting and encouraging me.

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Abstract

Restrictive practices "are an infringement of a person's fundamental rights to personal liberty and bodily integrity" (Health Information and Quality Authority, 2019, p.1). The most recent study in Ireland, found 23% of the 627 inspection reports by HIQA, human-right were violated by the use of restrictive practices (Murphy and Bantry-White, 2021). It is recognised that the core function of restrictive practices is to stop, or prevent, an individual from doing something they wish to do, in such a way that manages challenging behaviour outbursts, and provides safety for both staff and service users (Nankervis and Chan, 2021). The uncertain nature surrounding the definition of the term restrictive practices was evident in current literature, and gaps identified from previous literature provided the rationale for this research, such as the justification for the use of restrictive practices.

This study seeks to investigate the use and implementation of restrictive practices and associated terminology within services for adults with an intellectual disability from the perspectives of professionals and considers how intellectual disability services may charter a least restrictive environment. This research study is representative of organisations in Ireland who cater for people with intellectual disabilities. This research uses a qualitative methodology to gather perspectives of professionals regarding restrictive practices in services for adults with an intellectual disability. Interviews were conducted with health and social care professionals employed in services for adults with an intellectual disability.

The findings suggest that restrictive practices are necessary within intellectual disability services for adults, regardless of the negative connotations associated with their use, for the primary purpose of ensuring the physical safety of staff and service users. A stark finding of this research revealed current training does not reflect the needs of staff managing challenging behaviours, as staff often choose to use their own initiative rather than trainings provided when implementing restrictive practices. Furthermore, the findings revealed that staff shortages and insufficient training, often lead to an increased use of restrictive practices. Arising from current research, some practical recommendations are highlighted such as: effective evaluation of trainings regarding restrictive practices and challenging behaviours and, further suggest a policy be implemented by HIQA, regarding the ratio of service user to staff.

“From error to error,
one discovers the entire truth”

-Sigmund Freud

1. INTRODUCTION

1.1 Introduction and Background

Restrictive practices are, in general, a contested topic regarding services for adults with an intellectual disability. There has been a great deal of research and literature regarding the use of restrictive practices in services with an intellectual disability, however, negative connotations encompass their use.

Services for adults with an intellectual disability in Ireland have evolved in recent years due to legislative ratifications and professional standards of care, which promote restrictive practices are used as a 'last resort', however, restrictive practices have been sewn into service provision for several years and to detach from such long standing practices may arguably be a challenge for services (HIQA, 2019). Since the ratification of the United Nations Convention on the Rights of a Person with a Disability in 2018, adults with an intellectual disability are legally afforded equal rights and opportunities as a neurotypical individual. Therefore, their rights must be upheld by those who provide their care, regardless of their disability. However, previous research has provided that the paradigm shift the UNCRPD has brought, and will face challenges regarding its implementation in services for adults with an intellectual disability (European Foundation Centre, 2011). Factors that may challenge the implementation of the UNCRPD include staff levels, funding and staff burnout (Lang *et al.,* 2011). This highlights the complexity surrounding the implementation of the UNCRPD and how the slow movement of intellectual disability services in Ireland, moving towards a least restrictive environment is affected.

Restrictive practices, within services for adults with an intellectual disability are considered freedom- restricting measures, that include, but are not limited to, physical, mechanical, chemical, environmental and seclusion (Frederiks, 2020). Restrictive practices are commonly used within services for adults with an intellectual disability, to manage challenging behaviours and provide a safe environment. Behaviour can be described as challenging "when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion" (Royal College of Psychiatrists, 2007, p.10). Historically in the mid-1900's Ireland, individuals with an intellectual disability were committed to psychiatric institutions by medical practitioners under the 1945 Mental Treatment Act (Kilgannon, 2020). The rationale for such committal was due to a lack of services, specifically for individuals with intellectual disability, and because individuals with an intellectual disability did not 'fit in' with society (Browne, 2008). It was evident that individuals with intellectual disability were misunderstood, and were not afforded appropriate care, in comparison to professional standards within intellectual disability services today.

Restrictive practices have been present within services for adults with an intellectual disability in Ireland over a significant period of time (Kilgannon, 2020). Historically, restrictive practices were inappropriately used within intellectual disability services in Ireland and, lead to many cases of abuse (Commission to Inquire into Child Abuse, 2009). As restrictive practices impede upon a person's freedom of movement, negative connotations are often associated with the term restrictive practices and their use, however, such practices are within the professional standards of the Intellectual Disability Sector (The Health Information and Quality Authority, 2017). Services for adults with an intellectual disability in Ireland, are adapting and changing, following a set of standards and guidelines set out by the Health Information and Quality Authority (HIQA), established in 2007 (Mental Health Commission, 2007) which aim to achieve an overall person-centred approach regarding managing challenging behaviours and the implementation of restrictive practices. According to the Health Service Executive (HSE) (2011), the prevalence of challenging behaviours within services for adults with an intellectual disability requires the use of restrictive practices.

Restrictive practices, in its simplest form, are understood, to stop or prevent an individual from doing what they want to accomplish, in a way that regulates challenging behaviour outbursts and ensures the safety of both staff and service users (Nankervis and Chan, 2021). This research identifies gaps in previous literature and research, which provided the rationale for this research. Some of these gaps include:

examining the prevalence of restrictive practices used in services for adults with an intellectual disability; the impact of restrictive practices used; the effectiveness of trainings for professionals regarding restrictive practices and challenging behaviours and the considered necessity of restrictive practices used in services for adults with an intellectual disability.

1.2 Research Aims and Objectives

This research endeavours to understand what restrictive practices encompass, and explores the prevalence of such practices within services currently, including the justification for their use and various methods of implementation used within services for adults with an intellectual disability. The perspectives of professionals involved with the care of adults with an intellectual disability were examined, which provides a unique insight into the perceived need and effects of implementing such practices. This research investigated the application of relevant legislation, guidelines, policies and National Standards that specifically govern practices within these services in Ireland. Moreover, the terms associated with restrictive practices were explored, such as: challenging behaviours, risk management and least restrictive settings. As restrictive practices may be construed as ambiguous, associated terminology discussed within the literature, and the findings of this study, provide a further understanding of how, and why, restrictive practices are used within services for adults with an intellectual disability. In addition, previous research and literature highlighted, there is no one fixed operational definition of the term ‘restrictive practice’. Therefore, this study expands on current research, but also investigates a further in-depth perspective of restrictive practices from those who implement them on a daily basis.

There are a variety of trainings for professionals regarding restrictive practices and challenging behaviours, which can be categorised as reactive and proactive. Reactive trainings include physical interventions to control/restrict challenging behaviours (Maagerø-Bangstad *et al.,* 2020). In comparison, proactive trainings include “building a positive rapport, identifying behavioural triggers, actively teaching appropriate behaviour and social skills and improving communication” (Madden and Senior, 2018, p.189). Both trainings are still widely used in services for adults with an intellectual disability. Proactive trainings are preferred by professionals, as they are less invasive practices (Hewett, 2021). Reactive trainings, however, “bring about immediate behavioural change in an individual or establishing control over a situation” which may include “physical holds, mechanical, and manual restraint, seclusion and ‘time out’ or, the use of emergency medication” (The British Psychological Society and The Royal College of Psychiatrists, 2015, p.308). However, there is limited knowledge regarding the effectiveness of such trainings from the perspectives of professionals who utilise such trainings daily. Therefore, this research aimed to determine whether trainings regarding restrictive practices and challenging behaviours are effective, considering the appropriateness and/or suitability for professionals to use sometimes on a daily basis.

An additional goal of this research was to examine the impact of restrictive practices, used within services for adults with an intellectual disability. The function and purpose of restrictive practices, as mentioned previously, is to stop or prevent an individuals’ mobility and freedoms, and to provide safety for service users (Björne *et al.,* 2021). The impact of implementing such practices on a frequent basis, albeit to ensure the physical safety of the service user, may also have implications for staff. According to Rippon (2020) the impact of the use of restrictive practices does not only affect service users but also staff implementing such practices. Rippon *et al.,* (2020) highlight that, professionals managing challenging behaviours with the use of restrictive practices can incur negative emotional and psychological outcomes, such as stress. There are also physical risks for staff, in relation to, implementing restrictive practices such as facial and arm injuries, as reactive restrictive practice trainings involve physical holds of an individual (Rickard *et al.,* 2013). Therefore, this research aimed to investigate, the impact of the use of restrictive practices from the perspectives of professionals working within intellectual disability services with consideration given to moving towards a least restrictive environment.

1.3 Research Questions

The main research question of this study is: *What defines restrictive practices within services for adults with an intellectual disability?*

Three sub-questions are:

1. How effective is current training for professionals working within disability services, in implementing restrictive practices and responding to challenging behaviours?

2. Does the varied terminology used in conjunction with restrictive practices, such as challenging behaviours, have any impact on practice/s used?

3. Is it possible to move towards a least restrictive environment[1] in Ireland?

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[1] A Least Restrictive Setting "maximises both the autonomy and safety of service users, and reduces or prevents practices that restrict personal freedoms and are known to cause harm, such as restraint and seclusion" (Te Pou o Te Whakaaro Nuito, 2015, p. 5)

1.4 Overview of Thesis

This thesis comprises four chapters: Literature Review; Methodology; Analysis and Discussion; Conclusion and Recommendations. The content of each section is briefly detailed here:

The literature review examines previous research regarding restrictive practices, associated terminology and legislation governing services for adults with an intellectual disability in Ireland. There have been many investigations of restrictive practices, more specifically, categorising restrictive practices, investigating what may be considered a restrictive practice and the impact of restrictive practices on service users. However, there is limited research focussing on the area of professionals' perspectives of restrictive practices. The areas covered throughout the Literature Review are not offered as an exhaustive list of factors associated with restrictive practice, as that list may be endless; however, it attempts to recognise the complexity of restrictive practice and acknowledges the difficulties in identifying key factors associated with the justification and implementation of restrictive practices.

Chapter Three outlines the methodology used to conduct this research. In seeking an appropriate methodology for this research, consideration was given to the type of data that was collected. As this research sought empirical knowledge, a qualitative research method was chosen, this allowed for a flexible approach regarding the research design. A qualitative, research approach, explores human behaviour, attitudes, experiences and perspectives on certain social phenomena (Mohajan, 2018). Therefore, as this study set out to gather professionals' perspectives of restrictive practices a qualitative research method was deemed appropriate and was applied to the data gathered.

Semi-structured interviews were selected as it allowed for an extensive exploration of the interviewees' perspectives of restrictive practices, through open-ended questions which also allowed for discussion. In this sense, the research aimed to draw on the views and opinions of professionals working within intellectual disability services to assist in identifying key aspects of restrictive practices. Twelve professionals were interviewed for this study, selected from a large population of health and social care professionals employed in intellectual disability services in Munster. This group of interviewees was determined due to their expertise in the area and their involvement with services users on a daily basis in relation to the research topic. Purposive and snowball sampling enabled the process of gaining interviewees for this research. Further detail on the field work conducted is outlined in *Chapter 3 Research Methodology.*

Chapter Four, the analysis and discussion chapter explores restrictive practices and factors associated with their use within services for adults with an intellectual disability. The results of the interviews are presented as thematically, emerging from the primary data collected. The analysis of the results allowed for an understanding of restrictive practices within services for adults with an intellectual disability from the perspectives of professionals. The discussion of the findings allowed for the interpretation of the results to be identified, and provided an informed analysis of the research, providing answers to the research questions detailed above.

Chapter Five, the final chapter of this research, focuses on conclusion and recommendations, which recapitulates the findings and strives to provide a better understanding of restrictive practices within services for adults with an intellectual disability. This chapters draws a conclusion to the study. Some strengths and limitations of the research are presented. Finally, the chapter provides some recommendations for practice, policy, and future research, as a result of the research conducted.

2. LITERATURE REVIEW

2.1 Introduction

This literature review identifies and summarises some of the scholarship and debate on the topic of *restrictive practices* in services for adults with an intellectual disability. Many variations of the definition will be examined, in tandem with associated terminology and factors that contribute to their use or misuse. Whilst looking at the concept of restrictive practices other interconnected terminology will be explored, which includes, but is not limited to, challenging behaviour, restraint and intellectual disability. In the context of services for adults with an intellectual disability for the use of a restrictive practice there needs to be; (A) an incident or aggressive behavioural outburst and (B) the use of a restraint. The escalation from A to B combined contributes to the concept of 'restrictive practice' (Luiselli and Cameron, 1999).

There are many areas that can be explored in conjunction to restrictive practices, however, for the purpose of this literature review, the relevant areas that will be discussed, but are not limited to, are;

- Challenging behaviours
- Education and training for professional workers regarding restrictive practices
- The United Nations Convention on the Rights of a Person with a Disability

Therefore, restrictive practices are used as a 'lens' or 'looking glass' throughout this study.

The term restrictive practice is an old and ever-changing term (Mackelprang *et al.,* 2022), thus, no one fixed operational definition of restrictive practices is set at the outset as interpretations and applications of the term are explored throughout this literature review. However, as a leading definition, according to the Australian Centre for Health Law Research in the context of being used on individuals with an intellectual disability involves the "detention, seclusion and restraint of people with intellectual impairment" (Chandler *et al.,* 2016, p.362).

Also, as starting point ‘intellectual disability’ according to Brown (2007, p.3) refers to “some restriction or lack of ability having to do with human intellect”. This includes individuals who present with an intellectual disability, may also have a difficulty in learning. According to Boat and Wu (2015, p.170) the severity of an intellectual disability can be categorised as “mild, moderate, severe, and profound”, with “mild” being the least severe and “profound” as the most. Nonetheless, an individual with an intellectual disability and/or autism may face difficulty in certain aspects of their life, and there is a standard of which one must meet to provide their care and support. An additional factor that will be discussed whilst investigating challenging behaviours, is the verbal ability of individuals with an intellectual disability. According to Leader and Mannion (2016, p.4) “if an individual is non-verbal, they may communicate through challenging behaviours”. Highlighting, the relevancy of communication in conjunction with restrictive practices in this study.

Another important element that will be discussed in conjunction to restrictive practices is The United Nations Convention on the Rights of a Person with a Disability (UNCRPD), which globally governs the rights of a person with a disability. It is unclear currently how, or if, Ireland’s ratification of the UNCRPD will influence disability services regarding Nationals Standards, policies and procedures in relation to restrictive practice. Consideration of other Nations where the UNCRPD has been ratified for a number of years, is also taken into account for comparison purposes.

The topic of the social care profession will also be explored in connection with the use of restrictive practices in services for adults with an intellectual disability and the role of the Social Care Worker respectively. Considering both aspects, the role of the social care worker, and how, or if, this may influence services for adults with an intellectual disability in terms of governance, and the possibility of policies and procedures being reviewed. In addition, the social care profession will be discussed through the lens of the history of the profession, the upcoming professionalisation and the rationale behind the professionalisation of the profession. The professionalisation of the social care profession will also be examined in relation to how, or if, it may impact on services for adults with an intellectual disability and the use of restrictive practice.

As this study explores interpretations and applications of the term restrictive practices, variations of the definition will be examined along with associated terminology and factors that contribute to their use or misuse.

2.2 An Overview of 'Restrictive Practices'

In general terms, restrictive practices can be construed as ambiguous without any context or antecedent to the use of them. Meaning that, without any background to an incident or circumstance the term restrictive practice can/may be generalised. Hence without any context or circumstance, to restrict an individual is to limit or confine a person from something that they would do freely (Kumar *et al.,* 2008). Whereas a generalised definition of the term in the context of disability services refers to "the actions by which one person restricts the movement of another" (Harris, 1996, p.20). By contrast, restraint can be defined as "the use of force" to stop or prevent an individual from movement (Pu and Moyle, 2020, p.11). The use of the term 'force' highlights an almost dominant position when carrying out the use of a restraint. Within the intellectual disability service setting, this highlights a clear boundary/differentiation between the role of staff and service user. Restrictive practices, or restraints, are according to Friedman and Crabb (2018) generally associated with individuals who present behaviours that challenge or aggressive behaviour, therefore, would be present in intellectual disability services, mental illness services and/or criminal services.

Restrictive practices were not only reserved for adults with an intellectual disability but also were applied in children's settings as found in the Commission to Inquire into Child Abuse, (2009, vol.3, ch.13) or commonly referred to as the 'Ryan Report'. The Commission to Inquire into Child Abuse or Ryan Report (2009) is a record that found over the period of seventy-years, children and individuals with a physical or intellectual disability living within residential institutions run by the Catholic Church and funded by the Government of Ireland, were subjected to various types of abuse; emotional physical and sexual (Pine *et al.,* 2017). According to Brennan (2008), in Ireland, historically, restrictive interventions were carried out in schools and institutions, on children, mentally ill individuals and individuals with an intellectual disability. Confirming that restrictive practices were used on the most vulnerable individuals within Irish society. Brennan (2008) also argues that throughout this period, terms such as restrictive interventions, or restrictive practices, were not used, with the substitute term of 'abuse' being utilised, signifying that although the terminology has changed over time in Ireland, the various types of restrictions or restrictive practices used may not have changed, nor the reasons or justification for which they are used. This is a distinct viewpoint and continues to be addressed by HIQA and other organisational bodies, to ensure that standards, policies and protocols are upheld in accordance with the rights of adults with an intellectual disability, and to protect staff and organisations implementing such practices.

Additional significant literature regarding abuse and maltreatment in social care services in Ireland include, but are not limited to [2]'Suffer the Little Children: The Inside Story of Irelands Industrial Schools' (Raftery and O'Sullivan, 2001), [3]'Coercive Confinement in the Republic of Ireland: The Waning of a Culture of Control' (O'Sullivan and O'Donnell, 2007) and '[4]A Story to Tell: Learning from the Life-stories of Older People with Intellectual Disabilities in Ireland' (Hamilton and Atkinson, 2009). Furthermore, as Ireland has come from a history of abuse within services for vulnerable people in society, the use of restrictive practices presently are controversial due to ethical concerns regarding the use and over-use of such practices (Scheirs *et al.,* 2018). However, for the purpose of the literature review, restrictive practices in disability services will be the focus throughout.

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[2] Raftery, M.and E. O'Sullivan (2001)*Suffer the little children: The insidestory of Ireland's industrial schools.* New York: Continuum Publishers.

[3] O'Sullivan E., O' DonnellI.'Coercive confinement in the Republic of Ireland: The waning of a culture of control' in, *Punishment & Society.* 2007;9(1):27-48.

[4] Hamilton, C.& Atkinson D.(2009)'AStorytoTell':learningfromthelife-storiesofolderpeoplewith intellectual disabilities in Ireland' in *The British Journal of Learning Disabilities*. [Special Issue: Disability Research and Rights in Ireland] Volume 37, Issue 4, pages 316–322, December 2009.

Regarding the use of restrictive practices in the context of adults with an intellectual disability, The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations, (2013, p.3) in Ireland, provide some fundamentals of how restrictive practices are used which is “the intentional restriction of a person’s voluntary movement or behaviour”. The term ‘intentional’ within practice according to Finn and Sturmey (2009) highlights where one would purposefully stop, move, make an individual do something that they would not want to do, or prevent them from doing something that they would like to do, and in some cases excessive force is used. The question arises in relation to what the staff is trying to restrict, or stop, when using a restrictive practice and the outcome of using restrictive practices. It appears that from the analysis of Finn and Sturmey (2009) that the intentional use of a restrictive practice could derive from, ‘making the job easier’ for staff without consideration for the individual displaying an aggressive or challenging behaviour. This signals that negative implications may arise for the individual displaying such behaviours. On the other hand, The Health Information and Quality Authority (2019, p.5) argue that “the use of restrictive practices is warranted when there is a real and substantial risk to a person and this risk cannot be addressed by non-restrictive means”. However, there is no specification of what a ‘substantial risk’ is. Therefore, this does not clarify the appropriateness of the use of a restrictive practice and may be left open to staff members to decipher.

By contrast Sun *et al.,* (2020) argue that frustrating events or incidents can trigger the urge of an individual to act aggressively. This may be applied to both staff and service users, in the event of responding to heightened anger or frustration, staff may be more inclined to use a physical restrictive practice rather than a de-escalation method. Also, as previously mentioned if an individual is displaying a behaviour of concern, the use of a physical restrictive practice may escalate the behavioural outburst. This indicates the importance of standards regarding restrictive practices and challenging behaviours, where training and education is essential to limit the unnecessary and negative implications that arise from the use or misuse of a restrictive practice.

The element of staff training which is associated with the use of restrictive practice, can vary depending on different services and organisations, however, Connolly (2018) argues that staff working within intellectual disability services lack specific training for the appropriate use of restraints or restrictive practices. This along with overuse of restraints or restrictive practices may lead to misuse or institutional abuse.

Institutional abuse, according to McDonnell *et al.,* (2014, p.36) “occurs when the rituals and routines of a service result in the lifestyles and needs of individuals being sacrificed in favour of the needs of the institution”. In a similar way to the point mentioned above, it suggests that the use of restrictive practices may be linked with making the job easier for employees or the service when working with individuals who display behaviours that challenge. Whilst individuals with an intellectual disability may require interventions at times to ensure the safety of themselves and perhaps others around them, this poses the query for the justification for the use and possibly over-use of such restraints mentioned above. However, regarding medication within residential and/or day services, the Health Information and Quality Authority (HIQA) (2015, p. 27) state that “Schedule 2 and 3 controlled drugs (including those for self-administration) must be secured in a manner that meets legislative requirements as set out by the Misuse of Drugs Regulations”. This means that, by law, medications that come under schedule 2 and 3 of the Misuse of Drugs Regulations must be locked in a secure area. Therefore, this restriction in residential and/or disability services is justified by HIQA and the government as it is written in legislation. For example, a HIQA inspection report (2016, p.12) on designated residential service in Ireland found that “All medication was kept in a locked medication trolley”, however, this was justified as safe administration of medication and therefore, a justifiable restriction. However, as the storage and administration of medication may be deemed safe and justified as per HIQA guidelines, an additional point arises such as the ethical use of medication (PRN)[5] as a restrictive practice. According to Jimu and Doyle (2019) the most commonly used PRN given to an

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[5] PRN “stands for 'pro re nata,' which means that the administration of medication is not scheduled, the prescription is taken as needed”(Oh *et al.,*2014).

individual who is experiencing episodes of challenging behaviour and heightened anxiety are benzodiazepines, antipsychotics and sedative medications, which give a rapid sedated effect to the individual. Usher *et al.,* (2009) also highlight that there has been evidence of misuse regarding PRN's on individuals who present with challenging behaviours. Therefore, as PRN medication is not a scheduled medication, and provides and immediate effect to an individual's behaviour, like other forms of restrictive practices may be used in the event of heightened anger and frustration as previously mentioned by Sun *et al.,* (2020), and contribute to the overuse/misuse.

In a more recent study, Dorenberg *et al.,* (2018, p.31) found that the most common justification for the use of a restrictive intervention was to avoid danger to the individual, to staff and to others, to restore order to the group, to support the individual who is displaying aggressive behaviour or to "to restore authority". The statement to "restore authority" appears of a controlling nature, again highlighting the unequal power balance between staff and service users, with staff in a dominating position. The possible need for staff to restore authority, may be as a result of staff not being able to cope with the number of service users, in comparison to the ratio of staff that are on duty. Research by Dorenberg *et al.,* (2018), and The National Federation of Voluntary Service Providers Ireland (2016), argue in their report, that budget cuts regarding staff employment have been a determining factor in staff leaving organisations. Therefore, it appears that the issue of staff retention and staff shortages may be one of the many reasons why staff need to demonstrate control and authority within disability services. This suggests that there is not enough staff to meet the specific support needs of those availing of the service and such practices are used to avoid danger to the individual, to staff and to others' as there is no other alternative that can be safely implemented.

An additional factor relating to the use of restrictive practices on adults with an intellectual disability is *ableism*. Ableism "refers to the oppression of people in society that become marginalized based on their abilities" (Scheirs et al., 2022, p.49). According to Dhanani *et al.,* (2022) individuals with an intellectual disability are often over-looked or underrepresented in society, and more significantly in health and social care settings. In addition, Nixon (2019, p. 2) states that "there are norms, patterns and structures in society that work for or against certain groups of people, which are unrelated to their individual merit or behaviour".Dhanani *et al.,* (2022) also highlight that the most significant factor contributing to ableism regarding individuals with an intellectual disability is a lack of cultural understanding and understanding within the medical community. In a similar way, Shier *et al.,* (2011) argue that the lack of training for professionals involved in the care of adults with an intellectual disability also enables ableism. However, Shier *et al.,* (2011, p.50) also argue that "people that are disabled by our social environment". Therefore, professionals may have a predisposed bias regarding individuals with an intellectual disability based on society. In addition, this indicates that professionals involved in the care of adults with an intellectual disability and intellectual disability organisations implement a model of care that may not 'fit in' to the perspectives and environment that an individual with an intellectual disability may see fit.

In agreement, Giangreco (2020) argues that the use of restrictive practices to manage challenging behaviours, enables professionals to determine what is best for an individual without regard for the individual themselves but rather perceived needs. This highlights a power imbalance between staff and service user, as the use of restrictive practices to manage challenging behaviours is based off what the professional/staff determines what is best. In a similar way, Giangreco (2020) states that because of health and social care professional's biases towards individuals with an intellectual disability, the use of restrictive practices to manage challenging behaviours increases.

Moreover, the concept of ableism challenges health and social care professionals perspectives of society. Shier *et al.,* (2011) argue that in order for health and social care professionals to fully understand the concept of ableism, professionals must be able to connect theory and social, practical experiences in order to understand how individuals with an intellectual disability are marginalised and discriminated against in society. Therefore, it is important that health and social care professionals are selfaware and practice reflective learning to challenge their own personal biases, but also biases evident in society.

In relation to staff working with adults with an intellectual disability who display behaviours of concern, Ali *et al.,* (2014, p.186) argue that, for adults with an intellectual disability the display of challenging behaviours may be "an atypical presentation of core symptoms of a specific disorder (e.g. self-injury); it may occur as a secondary feature of mental illness (e.g. self-injury and aggression may be a feature of depression); and it may be reinforced by the symptoms of a mental illness". This highlights that an individual displaying challenging behaviours may be trying to communicate a possible concern or issue, particularly if they are unable to communicate verbally. Individuals with an intellectual disability who present with challenging and risk related behaviour such as self-injurious behaviours or aggression may be at risk to themselves or others. However, Hastings *et al.,* (2018) argue that this still does not justify the use of restraint or restrictive practice, that although the individual may be at risk to themselves or to others, the individual should not be vulnerable to restrictive practices. As noted previously, although some behaviours may not be challenging for the individual themselves, individuals who display behaviours of concern or of a challenging nature, may still be subjected to the use of restrictive practices as the behaviour may challenge staff or those who are involved with their care. As a result, such elements associated with the use of restrictive practices in intellectual disability services have a significant purpose or motive regarding their lawful use, which may increase the risk of a negative impact on individuals with an intellectual disability and/or staff.

2.2.1 The Physical and Emotional Impact from the use of Restrictive Practice/s

Whilst considering the impact of the use of restrictive practices on any individual, there are ethical concerns. Ethical concerns regarding 'restrictive practices' according to Friedman and Crabb (2018) relate to whether the practice poses a risk to the health and welfare of an individual of which a restrictive practice or restraint is being used on, therefore an impact, whether positive or negative is inherent. This implies that there is always an outcome to be considered when a restrictive practice is used. This section will examine the most widely used restrictive practices, or restrictive interventions, within services for adults with an intellectual disability, which include:

- Physical
- Chemical
- Mechanical
- Environmental
- Seclusion
- Electronic Surveillance

(The Health Information and Quality Authority, 2017, p.3-4).

Physical “any direct physical contact where the intervener’s intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person” (Social Care, Local Government and Care Partnership Directorate, 2014, p.26).

Chemical “The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness” (Social Care, Local Government and Care Partnership Directorate, 2014, p.28)

Mechanical “the use of a device to prevent, restrict or subdue movement of a person’s body, or part of the body, for the primary purpose of behavioural control” (Social Care, Local Government and Care Partnership Directorate, 2014, p.27)

Environmental “the intentional restriction of a resident’s normal access to their environment, with the intention of stopping them from leaving, or denying a resident their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties” (Department of Health, 2020, p.6)

Seclusion "the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving" (Social Care, Local Government and Care Partnership Directorate, 2014, p.28)

Electronic Surveillance "this includes electronic tags on people, exit alarms on doors and television cameras (closed circuit television (CCTV) to monitor people's movement". (Commission for Social Care Inspection, 2007, p. 9) [6]

According to Allen *et al.,* (2009, p. 160) "the use of more traditional and restrictive reactive strategies prevails". This highlights that restrictive practices are still commonly used within services for adults with an intellectual disability to this day, however, their use has an impact or outcome on both staff and adults with an intellectual disability, as stated by Friedman and Crabb (2018). The use of 'traditional restrictive practices' which according to Allen *et al.,* (2009) include physical holds, the use of restraints or medication/sedatives. As previously noted, this suggests the intentional use of a restrictive practice or restrictive intervention. On the other-hand, Deveau and McDonnell (2009) and The Health Information and Quality Authority (2016) argue that restrictive practices or restraint are intended to be used as a 'last resort'. This indication whereby restrictive practices are used in a traditional manner poses possible scenarios, that there are many individuals displaying behaviours of concern and have reached the level of intervention or that it is easier for staff to implement a restrictive practice.

The use of either chemical, or physical restraints, are generally used on individuals who display behaviours of concern to prevent the element of harm and provide a safe environment (Chan *et al.,* 2013). Such behaviours include those that put themselves

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[6] The particularities of each individuals restrictive practice (Physical, Chemical, Environmental, Mechanical, Seclusion and Electronic Surveillance) are not thoroughly distinguished for the purpose of this research study but treated rather, as a singular overall category for analytical purposes. Though each category brings its own set of distinct ethical, procedural, policy and practical concerns, such matter are beyond the boundaries of what is discussed in this particular thesis, however, this may be an area for further research.

or others at risk of harm such as self-injurious behaviour which include “poking oneself in the eye; harming oneself by hitting, scratching, or pinching; and pica (i.e., swallowing objects causing bodily harm)” (Tureck *et al,.*2013, p. 1). The impact of such restraints, or restrictive practice, may vary from the desired outcome, where the individual and those around them are safe or that the use of a restrictive practice may generate trauma for the individual and those around them. According to Friedman and Crabb (2018, p.172) the impact of the use of restrictive practice on individuals with an intellectual disability include “physical health risks, psychological trauma, limitations of personal freedom, and humiliation that the procedures impose upon people exhibiting aggressive behaviour”. In agreement with this statement, HIQA (2019, p.5) provide examples of the negative consequences of the use of restrictive practices such as “injuries or fatalities due to entrapment; functional impairment; pain; and negative emotions or experiences”. This indicates that the negative implications of a restrictive practice can not only have serious physical consequences for an adult with an intellectual disability, but also emotional and psychological.

Furthermore, whilst the impact of the use of a restrictive intervention can indeed cause more harm than the initial desired outcome, it can also lead to an increased risk of aggressive behaviour escalating. The use of an intervention such as a restrictive practice may prove necessary for the reasons as stated, such as due to lack of staff, provide order within services and to provide a safe environment within services for adults with an intellectual disability. Overall, it appears that there are many factors that contribute to the use of restrictive practices and the impact that they have, however. the emerging concept that represents the core feature when considering the use of restrictive practices is the display or outburst of challenging behaviours.

2.3 **Adults with an Intellectual Disability who display Challenging Behaviours**

> *Functions of challenging behaviour are considered to be attempts to control the environment, to communicate a message or need such as expression of pain, hunger, or thirst or, conversely, a request or rejection of objects, activities or environmental factors* (Dubé, 2012, p.8)

Behaviours that challenge, is arguably the cause or reason to justify the use of a restrictive practice, which is why it is key to discuss. The terms such as challenging behaviour, self-injurious behaviour, stereotyped behaviour and aggressive destructive behaviour have been used to describe different types of behaviours throughout history.

To understand what is considered a challenging behaviour, the concept of behaviour, in general, will be looked at. Behaviour is, according to Watzlawick *et al.,* (1967) a form of communication, all behaviour has a meaning and is an expression of a message and therefore, an expression of thoughts and feelings. Likewise, Umeda *et al.,* (1990, p.177) argue that behaviour "is the manner in which a thing acts under specified conditions or circumstances, or in relation to other things". This suggests that behaviour is a response to external stimuli. By contrast, Uher (2016) highlights that the concept of behaviour is difficult to define as researchers and philosophers think about behaviour in different ways. Pichot (1999, p. 117), a French philosopher, argues that behaviour is "the organised entirety of the relationships of the living being and its environment". Moreover, it is evident that the definitions provided, underline an understanding that behaviour is a response to a person, place or thing. In comparison to previous definitions, Bergner (2011, p.148) argues that behaviour is "an attempt of the individual to bring about some state of affairs", which means that an individual will act or behave in a certain way to get what they want or need. This definition regarding all individuals poses the query, do all humans behave in a way just to get what we want?

As a general understanding of what behaviour is, Qureshi and Alborz (1992, p.139) argue that for a behaviour to be defined as challenging an individual must meet one or more of the following three categories:

- The behaviour must have caused harm to the individual themselves or to another, such as a peer or staff if living in a residential community service or to a family member which requires first aid or medical treatment.

- The behaviour occurs once a week where a profession or an individual involved in their care must intervene for the safety of the individual, themselves or others.
- The behaviour occurs daily and is time consuming.

(Qureshi and Alborz, 1992, p.139)

In relation to individuals with an intellectual disability, the term 'challenging behaviour' has been linked to negative implications, suggesting that the individual is seen to be a problem or they are dangerous. However, alternative terminology has been adopted over the past few years, such as, 'behaviours of concern' and/or 'behaviours that challenge' which has been described as more person-centred (National Institute for Health and Care Excellence (UK) (2015). The National Institute for Health and Care Excellence (UK) (2015) argue that the new terminology was thought to have some advantages over the earlier terms, and also to be a reminder to professionals working with such individuals that the behaviour was not a challenge to the individual themselves, but a challenge to the service. This may suggest that the changing of the term 'challenging behaviour' shows progression within disability services. Implying that there is a purpose to the behaviour, it is a form of communication. Nevertheless, due to the nature of the term challenging behaviour, it is evident that the changing terminology proposes a more proactive response rather than reactive response regarding restrictive practices.

Furthermore, such changes in terminology may also propose that an individual who displays with 'challenging behaviour' may no longer seen as a 'problem' but functional (Emerson and Bromley, 1995). This essentially suggests that a 'challenging behaviour' should no longer be defined as 'challenging' but as a 'functional behaviour', as the behaviour presented may be used as a form of communication. Hong and Matson (2021) argue that all behaviour including challenging behaviours are a form of communication, more specifically that an individual's reaction to physical pain due to medical issues can be classed as a challenging behaviour. Within services for adults with an intellectual disability, physical pain due to a medical issue may arguably be a common occurrence. Moreover, each individual is different, therefore, signifying, the behaviour that is expressed may be similar to what another individual is expressing, the reason or cause to why they are expressing such behaviour may differ entirely (Leader and Mannion, 2016). Suggesting that although the physical action of the behaviour is similar, the function may be different. Demonstrating that perhaps no one form of a restrictive practice or restraint would provide any benefit for all individuals within services for adults with an intellectual disability as the behaviours all differ in terms of functionality.

By contrast, Tyrer *et al.,* (2017, p.522) argue that “challenging behaviour is the main cause of failure to accommodate to community placements and for transfer to other, more intensively staffed units, including hospitals”. This suggests that challenging behaviours are a response or a knock-on effect, to individuals with an intellectual disability placed in an environment that may not be suited to them. According to the National Intellectual Disability Database (NIDD) (2017, p.12) “69% lived at home with parents, siblings, relatives or foster parents; 26.9% were in receipt of full-time residential services; 15.5% in community group homes; and 4.3% were living in an independent setting”. The National Intellectual Disability Database (NIDD) was established in 1995, and is “a service planning tool designed to capture data on the usage of and the need for specialist disability services among people with intellectual disability” (HIQA, 2021, p.1). According to an Inclusion Ireland report (2019, p.17) “services and supports provided to people are based upon the availability of the service and not around the individual needs of the person, where the person lives or with whom the person would like to live with”. Therefore, this may suggest that intellectual disability organisations are not entirely person-centred and could be one of many reasons as to why an individual displays’ challenging behaviours as the individual’s needs are not heard or considered. Person-centred care is described by Van Diepen and Wolf (2021, p.549) as “directed at improving the health and recovery process of patients and improving the work environment of health-care professionals by forming a partnership between the patient/relatives and the health-care professionals”. This means that, for an organisation to be able to provide person-centred care, importance must be placed on the relationship between staff and service user. Similarly, individuals who display challenging behaviours are often left with inadequate specialist support and housing placement by the local authorities due to the high costs that it would entail (Emerson *et al.,* 2008 in Perry *et al.,* 2013). The lack of funding for intellectual disability services insinuates that it may be the root of many issues that are faced regarding challenging behaviours in adults with an intellectual disability.

According to O' Dwyer *et al.,* (2018) adults who display challenging behaviours can lead to an obstacle for integrating into the community, and may result in additional restrictive practices put in place within a residential setting. Similarly, individuals who display challenging behaviours in a community residential setting are more likely to consume resources, such as staff and funding and could also lead to a placement breakdown (Grant, 2021). This indicates that if an individual displays challenging behaviour it could mean that they are to be placed or housed elsewhere, which could mean that they are frequently located to different houses. This alone may make an individual anxious or upset if they are always meeting new people and being moved constantly. As noted by Emerson (1998 in Philips and Rose, 2010, p. 202) "challenging behaviour is no longer viewed as an 'inherent' personality trait, but rather as the result of a dynamic interaction between an individual and their environment". Therefore, suggesting that the environment where an individual who displays challenging behaviour resides can have a notable impact on their behaviour.

By comparison, Bowring *et al.,* (2019, p.173) argue that "understanding the prevalence of challenging behaviour in adults with intellectual disability is important for service planning and resource funding". This suggests that to properly place, or house, an individual who displays challenging behaviours, the governing body must first understand what challenging behaviour is and its function. Moreover, it is apparent that the housing placement and a good quality of life, as previously mentioned by Inclusion Ireland (2019) is important, an individual should be able to choose who they would like to live with as this may contribute to challenging behaviours, however, it appears that it is not always the case. This is due to the apparent lack of funding, resources and understanding of challenging behaviours.

According to Bowring *et al.,* (2019, p.174), the exact estimation of the prevalence of challenging behaviour in adults with an intellectual disability has been restricted to a certain group, however the prevalence can be estimated at "between 4–22% in previous total population studies to as high as 50–80% in studies looking at specific settings, sub-populations, or behaviours". Similarly, in Ireland O' Dwyer *et al.,* (2018, p.192) found in their study that "over half (53%; n = 362) reported displaying any problem behaviours (verbal aggression, physical aggression, destruction, self-injury, or "other" problem behaviours)". This suggests, however, that of the 362 individuals were observed in Ireland, that the prevalence of challenging behaviour in adults with an intellectual disability is nearly half of the intellectual disability population. O' Dwyer *et al.,* (2018, p.193) also provide information regarding the prevalence rate on the scale of challenging behaviour that are present in adults with an intellectual disability in Ireland that are; "between 5–15% have been reported for severe or demanding behaviours… and 45–62% for milder or less frequent behaviours". However, according to Grey and McClean, (2007 in Dubé, 2012, p. 4) "prevalence rates of challenging behaviour vary throughout the literature stemming from non-standardized reporting and diverse definitions of both intellectual disability and challenging behaviour". Furthermore, according to Hartley and MacLean (2007) despite a lack of consensus of the what the definition of challenging behaviour is and the scale of how to measure/record what type of challenging behaviours are present, it can be noted that these practices are prevalent in services for adults with an intellectual disability in Ireland.

Ravoux *et al*., (2012, p.1) highlight that, individuals with an intellectual disability "are less likely to receive empirically based management interventions". This leads to the presumption of staff not receiving adequate training regarding individuals with challenging behaviours or that 'restraints' or 'restrictive practices' are not used for the purpose that they were intended, which is controversial. According to Heyvaert *et al.,* (2014, p.172) the use of restraints or restrictive practices is only "legitimate under certain conditions". Therefore, the lawfulness, effectiveness, and ethical issues must be considered because of the impact that they may have on an individual with an intellectual disability. Whilst considering the lawfulness and ethical concerns of the use of a restrictive practice, it is important to understand what category or type of behaviour is displayed.

In summary, challenging behaviour is an umbrella term, whereas a rather significant finding was that of Bowering *et al.,* (2017, p.22) where they define what type of behaviours qualify under the structure of 'challenging behaviour'; "Self-injurious behaviour, Aggressive–destructive behaviour and Stereotyped behaviour". This clearly identifies the range of behaviours that would be present in services for adults with an intellectual disability. Henceforth, the categories of, Self-injurious behaviour, Aggressive–destructive behaviour and Stereotyped behaviour, appears to give a distinct insight into all challenging behaviours in a disability setting.

2.3.1 Self-Injurious Behaviour, Aggressive–destructive Behaviour and Stereotyped Behaviour

Self-injurious behaviour (SIB) can be defined as "a series of aggressive behaviours that an individual directs towards themselves, which include head banging, self-biting, skin scratching, hair pulling and hitting oneself against hard objects" (Steenfeldt-Kristensen *et al.,* 2020, p. 3858). This inherently causes damage to the individual themselves. With a prevalence rate of 4-17% in adults with an intellectual disability, it can be expected as a regular occurrence in services for adults with an intellectual disability (Cooper *et al.,* 2009). According to Bowring *et al.,* (2019) in their most recent study, it was found that the prevalence of self-injurious behaviour in adults with an intellectual disability is 7.5%. Additionally, it is evident that the range of severity and type of SIB can vary depending on whether an individual is diagnosed with Down syndrome, Fragile X syndrome or on the Autism Spectrum Disorder (ASD). Richards *et al.,* (2012) point out that individuals who are diagnosed with Down syndrome, or Fragile X syndrome have similar and well-documented behavioural phenotypes. This means that from past analysis and observations certain behaviours are pre-determined due to the diagnosis. Crawford *et al.,* (2019, p.2914) in agreement, state "the presence of self-injurious and aggressive behaviour in individuals with ID has been associated with specific behavioural characteristics". Whereas individuals who are on the Autism Spectrum Disorder whose behaviours can vary, or be inconsistent have a more severe impact regarding harm to the individual (Crawford *et al.,*2019). Characteristics of SIB include self-biting, head-slapping, picking at skin, gouging or striking the body or eating inedible material (Pica) (Richards *et al.,* 2012). Pica is according to Xiang *et al.,* (2018) a compulsive eating disorder in which people eat non-food items.

SIB is not challenging to professionals who work with these individuals in the context of the safety of others, however, the behaviour itself is a challenge to the individual (Friedman, 2020). It appears unlikely that staff are in any way physically susceptible by an individual displaying SIB. Nonetheless, perhaps due to the risk of mild to severe physical mutilation, or injury of the individual displaying SIB a restrictive practice or intervention may be required for the safety of the individual displaying SIB (Griffiths *et al.,* 2022).

McDiarmid *et al.,* (2021) highlight that, health and social care professionals have a duty of care to adults with an intellectual disability. This means that health and social care professionals have a responsibility to ensure that adults with an intellectual disability are protected from harm and must ensure positive wellbeing. Duty of care can be defined as “an obligation to conform to certain standards of conduct for the protection of others against an unreasonable risk of harm” (McDiarmid and Crestani, 2019, p.1). Health and social care professionals are legally obligated to protect adults with an intellectual disability from harm (CORU, 2017). Therefore, regarding challenging behaviours in services for adults with an intellectual disability, it is the responsibility of health and social care professionals to ensure that safety is provided, regardless of the type of challenging behaviour presented.

Aggressive-destructive challenging behaviour is common in services for adults with an intellectual disability, according to Tyrer *et al.,* (2016). It can be characterised as “as any instance of throwing items, kicking or banging on surfaces, sweeping items off a surface, breaking, tearing, or otherwise rendering any item non-functional” (Foxx and Meindl, 2007, p.86). Therefore, suggesting that this specific behaviour of aggressive-destructive, can cause physical harm to the individual’s environment and to those around them. In terms of aggressive-destructive behaviour within services for adults with an intellectual disability, it is evident from research by Foxx and Meindl (2007) that the characteristics of this behaviour can lead to the destruction of personal items. Such personal items can either be belongings of the individual displaying this behaviour or a peer's personal belongings, if living in a residential setting with other individuals. In addition, Rojahn *et al.,* (2012) provide similar characteristics whilst also including hitting, kicking, punching, pinching or biting others and spitting at others. According to Bowring *et al.,* (2019), their most recent study found that the prevalence of Aggressive-destructive behaviour in adults with an intellectual disability is 8.3%. Overall, aggressive-destructive behaviour can be deemed challenging, as the actions may require some form of intervention for the safety of the individual themselves or those around them. However, using a restrictive practice on the individual may also escalate the behaviour, therefore it may also present a secondary trigger.

The term 'stereotype' is in general, an overgeneralised belief about a particular category of people or group (Oakes *et al.*, 1999). Whereas, stereotyped behaviour when applied to individuals with an intellectual disability can be defined as "peculiar or inappropriate voluntary acts that occurred repetitively and habitually" (Van Ool *et al.,* 2018). The term 'peculiar' suggests a behaviour that is not normal, it does not fit societies 'norm'. In a similar way, Vollmer *et al.,* (2014 in Sturmey and Didden, 2014) provide that stereotypic behaviour includes but is not limited to hand-flapping, body-rocking and vocalizations. The repetitive nature is a key attribute to stereotyped behaviour in adults with an intellectual disability, as it may be ongoing and constant. In comparison, the term voluntary suggests that the behaviour may be a response to incident, stimulus or an individual, this is where stereotyped behaviour and self-injurious behaviour may be similar (Vollmer *et al.*, 2014). However, as stereotyped behaviour is repetitive in its nature Lewis and Baumeister (1982) disagree, and they suggest that stereotyped behaviour does not function as a response to an antecedent.

Bowring *et al.,* (2019) in their most recent study, found that the prevalence of stereotyped behaviour in adults with an intellectual disability is 10.9%. Additionally, such behaviours are linked with individuals with a specific diagnosis, such as individuals on the Autism Spectrum or Down syndrome. According to Sheth *et al.,* (2014, p.2496) some stereotyped behaviours associated with individuals with Down

Syndrome include but is not limited to: “high sociability, high rates of self-talk, noncompliance (stubbornness), attention problems, and compulsions”. Sheth *et al.,* (2014) highlight that such stereotyped behaviours can vary based on age and gender. Autism Spectrum Disorder or ASD is according to de Vaan *et al.,* (2019) a developmental disorder with many behavioural differences which may include but is not limited to: impairments of social interaction and communication and restricted, stereotypical, and ritualized patterns of behaviour. Again, the use of the term ‘ritualized’ links back to the repetitive nature of a stereotyped behaviour. Highlighting that whilst discussing stereotyped behaviour, any behaviour can be characterised as stereotypical if it is repetitive or ritualistic in its nature, however, it is to identify this in terms of the amount of time the behaviour is present.

Behaviour, in the context of services for adults with an intellectual disability, proved a challenge to define or identify, due to the inconsistency of its characteristics. It can be agreed on that behaviour in general, and behaviours of concern according to Watzlawick *et al.,* (1967) can be defined as a form of communication. The recurring use of the term ‘intentional’ regarding the use of a restrictive practice on an individual displaying challenging behaviour within practice indicates that negative implications would arise in result of a behavioural outburst (Finn and Sturmey, 2009). This indicates that there is inconsistency in relation to whether staff within a disability setting consider behaviour to be a form of communication, and furthermore, what is considered ‘acceptable excessive force’ to restrict a persons’ movement or behaviour regarding the use of a restrictive practice. However, the objectives and purpose of education and training for professionals working within disability services may provide clarity regarding the use of restrictive practices.

An additional aspect of challenging behaviour includes inappropriate sexual challenging behaviour (The Challenging Behaviour Foundation, 2021). Inappropriate sexual challenging behaviours characteristics may include, but are not limited to, “self-directed masturbation, attempted masturbation, other directed such as inappropriate touch to staff or to client, invasion of personal space and inappropriate communication” (Lockhart *et al.,* 2009, p.296). According to Lockhart *et al.,* (2009, p.293) “inappropriate sexual behaviours are a subset of challenging behaviours”. This indicates that inappropriate sexual behaviours displayed by adults with an intellectual disability is not classified specifically as a challenging behaviour, however is displayed in conjunction with any challenging behaviour. However, Doyle (2004) differentiates challenging behaviour and inappropriate sexual behaviour, arguing that the characteristics of challenging behaviour focuses on the consequences of challenging behaviour on both the individual themselves and others rather than the behaviour itself. Whereas, inappropriate sexual challenging behaviour faces more serious consequences, in terms of the individual and the victim (Doyle, 2004).

There are similarities with both challenging behaviour and inappropriate sexual behaviour, however, the consequences differ. One significant factor associated with challenging behaviours and sexual inappropriate behaviours, according to Boer and Iyer (2020) can be that they are offending behaviours. However, according to Boer and Iyer (2020) one factor that determines whether the behaviour is offending or not, is an individual’s cognitive ability which as previously discussed includes mild, medium, severe and profound. Boer and Iyer (2020) suggest that if an individual with a mild intellectual disability diagnosis engages in inappropriate sexual challenging behaviours, the consequences would be more severe. This is because they have a better understanding what is, and what is not, acceptable behaviour. In comparison, an individual with a severe intellectual disability diagnosis would not receive a severe consequence or any consequence at all. This is because the individual may not have the capacity to understand what it is that they are doing. However, according to Smith and Willner (2004), regardless of an individual’s capacity and cognitive ability, the impact of inappropriate sexual challenging behaviour on staff, proves to have negative psychological consequences such as, stress, fear and the inability to provide effective care for the individual displaying such behaviours. Furthermore, although inappropriate sexual challenging behaviour is not considered as a stereotypical challenging behaviour, it is evident from literature and previous research that it is prevalent within services for adults with an intellectual disability.

Overall, these categories of challenging behaviours that occur within services for adults with an intellectual disability have some of overlap. These characteristics of these behaviours, to be considered challenging, are repetitive and/or occur regularly (Wolkorte *et al.,* 2019). Additionally, these behaviours are considered not normal or abnormal, behaviours as such, would not be expected to occur in everyday 'normal' society. Furthermore, the behaviours displayed may not always be a risk to the safety of staff or other individuals within a disability service. The behaviours discussed, such as self-injurious behaviour where an individual may be causing harm to themselves and/or aggressive-destructive behaviour where an individual may be breaking or destroying property either belonging to themselves or others. The staff that provide care for adults with an intellectual disability, have a duty of care and are responsible for the safety of all those in their care and therefore, a restrictive practice may be necessary to achieve and maintain safety within the service. However, trainings for professionals regarding challenging behaviours and restrictive practices, are an additional method of ensuring such practices are completed safely, not to cause further harm to the service user or place others at risk when being implemented.

2.4 Education and Training for Professionals regarding Restrictive Practices and Challenging Behaviours

> *Staff provide the interface through which national, regional, and organisational philosophies and policies are translated into practical action directly affecting the lives of people with intellectual disabilities* (Hatton *et al.,* 1999, p.270).

Regarding the use of restrictive practices on individuals who display challenging behaviour, those working with individuals who display such behaviours "must ensure that there are appropriately skilled and qualified staff available at all times" (Department of Health, Ireland, 2020, p.8.). 'Appropriately skilled and qualified' determines that professionals must meet the requirements set out by any organisation, course or training before engaging in any form of restrictive practice in managing a behavioural outburst. Similarly, Chan *et al.,* (2013) in an Australian study, state that individuals, or staff, working within disability services must be appropriately trained. However, no specific requirements are mentioned. This may imply that, a framework of policies, education or training must be available/provided to professionals working with individuals who display behaviours of concern, however no specifications have been listed. In agreement Rojahn *et al.,* (2012, p.528) state that challenging behaviours "have a variety of negative effects for the individual as well as for family members and service providers, often so much so that they require some form of intervention". However, the vagueness surrounding the threshold point at which an intervention may be implemented and what is deemed appropriately skilled and qualified is apparent. In Ireland, a "care assistant, is a care role where the worker is required to assist in the physical care needs of people within their own home or disability or elderly care services. The qualification level for care assistant is QQI level 5" (Lyons, 2017, p.42). Other professionals employed in intellectual disability services include who work directly with adults with an intellectual disability include, "Occupational therapy, Physiotherapy, Psychology, Speech therapy" (Workability, 2022, p.1), however such professionals are categorised as specialist support jobs and would not work with adults with an intellectual disability regarding personal and intimate care (Workability, 2022). Professionals that provide personal and intimate care for adults with an intellectual disability include, healthcare workers, social care workers and intellectual disability nurses (HSE, 2022). However, irrespective of the qualification a professional receives, additional specific training is required regarding, responding to challenging behaviours (HIQA, 2019).

The Faculty of Learning Disability Psychiatry Ireland (2016, p.3) outline that "service providers should ensure that all staff working with people with ID and challenging behaviour are trained to deliver proactive strategies to reduce the risk of challenges, working with individuals with an intellectual disability who display behaviours that challenge". Yet, as previously mentioned this is vague, there are no specific requirements, or indicators, provided throughout the text of what training is required by staff when working with such individuals. Services, however, must meet a standard of ethical morals or tokenism in setting out policies and procedures in accordance with National Standards, Guidelines and the United Nations Convention on the Rights of a

Person with a Disability. Tokenism is, in the context of staff education and training, ensuring that staff receive training to meet regulation standards (Anand, 2019). Training regarding restrictive practices and challenging behaviours may be considered a “camouflaging technique” where there can be no repercussions (Anand, 2019, p.2). Staff or individuals with an intellectual disability living within a residential care setting may not be allowed to protest if an injury or negative experience occurs as the ‘box’ has been ticked that they received the training and if an injury did occur the service or organisation cannot be held liable as they provided the necessary training. As mentioned previously, there has been a sense of ambiguity surrounding the impact or negative implications of the use of restrictive practices/interventions on individuals with an intellectual disability and those who provide their care (Mackelprang *et al.,* 2022). Therefore, the importance of clear requirements is critical to remove ambiguity surrounding training or education requirements.

In addition to the importance of staff training regarding the use of a restrictive practice, the Royal College of Psychiatrists (2018, p.12) state that “services should record, monitor, and report the full framework of techniques used”. The monitoring and recording of the use of a restrictive practice highlights that there is legitimacy behind it. Organisations need to ensure that restrictive practices are being used in accordance with the standards, policies, and legislation on restrictive practices. Similarly, in Ireland The Health Information and Quality Authority (HIQA) inspect and monitor disability residential services. The aim of these inspections is to “focus the attention of providers and persons in charge on certain critical aspects of care and service delivery” (HIQA, 2019, p.2). HIQA also provide a set of guidelines, namely, ‘Guidance on promoting a care environment that is free from restrictive practices’ (2019) which set out guidelines to improve services and the quality of lives in accordance with the HIQA National Standards for Residential Services for Adults with Disabilities (2013). However, the ‘Guidance on promoting a care environment that is free from restrictive practices’ (2019) is a ‘guidance’, they are not a set of standards or legislation, whereby a service will not be legally penalised if the guidelines are not put into practice. Therefore, HIQA record and monitor intellectual disability services, of the use of restrictive practices through inspections. Coulton *et al.,* (2015 in Kelly *et* *al.,* 2019) suggest that “the research community, through its scrutiny of existing datasets over specific time periods, could assist policy makers with monitoring and evaluating implementation strategies”. This suggests that to gain everyday inspection of services evidence must be presented through research of how services may be monitored on a daily occurrence. However, as funding for intellectual disability services is tenuous, it does not seem feasible for everyday inspections by HIQA to occur.

In addition to this, Emerson and Bromley (1995, p.388) argue that regarding restrictive interventions and behaviours of concern that interventions should be based “upon a thorough understanding of the function or the motivational dynamics underlying the behaviour in question”. This suggests that the importance of staff knowing the individual who displays behaviours that challenge well, and understanding the individual such as what may trigger this individual can be a key element in creating an in-depth care plan and choosing the best intervention or treatment. In agreement, Hayward (2011) argues that the management of the challenging behaviour depends on the level of risk posed, clearly suggesting that the intervention applied should match the behaviour expressed. Implying that the purpose of a restrictive intervention should be used in accordance with the behaviour that is expressed and should not do more that its’ intent. In a similar way Davies *et al.,* (2016, p.187) argue that “understanding the causes of challenging behaviour within any setting is essential when considering how to best utilise effective strategies to help reduce the frequency, intensity and duration of such behaviours”. Therefore, the concept of ‘understanding the behaviour’ that Davies *et al.,* (2016) argue, is also apparent with Emerson and Bromley’s (1995) argument where interventions should not be applied without a full understanding of the individual, the behaviour they present and the cause of such behaviours.

As noted previously, Ravoux *et al.,* (2012) and Allen *et al.,* (2007) argue that adults with intellectual disabilities who display behaviours that challenge are less likely to receive pragmatic- based management interventions. This may be the result of inadequate training or understanding of the individual. In comparison, Gates *et al.,* (2011) argue that if staff or caregivers, with adequate training and education are subjected to workplace violence, that it may have a negative impact on the care that is given. As the stressors that occur can create the element of fear and create perception of fear surrounding the individual who displayed challenging behaviours. Furthermore, the education and training received by professionals and those involved in providing care are crucial for effective service provision within intellectual disability services, particularly in responding to challenging behaviours, however, other factors such as stress and fear may be present which may impact the action taken. Therefore, the need for intervention/specific training is essential for the safety of the individual themselves and those who provide their care.

There are many forms of training regarding behaviours of concern, for example, Management of Actual or Potential Aggression (MAPA) training. MAPA training can be considered as a reactive strategy regarding managing actual and potential aggression. Aggression Management training claims to provide staff confidence and, the safest and least restrictive techniques to provide support to those displaying behaviours of concern (Heckemann, *et al.,* 2016). Heckemann *et al.,* (2016, p.574) also found in their study that "aggression management training increases skills, knowledge and confidence in dealing with patient or visitor aggression, but the emotional management remains a challenge". MAPA training or aggression management training can be categorised as a reactive response to individuals who display challenging behaviours (Ravoux *et al.,* 2012). A reactive strategy or response is when staff use a restrictive practice as a rapid response to the individual, who challenges to control their risky behaviour, in the safest and most effective way and to "reduce episodic severity" (Willis and La Vigna, 2012, p. 186).

Positive Behaviour Support Training is another training regarding challenging behaviours, it can be considered an alternative approach or proactive approach to managing challenging behaviours, or behaviours of concern. Positive Behaviour Support Training examines what triggers a certain behaviour and a non-physical de-escalation process. Haeyvert *et al.,* (2013, p.493) state that "proactive and reactive interventions are applied to reduce CB (challenging behaviour)". This means that proactive and reactive strategies are the main 'go to' strategies for professionals when working with adults with an intellectual disability who display challenging behaviours. However, Haeyvert *et al.,* (2013, p.493) argue that restrictive practices can have "effectiveness issues" and that the use of restrictive practices "can provoke additional challenging behaviours". This suggests that the use of restrictive practices can have a knock-on effect that may not be beneficial to the individuals that they are being used on. By comparison, Adams and Allen (2001, p.335) argue that "effective support for aggressive behaviour is likely to require both pro-active behaviours change strategies ... and reactive behaviour management plans". This by contrast with Haeyvert *et al.,* (2013), implies that a possible combination of proactive and reactive strategies can be effective when used to support individuals who display challenging behaviours.

De-escalation is, according to the Canterbury District Health Board (2018, p.3) "a complex interactive process in which the highly aroused individual is re-directed from an unsafe course of action towards a supported and calmer emotional state". Therefore, minimising the risk of a behavioural outburst using the least amount of restriction in the form of re-direction. Denne *et al.,* (2015) state "positive behavioural support (PBS) is the recommended intervention for people with intellectual disabilities at risk of behaviours that challenge" (Denne *et al.*, 2015, p.43). Positive Behaviour Support may be viewed as the recommended intervention as it considers a human rights-based approach, which limits taking away an individual's right to move freely. Positive Behaviour Support training correlates with the concept of a 'least restrictive setting' due to its nature and framework. It promotes a non-physical or mechanical approach. Carr *et al.,* (2002) describe key elements of Positive Behaviour Support training as "comprehensive lifestyle change, prevention, partnership, collaboration, multicomponent interventions, and systems change" (in Kincaid *et al.,* 2006, p.183). Such elements take into consideration not just the behaviour of concern, but rather look at the antecedent of the behaviour. A multi-disciplinary team and in some cases family members come together to determine which approach is best suited, promoting a least restrictive setting. The application of Positive Behaviour Support may be interpreted as a proactive response, as it limits the impact of the use of a restrictive practice or restraint and makes considerations for the rights of an individual with an intellectual disability. However, Randell *et al.,* (2017, p.2) challenge the framework of Positive Behaviour Support training, stating that it has “no outcome measures designed to assess staff empathy”.

By contrast, the *Who’s Challenging Who?* (WCW) training, according to Randell *et al.,* (2017, p.1) “is designed to emphasise the role of staff in residential settings as a challenge also to people with intellectual disability”. This training course is delivered by two trainers, an individual who has an intellectual disability and an individual who does not have an intellectual disability (Randell *et al.,* 2017). Similarly, Hastings *et al.,* (2018, p.799) argue that the *Who’s Challenging Who?* training is specifically designed to support staff and was “designed to fill the gap in the research literature for an empathy/attitude change intervention”. The *Who’s Challenging Who?* training is specifically designed for intellectual disability services and is based on the experiences of individuals who display challenging behaviours, healthcare professionals and family members, however, it is based fundamentally on the stigma that surrounds mental health (Hastings *et al.,* 2018). Evaluating the effectiveness of this training, Hutchinson *et al.,* (2014), conclude that there was immediate positive change in staff and there was long -term and short -term change for staff responding to individuals who display behaviours of concern. Hutchinson *et al.,* (2014) also point out that staff perceptions’ on challenging behaviour also changed as they were able to listen to real life experiences from the course trainer who has an intellectual disability. Moreover, this training provides a person-centred, pro-active response to individuals who display challenging behaviours by including a trainer who has an intellectual disability but also by challenging staffs’ cognitive reasoning.

There are many other different types of training that are available in managing challenging behaviours which include but is not limited to:

Multi-Element Behaviour Support (MEBS) is, according to Doody (2009, p.294) “a structured and formal model for the delivery of PBS. It is a framework for systematically assessing and drawing up interventions that are functionally based, to meet the individual needs of persons with behaviours that challenge”. This means that MEBS training is a proactive response to challenging behaviours. MEBS training also focuses on the idea that difficult, or challenging behaviour, is a form of language (Callan Institute for Positive Behaviour Support, 2010). As previously mentioned, behaviour is a form of communication and therefore, MEBS training suggests a better understanding of what behaviour is rather than the actual behaviour itself.

Risk Management, in the context of services for adults with an intellectual disability, involves "choice making in the context of uncertainty through the weighting of possible rewards against probable harms" (Wiesel *et al.,* 2021, p.36). The Health Service Executive (2007, p.3) state that effective risk management should include: "Better patient care, a more proactive approach to managing risk, reduced likelihood of unexpected events and a more open culture". As previously mentioned, there has been history of abuse in social care services in Ireland (Scheirs *et al.,* 2018), therefore, the suggestion of a more open culture regarding risk management suggests that Ireland may be moving towards a more proactive response to challenging behaviours.

The Challenging Behaviour Attribution Scale is a questionnaire for individuals who display challenging behaviours, however it has been adapted from previous research on staff experiences with challenging behaviour (Hastings, 2007). Hastings (2007, p. 496) states that professionals are given "a description of a challenging behaviour and were asked to rate the likelihood that each behaviour occurring". The Challenging Behaviour Attribution Scale is not a 'training' in strict terms, however, is a tool used in conjunction with trainings regarding challenging behaviours in social care services. The Challenging Behaviour Attribution Scale provides a reflective exercise for professionals working with adults with an intellectual disability, as they must analyse the behaviour presented by individuals they care for, which also promotes person-centeredness.

Advanced MAPA Training, is similar to MAPA training, but is a more advanced approach when working with challenging behaviours. Advanced MAPA training according to Crisis Prevention Institution (2021, p.1) "enables staff to identify higher risks and intervene appropriately, without putting themselves or the patient/service user at unnecessary risk". There has been little to no research on Advanced MAPA training, therefore, the Crisis Prevention Institution who is the provider of this training, offers an insight to what the training includes such as; "'Trauma Sensitive (Informed) Care', using a 'Safety and Support Plan', building non-verbal and verbal skills and giving participants an advanced understanding of how to manage fear and anxiety in a crisis situation and developing skills to give participants the ability to make more accurate assessments of behaviour so that effective preventive interventions can be used" (Crisis Prevention Institution, 2021, p.1). However, like MAPA training, Advanced MAPA is a reactive response to challenging behaviours.

Nidotherapy is according to Tyrer (2003 in Tyrer *et al.,* 2017, p. 522) "a new treatment approach that attempts to treat the problems of aggressive challenging behaviour in a different manner, not by treating the behaviour directly, but by changing the environment to create a better fit between the person and society". Similarly, Chamberlain and Sampson (2013, p.17) argue from their research that "nidotherapy-enhanced standard care was favoured over standard treatment or care for social functioning". Nidotherapy appears as an alternative approach to working with challenging behaviours and suggests a holistic framework.

By contrast to the trainings, regarding challenging behaviours, Ravoux *et al.,* (2012) argue that for staff, 'confidence' is a factor in engaging with individuals who display behaviours of concern, also that it is about knowing the individuals who display behaviours of concern. Davies *et al.,* (2016) argue that staff confidence is a contributing factor to the proactive use of a restrictive practice on individuals who display challenging behaviours. Factors that impacted the most on staff confidence to manage challenging behaviours were knowledge, experience and skill, management of aggression training, use of prevention and intervention strategies, teamwork and the staff profile" (Martin and Daffern 2006, p.90). Staff confidence appears to be a fundamental value, or skill, when working with individuals who display challenging behaviours. Davies *et al.,* (2016), found that staff confidence levels in working with individuals who display challenging behaviours, appeared to increase after receiving Positive Behaviour Support (PBS) training. Due to the increase in staff confidence when working with challenging behaviours, a positive or proactive response can be determined by how PBS training is fulfilled within disability services. By contrast, Tierney *et al.,* (2007) found that MAPA training, increases staff confidence when responding to challenging behaviours.

However, Adams and Allen (2001, p. 336) argue that staff training regarding the use of reactive strategies on individuals who display behaviours of concern have a "one size fits all" approach. This implies that when training is given to healthcare professionals it is generalised, and it is not specific to an individual or the behaviour they may express. As previously mentioned, challenging behaviours can present or be displayed differently by any individual with an intellectual disability, therefore the "one size fits all" approach to staff training appears unrealistic in the sense that the training would not be able to cover every aspect of challenging behaviour. In a similar way, Kaehne (2018) queries whether the one size fits all approach is justified regarding individuals within the care system, and different intellectual disability organisations. Additionally, The Department of Health, Ireland (2020, p.8) recommend that staff working with adults with an intellectual disability are "appropriately skilled and qualified". This does not clarify what type, or sort of skills are required, rather a baseline of what is expected of professionals working with adults with an intellectual disability. Similarly, Philips and Rose (2009, p.203) argue that regarding challenging behaviour "such services tend to provide less training and on-the-job coaching, and the training that does take place is likely to be less appropriate". This again highlights the term 'appropriate', for example, what is meant by appropriately trained and how is this evaluated. Although there are many different further trainings that social care workers and other professionals can avail of once qualified, it is widely agreed that the most important aspect that is needed for professional development is that of supervision (Carpenter and Webb *et al.,* 2012). Supervision focuses on "management and support, and the role is to teach, debrief, coach, assess, and to challenge the student" (Davys and Beddoe 2000 and Goorapah 1997, in Löfmark and Morberg *et al.*, 2009, p.8). Similarly, Carpenter and Webb *et al.,* (2012, p. 10) state that "supervision appears to help reduce staff turnover[7] and is significantly linked to employees' perceptions of the support they receive from the organisation".

In agreement, Hansung and Sun Young (2009, p. 365) state that within healthcare "effective supervision is essential to preventing burnout and turnover". However, according to the Health Service Executive Report on Health Sector- Staff Turnover (2019) there has been 6.2% staff turnover in Social Care, 9.2% staff turnover in Health and Social Care and 5.6% staff turnover in Healthcare Assistants, with Health and Social Care being the third highest staff turnover rate within the healthcare sector. These numbers suggest that staff working within these services, may not be receiving adequate supervision and/or support. The impact of effective supervision can help reduce stress experienced by staff, and can act as a coping resource, and therefore may prevent staff turnover (Hansung and Sun Young, 2009). This, in turn, may lead to a more positive and supportive environment when working with individuals who display behaviours of concern. In a similar way, The Health and Safety Authority (2007, p.1) provide a clear definition of what workplace violence is, "workplace violence occurs where people, in the course of their employment, are aggressively verbally abused, threatened or physically assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, wellbeing and health". This clarifies that workplace violence is any act or action from another that causes harm or hazard to an individual within a workplace setting. However, professionals employed in services for adults with an intellectual disability should not be subjected to violence at all in the first instance. The Social Care Ireland, Crisis Concern and Complacency report (2016, p.3) found that "90% of social care workers across a variety of social care settings had experienced workplace violence". Therefore, supports and measures that are in place for staff are insufficient regarding the safety and welfare of staff as incidents of workplace violence are still occurring.

In addition to a lack of supervision, another factor that is linked to staff turnover and challenging behaviour, is physical and verbal violence toward healthcare workers

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[7] A definition of *staff turnover* is the rate at which employees leave an organisation within a period of time, due to stress, workplace demands and burnout (Chiou, 2021).

(Rosenthal *et al.,* 2018). Chiou (2021) found that staff experiencing behaviours that challenge in the workplace, particularly aggression, has been linked with staff turnover and burnout[8]. This indicates that staff are experiencing challenging behaviours with presumably little support as this leads to burnout. According to Murphy (2021, p.1) in 2021 "there were 8,667 reports of assaults on HSE staff in 2020. Some 6,900 involved direct physical attacks, while 1,707 were verbal and 60 were sexual assaults". These numbers are the cases of workplace violence that were reported. In a similar way, Baker (2019, p.1) reported that "24% of social care workers reported they experienced workplace violence daily", Johnson (2021, p.1) reported "3,569 ambulance staff were physically assaulted by members of the public", and Fox (2022, p.1) reported healthcare workers experienced over "5,500 assaults, more than twelve a day, in the last fifteen months". These figures strongly highlight that workplace violence towards health and social care professionals is a significant issue within the health and social care sector in Ireland. In agreement, Philips (2016, p.1661) argues that violence towards healthcare professionals occurs daily and that "health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored". Similarly, Rosenthal *et al.,* (2018, p.585) argue that many healthcare workers are reluctant to report workplace violence for a number of reasons which include but are not limited to "multiple disconnected and laborious reporting systems, limited knowledge of reportable event criteria, healthcare worker reluctance to "complain," lack of education on post-traumatic symptoms, unfamiliarity with best reporting practices or available support services, and disinterest or cynicism about reporting sequela, such as counselling".

In addition to this, Philips (2016, p.1664) further argues that the reason why violence towards healthcare professionals is underreported is because of the "health care culture that is resistant to the belief that providers are at risk for patient-initiated violence and to a complacency in thinking that violence is "part of the job"". This suggests that a culture has developed within healthcare settings whereby employees are almost

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[8] *Burnout* is, in the context of individuals working within disability services, ''a prolonged response to chronic emotional and interpersonal stressors on the job, and it is defined by the three dimensions of exhaustion, cynicism and professional inefficacy'' (Maslach *et al.,* 2001, p. 397)

expecting to be harmed, either physically, or emotionally, on a regular basis. It appears that workplace violence is now considered part of the job, according to Keogh (2001 in Keogh *et al.,* 2016, p.10) who found that "social care workers often do not report incidents of workplace violence as it is perceived to be part of the job". This poses the query in relation to, why is it not reported? Is it considered 'normal' or 'expected' of social care workers or healthcare workers to be subjected to workplace violence? Whilst it may be inevitable that staff will be exposed to such experiences due to the nature of the health and social care sector, it appears that the level, and frequency of workplace violence is not managed effectively, such as the lack of supports and non-reporting of incidents. Lovell and Skellern (2013, p. 2264) provide an interesting insight why they believe workplace violence occurs and/or goes unreported:

- Lack of time
- Lack of support
- Classification of incidents as minor
- Reporting perceived as a waste of time
- Fear of repercussion

According to Hennessey (2016, p.1) "90% of social care workers had experienced workplace violence and staff expected to deal with situations take abuse 'because it's our job'". In agreement, Baker (2019, p.1) found that "40% of social care workers employed in the disability sector experience workplace violence on a weekly basis, and that a majority of those working in the sector feel their employers are not addressing the issue". Similarly, in an Irish study Keogh and Byrne (2016) and Emerson and Hatton (2000) found that social care workers working within intellectual disability services are the most affected by violence in the workplace. The healthcare profession is unlike any other profession, specifically those working within services for adults with an intellectual disability regarding violence in the workplace (The Health and Safety Authority, 2014). This may be because social care workers and healthcare workers work closely with the individuals they care for, and experience difficult circumstances, such as working with individuals who display challenging behaviours. Mech-Butler and Swift (2019) also question why workplace violence goes unreported and argue that employees working within intellectual disability services do not have an overall understanding of what the concept of workplace violence is. This may suggest that employees are not fully aware of their rights working within an organisation as a healthcare or social care worker. The low number of reports of violence in the workplace from staff may be a result of limited or insufficient training, support, or supervision (Song *et al.,* 2021). This again correlates with Philips' (2016) point, whereby a culture has developed of staff working within a healthcare setting not reporting cases of violence. Furthermore, Stevens *et al.,* (2019 in McKenzie *et al.,* 2021, p.26) argue that "a high level of burnout and turnover is not only detrimental for staff, but also has a negative impact on care quality and significant financial and organisational costs for employers". This is hindsight suggests that lack of staff or staff shortages has a negative impact on the care that staff provide.

Furthermore, the prevalence of staff turnover in healthcare settings and violence towards healthcare workers as discussed above suggests that training and education standards are not being met due to the statistical evidence provided. If the workplace culture of an organisation was favourable, the rate of staff turnover should not make it the third highest staff-turnover rate within Ireland. Therefore, it appears that a pattern has emerged whereby there is not a concise level of standards of training for professionals when working with adults with an intellectual disability who present with behaviours of concern, nor is there sufficient avenues to seek support in managing the impact of such experiences. Finally, it is important that specific and effective training and supports are provided for those who are involved with the care of adults with an intellectual disability, in order that staff turnover is minimised, and to that end effective care is being provided within disability services. It appears that a concise set of legislative standards should be followed regarding specific training and supervision for healthcare workers and/or a bill of rights for healthcare workers, which adults with an intellectual disability have.

2.5 The concept of a ‘Least Restrictive Setting’

In response to the concerns regarding the impact of the use of restrictive practices on adults with an intellectual disability, New Zealand have taken a different approach. Providing a perspective for the ‘least restrictive’ setting, which is to “maximise both the autonomy and safety of service users, and to reduce or prevent practices that restrict personal freedoms and are known to cause harm, such as restraint and seclusion” (Te Pou o Te Whakaaro Nuito, 2015, p. 5). The Health Information and Quality Authority (HIQA) (2017, p.79) states in the National Standards for Residential Services for Children and Adults with Disabilities that “the use of restrictive procedures follow outlined policies, procedures and best practice guidelines, takes the least restrictive approach to management, is clearly documented and is subject to review by the appropriate professionals involved in the assessment and interventions with the individual”. The phrase ‘takes the least restrictive approach’ indicates that Ireland is moving towards a least restrictive setting. Although it is not a separate standard in itself, elements of a least restrictive setting are found in Standard 3.3 of the National Standards for Residential Services for Children and Adults with Disabilities (2017), which indicates that disability services in Ireland should be moving away from the use of restrictive practices. Similarly, in the HIQA Guidance on promoting a care environment that is free from restrictive practice Disability Services (2019) state that services “should strive to deliver care in a restraint-free environment” (HIQA, 2019, p.5). The term *strive* suggests that services may not always be able to be restraint-free however, but aims to achieve and promote a least restrictive environment. This, in accordance with the New Zealand policy of a least restrictive setting promotes autonomy, safety for service users and pain-free techniques (Social Care, Local Government and Care Partnership Directorate, 2014).

Although the concept is generally associated with educational institutes for individuals with a disability or mental health facilities as stated by Aron and Loprest (2012), this concept can be interpreted to apply to individuals who would not fit societies ‘norm’, where accessibility would not present with any difficulty. The approach is instead, of setting forth a definition of what ‘restrictive practices’ are, promotes what elements a least restrictive setting should have in place. In a similar way, Palley (2006) provides what constitutes as a least restrictive practice which is an inclusive environment, which addresses an individuals' rights determining whether a restriction is necessary. The term 'necessary' provokes the opposite 'unnecessary', meaning that there should always be an alternative solution regarding the use of restraints.

The concept of a least restrictive setting, according to Ryan *et al.,* (2015) promotes the freedom and human rights of an individual, in-keeping with the United Nations Convention on the Rights of a Person with a Disability framework. Arguably, it provides more of a proactive strategy rather than reactive. As mentioned previously, reactive strategies can be defined "as one that has the purpose of bringing about the rapid or safe resolution of a behavioural incident" (LaVigna and Willis, 2005, p.48). This implies that a reactive response occurs amidst the incident or behavioural outburst. Additionally, Francisco *et al.,* (2020) argue that services for individuals with an intellectual disability are the most restricted due to challenging behaviours. In comparison, a proactive approach looks at de-escalating or eliminating targeted behaviour (Luiselli and Cameron, 1999). This suggests that proactive strategies limit the effects, emotional or physical stress, of a targeted behaviour or may decrease the chances of a behavioural outburst. Proactive strategies include environmental changes, timetabled based schedules, communication style or protective helmets (Poling and Normand, 1999). Similar to the New Zealand approach, Valle and Connor (2019, XIV preface) argue for a more proactive response in the context of restrictive practice dealing with behaviours of concern displayed or engaged in by a person with a disability "how we choose to respond to disability shifts significantly depending on whether we perceive that "something is 'wrong' with disabled people" or "something is 'wrong' with a social system that disables people". Again, this presents the idea that individuals with an intellectual disability do not fit societies norm and therefore the UNCRPD gives these individuals greater access to the society in which they live. The alternative of a 'least restrictive setting' whilst considering restraint minimisation may be the future for services for adults with an intellectual disability, as such services would offer person-centred and individualised care, whereby service users' capacity is addressed and their needs and wants.

In conjunction with the concept of 'the least restrictive setting' the term 'restraint minimisation' is often associated in the context of services for adults with an intellectual disability. According to the Canterbury District Health Board, New Zealand (2018, p.3), restraint is "the use of any intervention, by a service provider, that limits a patient's/ consumer's normal freedom of movement". In a similar way, Peisah *et al.,* (2019), in their Australian study, argue that a restraint or a restrictive practice is used by staff to manage behaviours of concern presented by individuals they care for. It is evident that both New Zealand and Australia have implemented parts of the United Nations Convention on the Rights of a Person with a Disability (UNCRPD), as mentioned that the term 'restraint minimisation' is a relatively new term and follows a HIQA, human- rights based approach (Riahi, 2019). Nonetheless, the concept of a least restrictive setting and restraint minimisation convey the ideology of an alternative setting regarding restrictive practices in services for adults with an intellectual disability. This perhaps has developed from the United Nations Convention on the Rights of a Person with a Disability.

2.6 The United Nations Convention on the Rights of a Person with a Disability

Throughout this literature review, The United Nations Convention on the Rights of a Person with a Disability (UNCRPD) has appeared in the background of many key factors contributing to the use of restrictive practices, such as rights restrictions, quality of life and human- rights based approach. The UNCRPD can be deemed as a framework for the change in disability rights globally, which over time has led to the change to legislation, policies and procedures and is arguably steering change of public opinion regarding the quality of life of individuals with a disability. The UNCRPD alone is a standpoint on how this has occurred, as it is the first legally binding treaty that has been signed internationally which focuses on the rights of individuals with a disability (Lombardi *et al.*, 2019). The UNCRPD has evolved from other United Nations Conventions such as the Declaration on the Rights of Retarded Persons (1971), the Declaration on the Rights of Disabled Persons (1975) and the

Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993). Therefore, according to Lombardi *et al.,* (2019) this is not a new phenomenon however, the 2006 UNCRPD compiles aspects regarding individuals' rights and quality of life (Lombardi *et al.,*2019). The influence of the UNCRPD has created a paradigm shift in Ireland's disability services from the medical model to the social model. Whelan (2017) mentions that, in Ireland, there has been a positive change whereby an emphasis has been placed on an individual's (living within a social care service) decision making and allows for choice.

According to Murphy and Bantry-White (2020), Ireland was amongst the first nations to sign the UNCRPD in 2007 however, it was not until the 7 March 2018, when the Irish Government finally passed a motion to ratify the UN Convention on the Rights of Persons with Disabilities– eleven years after Ireland signed the Convention. In comparison, The National Health Service (2018), United Kingdom, whereby the United Nations Convention on the Rights of a Person with a Disability has been ratified since 2009. Similarly, New Zealand and the Australian Government ratified the Convention on the Rights of People with Disabilities early on, in 2008. Doyle and Flynn (2013) highlight Irelands biggest difficulty in the ratification process was the ward of court system. The wardship system in Ireland is still compliable until The Assisted Decision-Making (Capacity) Act 2015, commenced. Therefore, Ireland had to first amend other laws before ratifying the UNCRPD.

The Statutory-Instrument. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, attempts to provide standards and clarity regarding what legal rights an adult with an intellectual disability in Ireland have. McCausland *et al*., (2018) demonstrate the key principles of the UNCRPD, "autonomy, choice, independence, equality and participation for individuals". (McCausland *et al*.,2018, p.876). Ireland's ratification of the UNCRPD has been the benchmark in determining disability rights in Ireland.

As previously mentioned, the use of restrictive practices neglects a person's human rights (HIQA, 2019). The National Health Service (2018), state in article 3.1, that restrictive practices are those which that "comprise a wide range of activities that either individually or in combination involve 'making someone do something they don't want to do or stopping someone doing something they do want to do'. Such acts risk engaging or possibly "breaching a person's human rights", which goes against what is set out in the UNCRPD. (National Health Service, 2018, p 5). Irrespective of the ratification of the UNCRPD, it is evident that the use of restrictive practices is increasing, as Campell (2018) reports that restraints or a 'restrictive practice' were used in UK services (intellectual disability services for adults) 2,200 times in 2016, the figure rose to 3,100 in 2017" (Campell, 2018, p. 1).

Although, the UNCRPD promotes the rights of an individual with a disability, there appears contradictions within services for adults with an intellectual disability regarding 'restrictive practice'. As mentioned previously, restrictive practices are intended to be used as a 'last resort' according to Deveau and McDonnell (2009), however they are widely used within services for adults with an intellectual disability. According to the Mental Health Commission (2021) report of the use of restrictive practices within health and social care services in Ireland, the use of physical restrictive practices declined, the use of mechanical restrictive practices increased, and seclusion was used in 41% of designated service providers. 'Restrictive practice' or "rights restraints" (The Health Information and Quality Authority, 2019, p.3) impinge on the rights of an individual within a service for adults with an intellectual disability. This highlights the need for involvement of adults with an intellectual disability's input in their care. The Ministry for Justice (2008) in the United Kingdom suggests that where a 'restrictive practice' or 'restraint' has an ongoing or frequent use, it can be deemed a deprivation of liberty. Deprivation of liberty in its simplest forms can be defined by "being under continuous supervision and control and not free to leave" (Blamires *et al.,* 2017, p.716). This implies negative connotations that a person is unable to move freely, as per with the UNCRPD.

Nonetheless, according to Beresford (2002) and Means and Smith (1998), since the late 1990s organisations and policy makers have been increasing the participation of individuals with an intellectual disability in policy making. This increasing involvement of both individuals with an intellectual disability and staff in their care, is one key element of a social care workers profession (Lalor and Share, 2013). It is evident that in Ireland the UNCRPD may not be implemented to its fullest, as disability services in Ireland are slowly moving away from the medical model and moving toward a social, human- rights based approach (Irish Human Rights Commission,2020). Additionally, The Irish Human Rights Commission (2020, p.1) argue that within disability services in Ireland, “more work needs to be done, both administratively and legislatively, to give the UNCRPD legal effect and practical meaning in the lives of disabled people”. This suggests that there is still a long way for disability services in Ireland to go to be able to meet the requirements set out by the UNCRPD.

2.7 The Professionalisation of Social Care: What does this mean for intellectual disability services for adults?

> *The professional provision of care, protection, support, welfare and advocacy for vulnerable or dependant clients, individually or in groups. This is achieved through the planning and evaluation of individualised and group programmes of care, which are based on needs, identified where possible in consultation with the client and delivered through day-to-day shared life experiences. All interventions are based on established best practice and in-depth knowledge of life-span development* (Joint Committee on Social Care Professionals, 2002, p.9).

The social care profession has existed for many years, the first definition of the characteristics of the Social Care Profession in Ireland was brought about in 2002 by the Joint Committee on Social Care Professionals. Historically, according to Boyd (2013) the Irish Catholic Church (both male and female religious orders) governed social care services, of which there was no regulation or inspection of services. Highlighting that children and adults with an intellectual disability were under the care of the Irish Government, to which the Catholic Church ideals were set forth by the Government of Ireland in the 1937 Irish Constitution (Nolan, 1975). During this time many cases of child abuse and abuse of vulnerable adults were reported.

The type of abuse that occurred ranged from sexual abuse by both male and female religious orders, to neglect and corporal punishment (Maguire and O Cinneide, 2005). A recent case of abuse occurred in Áras Attracta, run by the Health Service Executive (HSE), where adults with an intellectual disability were subjected to abuse (Murphy and Bantry-White, 2020). This case involved individuals who were living within this community residential- based service were subjected to being kicked, threatened, and prevented from using the toilet (Ó Cionnaith, 2014). Furthermore, this and other similar cases led to the recognition of regulating the Social Care Work profession. In a similar case in the United Kingdom, specifically Winterbourne View, Bristol, individuals with an intellectual disability were subjected to abuse and torture by individuals working with the service. Deveau *et al.,* (2014, p.36) describe the torture which occurred in this case as "prolonged verbal and physical assaults on specific clients". Other factors that contributed to the ongoing abuse and torture was fraudulent reports of incidents that occurred within the Winterbourne service. Nonetheless, both cases discussed are not isolated incidents, there are many cases of abuse and maltreatment of individuals within services for adults with an intellectual disability. However, although vocation of the social care worker has changed many of the primary characteristics remain the same with further legislation, policies and guidelines being introduced. This is to promote the confidence of the public in the profession, as the social care profession work with the most vulnerable members of society.

The social care profession is according to Lalor and Share (2013, p.4) "a profession committed to the planning and delivery of quality care and other support services for individuals and groups with identified needs". The social care profession covers a vast range of services for example youth and community, addiction, disability, homelessness and children and family. Therefore, as the profession can be applied to a variety of sectors within society, the definition of the profession can lack clarity. Lalor and Share (2005, p.4) define social care as a profession that "it is not just an ordinary job or that it is done on a voluntary or amateur basis, which distinguishes it from the (equally valuable) care that is carried out informally in Irish society by family and community members".

The Social Care profession has been mistaken for the social worker profession in public opinion; however, they present with very different job descriptions (Lalor and Share, 2013). Similarly, Lymbery (2006) argues that it is the differences in power that distinguish between the social care profession and the social work profession. The power differences between both occupations is, according to Browne (2006), that although the social care profession provides more personal care to individuals on a one-to-one basis, the social work profession has the authority to make decisions regarding the welfare and safety of an individual. This includes, removing an individual from a place of residence if they believe their rights are not being met, or if the care provided is not to standard. The social care profession can report cases where an individual is not receiving adequate care, or being abused, to a designated body. However, the social care worker does not have the power to lawfully remove an individual from a place of residence.

Currently, staff with social care and other qualifications may be employed as "healthcare assistants, project worker, outreach worker, aftercare worker, family support worker, support worker, care worker" (Byrne, 2016, p. 14). At present in Ireland, for an individual to work with adults with an intellectual disability, or within healthcare services, one must have received an education of at least level 5 Quality and Qualifications Ireland or Further Education and Training Awards Council course. This implies that social care is an umbrella term which covers many professions within the social care sector, including intellectual disability services. In agreement, the National Advocacy Unit (2014, p. 17) state that "health and social care professional is generally used as an umbrella term to cover all the various health and social care staff". Drennan *et al.,* (2018) highlight that the majority of healthcare assistants are employed within the social care sector, suggesting that not all social care qualified staff are in a position of a 'Social Care Worker' but rather 'Care Assistant'. This trend has been identified as the social care profession by CORU. This provides further insight into the inconsistencies within the social care sector given that staff may have received different levels of formal education yet are assuming the same role/title as a care assistant. This external training for professionals who are working with adults with an intellectual disability can vary depending on the procedures of an organisation regarding their policy on staff training.

The definition of social care is developing in Ireland, due to the forthcoming professionalisation of the social care profession. *Professionalism* "is a belief system that guides actions and highlights the critical role for professionals with regard to delivering competent services to society and protecting social values. Professionals have a mandate to enact the shared values and standards that govern their work and discipline" (Grus *et al.,* 2018, p.451). In Ireland, a reform began when CORU established the Social Care Workers Registration Board in 2015, this meant that social care workers must undergo statutory registration by CORU like doctors, nurses, physiotherapists etc. (Flynn, 2021). Social Care Ireland (2022, p.1) define Social Care Work as “a relationship based approach to the purposeful planning and provision of care, protection, psychosocial support and advocacy in partnership with vulnerable individuals and groups who experience marginalisation, disadvantage or special needs. Principles of social justice and human rights are central to the practice of Social Care Workers. This definition suggests that the social care profession covers an array of health, and social care services within Ireland, but more importantly it is a relationship-based profession. This definition also highlights that a certain standard of care must now be provided and is expected, and a legal responsibility is placed on social care workers. This definition further ensures responsibility, but also suggests that service provision may change regarding a least restrictive setting and follow a human-rights based approach.

Social care workers will be “answerable to” the service user, the disciplinary norms of social care practice, codes of behaviour and, in the near future, state regulatory mechanisms (Biesta, 2004, p.234) This upcoming professionalisation of the social care work profession has brought about governance and regulation to this profession. Similarly, the professionalisation of the profession was brought about due to the ambiguity of the social care role (Flynn, 2021). According to Chris (2018), social care workers provide more personalised care within social care services. The concept of more personalised care suggests working with an individual with an intellectual disability on a one-to-one level whilst considering the newly ratified UNCRPD.

On the 19 February 2019, S.I. No. 52/2019 - Social Care Workers Registration Board Code of Professional Conduct and Ethics Bye- Law 2019 was enacted into Irish law. Halton *et al.,* (2015) argue that in Ireland the “expanded regulation of health and social care professionals has occurred due to highly publicised cases of poor or dangerous practice” (in Byrne, 2016, p.16). The implementation of this in relation to the use of restrictive practices highlights that the social care profession can now be held accountable for their actions, the misuse of restrictive practice or ‘restraints. The core purpose of registration and professionalisation of social care workers under CORU is as stated by Hanrahan (2016) to increase public confidence in individuals working within the health and social care sector (in Byrne, 2016, p.12). As previously mentioned, the social care profession like doctors and nurses will have to register with CORU to practice (Hanrahan, 2016 in Byrne, 2016). The social care profession will be a recognised profession in Ireland. Moreover, registration with CORU will also include mandatory training and Continuing Professional Development (Byrne, 2016).

However, according to CORU (2020) the opening of registration to social care workers has been postponed from 2022 to 2023 due to the Covid-19 global pandemic. This is since the closure of educational institutions, the lack of review teams and the uncertainty the surrounding the progress of the pandemic (CORU, 2020). Therefore, the monitoring process of the professionalisation process has been put on hold temporarily, prolonging the uncertainty surrounding the professionalisation of the sector. In a similar way, Flynn (2021) argues that the lack of literature background and Evidence- Based Practice has slowed the professionalisation process in Ireland. Evidence-Based Practice, according to Aveyard and Sharp (2009, p. 4), is "practice that is supported by a clear, up-to-date rationale, taking into account the patient/client's preferences and using your own judgement".

2.8 Conclusion

In summary, this chapter provides an insight to the background on the use of restrictive practices in services for adults with an intellectual disability, which are often associated with negative connotations due to the history of abuse in health and social care services. Factors such as education and training for health and social care professionals, is essential for the appropriate implementation of restrictive practices and managing challenging behaviours. This review highlights and explores terminology associated with the use of restrictive practices and discusses factors that contribute to their use, moreover, examining how intellectual disability services for adults in Ireland strive to move towards a least restrictive setting. Proactive strategies, appear to provide a person-centred, and human-rights based approach, in conjunction with the UNCRPD. In addition, this review highlights gaps that are present regarding the use of restrictive practices in services for adults with an intellectual disability, such as the inconsistency of trainings for professionals regarding challenging behaviours and the justification for using restrictive practices. It is evident from literature, that there is no one fixed operational definition of the term restrictive practices, however, associated terminology provides some understanding of how, and why, restrictive practices are used within services for adults with an intellectual disability. This accentuates the rationale for this study, whereby further inquiry to the definition of restrictive practices, the effectiveness of training within services for adults with an intellectual disability and the impact associated terminology on restrictive practices used, is called for.

The following chapter will outline the design of this research study, presenting the theoretical framework, methodology and data analysis approach appropriate for this study.

3. METHODOLOGY

3.1 Introduction

The purpose of this study is to gain perspectives of professionals working with adults with an intellectual disability and those involved in their care. To gain these perspectives, empirical research was carried out to collect primary data. Primary data is, according to Hox and Boeiji (2005, p.593) "(original) data that is collected for the specific research problem at hand, using procedures that fit the research problem best". The term social research involves research that draws on possible gaps in literature or theories in fields such as "sociology, social policy, human geography and criminology" (Bryman, 2016, p.3). Similarly, Pole and Lampard (2002, p.2) state that by "conducting research, the researcher is attempting to make a contribution to his/her field of enquiry and, consequently, to what we know in the social world". The gaps that are present in literature or past studies act as a facilitator to this study and highlights the significance of why social research is conducted (Bryman, 2016). In is simplest form 'research' is about "finding or about producing knowledge we assume either that knowledge is there to be discovered or that is something created by the research process" (Pole and Lampard, 2002, p.3).

There are many different philosophical or learning techniques, epistemology "is a branch of philosophy concerned with how we know things" (Seale, 2018, p.10). Popper (2003 in Garrett, 2018, p.57) believed that "critical rationalism supported the principal of an objective reality, and that knowledge is objective (and not relative)". Therefore, meaning that knowledge is not limited or subjected to one form or learning.

Kuhn (cited in Borradori and Crocitto,1994) explains that with any social research and philosophical approach there are different methods of how knowledge can be obtained, how research is carried and how we make decision, this is known as a 'paradigm'. A paradigm is a set of assumptions and perceptual orientations shared by members of a research community. This determines that specific techniques are used regarding social science research (Seale, 2018). In conducting social research, qualitative or quantitative research methods are used, or mixed methods which is a combination of qualitative and quantitative (Bryman, 2016, p.634). In addition to the paradigm, there is also the question as to what type of data is being researched. According to Antonides (cited in Ranyard, 2017, p.54) empirical research is "based on data gathering and can be either deductive – testing hypotheses based on theory – or inductive – theory is constructed after data analysis, without testing a priori hypotheses". In simple terms, the term empirical, according to Punch (2014, p.2) means a "direct experience or observation of the world". Therefore, the researcher is exploring human experiences, observations or knowledge. In addition, the method that will be used to gather human experiences is a grounded theory approach.

The framework for this research also has elements of a grounded theory approach. The interview schedule has elements of grounded theory analysis which offers flexible yet systemic methodological strategies that provide clarity throughout the research process (Charmaz and Bryant, 2016). This chapter aims to discuss and argue the research design which is best suited to this study and to explore the process of how this research design was built.

3.2 Quantitative versus Qualitative Research

Quantitative and qualitative research have different research paradigms in that they both have distinctive belief systems that carry philosophical assumptions (Seal, 2018). Strijker *et al.* (2018, p.263) argues that "economics and parts of sociology are more quantitatively oriented, and geography and other parts of sociology more qualitative". Furthermore, Bryden (cited in Strijker *et al.,* 2018, p.263) states that "both approaches are based on completely different philosophical positions and assumptions about social research". As both methods of research, qualitative and quantitative are seen to have strengths and limitations, both were considered for the purpose of this research.

Quantitative research can be described as a "distinctive research strategy" (Bryman, 2016, p.149). According to Bryman (2016, p.694), quantitative research can be defined as "where the researcher works with quantifiable data, by collecting numerical or mathematical data". This means that the researcher collects numerical data through the means of questionnaires, surveys or polls (McGowan, 2014, cited in Punch, 2014). Spicer (cited in Seale, 2018) argues that quantitative research offers a structured approach, which suggests that data which is collected through quantitative methods is limited. Therefore, the data which is collected can be restrictive in terms of the quality of the answer. However, quantitative research offers, in the stage of analysis, unexpected patterns, interconnections between concepts and ideas may emerge (Seale, 2018).

Qualitative research, on the other hand, became well established and was employed in other social science disciplines including nursing, social work, education and communications (Fitzsimmons, 2012). Crossman (2019, p.1) states that qualitative research is typically where the study “collects and works with non-numerical data and that seeks to interpret meaning from these data that help us understand social life through the study of targeted populations or places”. In a similar way, Pole and Lampard (2002, p.4) characterise qualitative research as a method which “seeks to convey the essence or the quality of the experience”.

Similarly, Llewellyn *et al.*, (2004, p.213) argue that the goal of qualitative research is to “develop or construct theory from real-life data, not to test a theory”. Whereas in quantitative research the “hypotheses are constructed from general principles prior to data collection and the tested out during the study” (Llewellyn *et al.*, 2004, p.213). Qualitative research strategies are useful for the “generation of theories from data that occur naturally” (Silverman, 2011, p. 17). Therefore, theories or themes emerge from the data collected. The use of qualitative methods “are most useful in the beginning stages of the research process and can help in developing concepts, becoming aware of relationships between concepts and behaviour, and making sense of an often overwhelming amount of data” (Antonides, 2017, p.55). Similarly Flick *et al.,* (2004, p.3) state that “qualitative research claims to describe life worlds 'from the inside out' from the point of view of people who participate”. As this research study aims to collect human experiences and/or perspectives, the qualitative method offers this result. This means that the qualitative research method is best suited in gathering observations or perspectives of individuals.

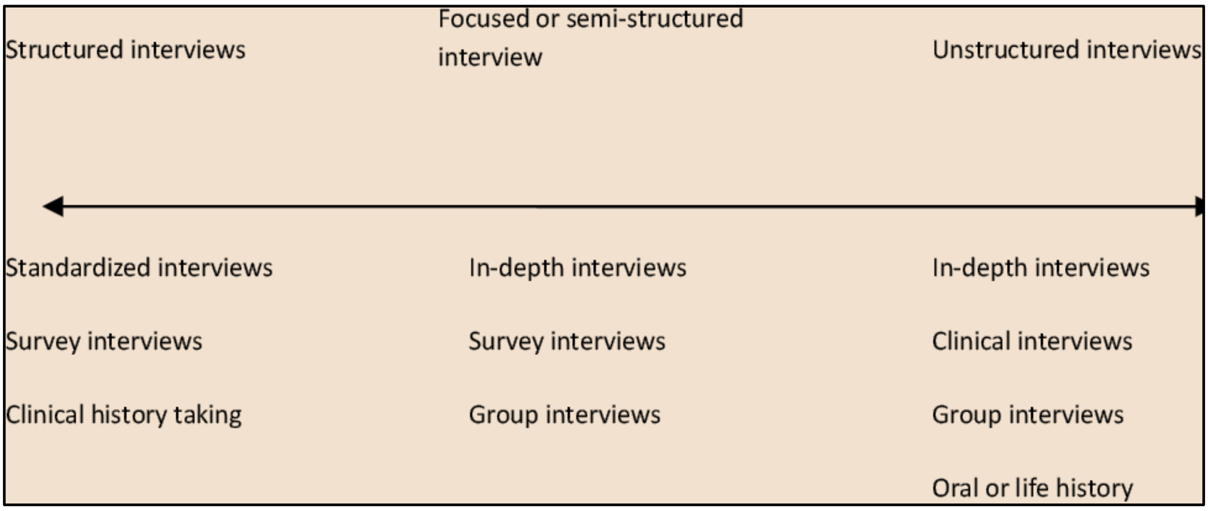
Qualitative methods include:

- In-depth Interviews,
- Focus Groups
- Content Analysis. (Antonides, 2017, p.55)

The use of qualitative research methods provides a greater insight in gaining empirical based knowledge. Parahoo (1997, p.59) defines qualitative research as "collecting data from respondents often in their natural environments taking into account how cultural social and other factors influence their experiences and behaviour". As this research study is steered towards human perspectives and/or experiences, the qualitative method may allow the researcher to gain in-depth experiences and/or perspectives of the interviewees, rather than the quantitative method, where the quantitative method would not function to allow for the type of data to be collected. The qualitative method was determined the best approach, and best suited to this research study as the researcher had the benefit of going to the source for their experience and/or perspective. Additionally, to gain extensive knowledge on the use of restrictive practices in services for adults with an intellectual disability, the qualitative research method was deemed best suited for this study as it allowed the researcher to gain unscripted views from various professionals based on their experience working both at managerial level and on the front line.

In consideration of both methods for this research study, the qualitative method offers a clearer insight to an individual's perspective on the chosen topic in comparison to quantitative. There are strengths and limitations of both research methods, one difference being that the quantitative method analyses numbers and the qualitative method analyses words. However, Miles and Huberman (1994, p.56) argue "that although words may be more unwieldy than numbers, they render more meaning than numbers alone and should be hung onto throughout data analysis". From the outset the research question shaped the formulation of the research method that was chosen as it sought the perspectives of restrictive practices in services for adults with an intellectual disability from professionals and those involved in their care. Therefore, by the process of in-depth, semi-structured interviews the perspectives and/or experiences of professionals and those involved with the care of adults with an intellectual disability were sought.

As previously mentioned, qualitative research methods include: “in-depth interviews, focus groups and content analysis” (Antonides, 2017, p.55). Interviews are a very good way in accessing a person’s perceptions, experiences and meanings (Punch, 2014). Whereby, Minichiello *et al.,* (1990) provide an insight to the continuum model for interviews.



Structured interviews	Focused or semi-structured interview	Unstructured interviews
Standardized interviews	In-depth interviews	In-depth interviews
Survey interviews	Survey interviews	Clinical interviews
Clinical history taking	Group interviews	Group interviews
		Oral or life history

Figure 1*: Continuum Model for Interviews (Minichiello et al., 1990, p.145)*

In-depth, semi-structured interviews were chosen as the most suitable qualitative research method as this allows for a flexible research design and open-ended questions in gaining the perspectives and/or experiences of professionals and those involved with the care of adults with an intellectual disability. Focus Groups and/ or Group Interviews were not considered suitable for this research as the research generally has less control on the information received and focus groups and/or group interviews tend to produce a chaotic data (Mansell *et al.,* 2004).

3.3 Research Design

A research design has been described as, “the plan for collecting and analysing evidence that will make it possible for the investigator to turn whatever questions he or she has posed into answers” (Flick *et al.,* 2004, p.146). A research design is a map for conducting research, it is also the overall plan for a piece of research, including four main ideas;

- Strategy
- Conceptual Framework
- Question of who and what will be studied tools to be used for collecting and analysing

(Punch, 2014, p.206)

According to Ary *et al.* (2010), the research design is the researcher’s plan of how to proceed to gain an understanding of some groups or some phenomena in its natural setting. However, Pole and Lampard (2002, p.11) argue that regarding the research design; “the initial design phase needs to maintain a degree of flexibility to accommodate changes necessitated as the research progresses”. This allows for the research design to be flexible in changes or limitations that may occur, as social research explores phenomena in the natural world, difficulties may arise that would lead to the researcher adapting to these changes.

Creswell (2003) highlights when undertaking qualitative research, it is done in a natural setting where data is collected by the researcher through words and analyses them empirically, focusing on the meaning of what is said and describes a process that is expressive. The natural setting around the world has changed as a result of the global pandemic, which means that while interviews may not be feasible in pre-existing natural environments, they will be conducted in the current environment, which is likely to be considered *new* natural setting. A natural setting, pre-global pandemic, in qualitative research involves conducting interviews in an environment that an individual is familiar with (Bryman, 2016). According to Pumberger *et al.,* (2020) to best contain the spread of the Covid-19 virus, many services, organisations and universities were shut down globally. Therefore, when carrying out this research study alternative methods of research were carefully considered which will be discussed in the procedure section. A semi-structured interview approach was determined best suited for this research design as it allows for broader conversation surrounding the topic in question. It also allows for new information to be collected and affords the ability to question further experts in the area. It does not restrict the research design. In addition to the use of semi-structured interviews, elements of a grounded theory approach were accomplished for this research design.

According to Gobo and Marciniak (cited in Silverman, 2016) grounded theory is a complex methodology but research employing this approach often starts with a question or with a collection of qualitative data rather than beginning with an established theory. Grounded theory was first introduced in 1967 by Glaser and Strauss (cited in Fitzsimons, 2012, p.60) and is "regarded as an inductive approach to research whereby hypothesis and theories emerge out of, or are grounded in, data". Grounded theory, according to Glaser and Strauss (1967, p.1) is, in its simplest form, "discovering theory from data". Charmaz (2014, p.3) also explains that grounded theory studies "empirical events and experiences and pursue our hunches and potential analytic ideas about them". This is when the researcher uses data that has been already collected and analysed to formulate theories which may influence the research study further. This study is not an example of a grounded theory approach in answering the research question, however, elements of grounded theory are borrowed for the purpose of analysing findings. Creswell (2009, p.13) describes grounded theory as "a qualitative strategy of inquiry in which the researcher derives a general abstract theory of process, action, or grounded in the views of participants in a study". On the other hand, Howell (2015, p.135) argues that grounded theory "is about building theory through the collection and analysis of rich data; that is data that exists below the surface of the social entity being investigated". The term 'rich data' coincides with "information-rich cases" as set out by Patton (cited in Llewellyn *et al.,* 2004, p.213) regarding purposeful sampling which is discussed further below. Therefore, the use of grounded theory emphasizes the quality of the information that is collected.

To build grounded theory research, there must be an overlapping of themes or codes (Ramussen *et al.,* cited in Jason and Glenwick 2016). This means that themes or theories emerge from the data collected. Coding in grounded theory according to Engler (2011, p.257) includes "read[ing] closely through field notes, documents or interview transcripts, making marginal notations, filling in database fields, or making notes on index cards". The codes or themes that emerge from analysis form concepts, which" are as yet entirely provisional; but thinking about these results in a host of questions and equally provisional answers'" (Strauss, 1987, p.28). Moreover, grounded theory argued by Engler (2011, p.269) "has great potential promise for building concepts and theories from empirical materials and as a way to assess the extent to which existing theoretical frames and categories of analysis are adequate to the empirical materials that we study". Therefore, grounded theory was chosen for this research study as new theories emerged from the data that was collected through examining the interviewee's perspectives and experiences and continual analysis of the data where themes began to emerge.

3.4 Semi-Structured Interviews

The interview according to Punch (2014, p.144), is the "most prominent data collection tool in qualitative research". Patton (2002, pp. 340-341) argues that "we interview people to find out from them those things we cannot directly observe … and we cannot observe feelings, thoughts, and intentions". For this research study, a qualitative method was adopted by conducting interviews for this research study. The type of interview that was chosen was the in-depth, semi-structured interview. A semi-structured interview, is a "term that covers a wide range of instances. It typically refers to a context in which the interviewer has a series of questions that are in the general form of an interview guide but can vary the sequence of questions" (Bryman, 2016, p.201). When carrying out a semi-structured interview, the researcher or interviewer relies on an interview guide that includes a consistent set of questions of topics, moreover, the researcher is allowed more flexibility to digress and to probe based on interactions during the interview (Blee and Taylor 2002 cited in Klandermans and Staggenborg, 2002). The use of a semi-structured interview guide also allows the researcher to ask interpreting questions, which allows the researcher to verify the interviewees views during the course of the interview "by offering tentative summaries and inviting participants to challenge or confirm their understanding" (Bosley *et al.,* 2009, p. 1499).

In addition, Holland and Ramazanoglu (cited in Byrne 2014, p.224) characterise interviews as "stylized social events". Therefore, formulating an argument that interviews may prove beneficial when undergoing social research, as viewed as a social meeting of two human beings. According to Cohen and Crabtree (2006, p.1) characteristics of a semi-structured interview include:

- The interviewer and respondents engage in a formal interview.
- The interviewer develops and uses an 'interview guide.' This is a list of questions and topics that need to be covered during the conversation, usually in a particular order.
- The interviewer follows the guide, but is able to follow topical trajectories in the conversation that may stray from the guide when he or she feels this is appropriate.

This means that the use of semi-structured interviews does not limit the approach to the interviewees' knowledge and/or experience and is therefore one example of why this type of interview was chosen. Semi-structured interviews "emphasize a more open-ended view of the research process" (Bryman, 2016, p.10). The term 'open-ended' provides the "opportunity for identifying new ways of seeing and understanding the topic at hand" (Cohen and Crabtree, 2006, p.1). This means that the interview guide is not limited by the answers that interviewees may give. The semi-structured interviews were conducted through Zoom and were audio-recorded through a mobile phone.

Zoom is "an innovative videoconferencing platform—has a number of unique features that enhance its potential appeal to qualitative and mixed-methods researchers" (Archibald *et al.,* 2019, p.1). Similarly, Sullivan (2012, p.60) states that "the potential for video conferencing as a research tool is almost unlimited". The use of Zoom for this research study had both positive and negative characteristics, which are listed below in Table 1, Carter (2019, p.1) states that the use of online video or audio calls allows "researchers to interview research participants anywhere in the world as long as the participant has access to a telephone or computer with a headset or webcam". Archibald *et al.,* (2019, p.4) argue that Zoom allows for the "the ability to see the researcher and respond to nonverbal as an important aspect of establishing rapport, building interpersonal connection". In addition to this Archibald *et al.,* (2019, p.4) found in their study that "participants and researchers commonly cited convenience, particularly in terms of access to geographically remote participants, cost-effectiveness, and time effectiveness, as a key advantage of Zoom".

As this study focused on intellectual disability organisations in Munster as the geographic location, Zoom facilitated this. The use of Zoom allowed for cost-effectiveness as neither the researcher nor the interviewees had to spend money or time travelling to a specific location within Munster. The use of Zoom benefitted this study as in-person interviews were not feasible, therefore, the advantages of Zoom allowed for an added-bonus. Zoom was chosen for this study in comparison to audio-telephone calls as the audio-visual allowed the researcher to build a rapport with the interviewees and to also be able to see body-language and facial expressions as one would see in a 'natural-setting', of a face-to-face interview. The advantages and disadvantages of using Zoom for this research study included but are not limited to;

Table 1: *Positives vs Negatives of using Zoom (LDA Research, 2021)*

	Positives √	***Negatives*** *X*
▪	Convenient	▪ Internet connection was not reliable
▪	Interviewees did not have to leave the comfort of their home.	▪ Poor audio or video quality
▪	Cost-effective	▪ Poor audio recording of interview
▪	Build rapport	▪ Possession of a webcam

However, it was evident that the positives outweighed the negatives, as although technical difficulties and internet connection was an issue it was solved quickly. However, according to Sy *et al.,* (cited in Roberts *et al.,* 2021, p.3) "virtual methods may also present new privacy concerns, as researchers may be intruding into participants' personal space, especially if participants are in their own homes and do not use a virtual background or have access to headphones". This concern was met throughout the interviews as many of the interviewee's were taking part from their homes and outside of their working hours. Moreover, the adapted layout of research, due to the Covid-19 pandemic, facilitated opportunities for the researcher to contact and select interviewees with ease.

3.5 Purposeful Sampling

"Qualitative research is purposeful; participants are selected who can best inform the research questions and enhance understanding of the phenomenon under study" (Creswell, 2009 and Kuper *et al.,* 2008 cited in Sargeant 2012, p.1). Purposeful sampling is, according to Patton (cited in Palinkas *et al.,* 2013, p.3), "a technique widely used in qualitative research for the identification and selection of information-rich cases". Patton (cited in Llewellyn *et al.,* 2004, p.213) argues that the "rationale behind purposefully selecting participants is to provide 'information-rich' cases for study in-depth". The term 'information-rich' used by Patton, highlights the query of what is considered 'information rich'? This term underlines the importance of sampling, and how interviewees were chosen to provide 'information-rich' perspectives. Purposive sampling is where participants are selected based on characteristics and experiences of a population and provides insights to the objective of the study (Crossman, 2020).

In addition, snowball sampling was accomplished throughout the research process. Snowball sampling according to Llewellyn *et al.,* (2013, p.226) "involves asking well-situated people (key informants) 'Who should I talk to?' or identifying examples that appear, on face value, to be information rich on the phenomenon of interest". This allowed for 'information-rich' perspectives and experiences and allowed for the researcher to gain access to a broader sample of professionals. Moreover, snowball sampling is used when there may be limited access or if there is a difficulty with coming into contact with a population (Sedgwick, 2013). Snowball sampling was used, specifically for this research study, as it was found to be difficult to come into contact with professionals working within intellectual disability organisations. The researcher was also adhering to the General Data Protection Regulation (GDPR). GDPR is a regulation under EU law that "protect(s) and empower(s) all EU citizens data privacy" (Ibáñez *et al.,* 2018, p.1).

Three intellectual disability organisations in Munster were specifically chosen for this research study and three participants were chosen from multiple agencies. The organisations chosen included two charitable organisations who are funded by self-fundraising and the Health Service Executive, and one private organisation, of the agency staff that were selected they came from charitable intellectual disability organisations. These organisations were chosen to facilitate the perspectives of a various professionals from both private and public (non-paying) organisations. These organisations were chosen to critically analyse the procedures that they follow and to allow for a range experiences of disability services within Munster.

It was not deemed suitable for this study to choose organisations across the entire island of Ireland, as only three organisations plus agency staff, were chosen and would not represent the perspectives of every professional working within intellectual disability services for adults in Ireland. Therefore, the geographical location was condensed, focusing on the perspectives of professionals working within intellectual disability services within Munster.

Another element that was involved in the sampling process was theoretical sampling. Theoretical sampling is according to Ramussen *et al.,* (cited in Jason and Glenwick 2016, p.24) "a purposive sampling process in which researchers select participants and groups for comparison in order to generate categories of meaning in their data". Additionally, Hood (2007, p.161) argues that theoretical sampling is "inductive and contingent", which means that theoretical sampling is based on the continual analysis of data “to direct further selection of participants” (Ramussen *et al.,* 2016 cited in Jason and Glenwick 2016, p.24). Theoretical sampling was chosen as it allowed this research study to branch off and identify gaps that were present during the initial analysis.

For this research study, the interviewees were specifically chosen based on their experience relating to the research question. According to Llewellyn *et al.,* (2004, p.212) “a good sample is a subgroup of a population which is regarded as representative in some way of the entire group or set of situations”. This research sample did not examine every individual or professional who provides care to adults with an intellectual disability, however a representative group of professionals working within the disability sector within Munster was purposefully chosen. A group of twelve interviewees were selected from a large population of professionals who work within intellectual disability services allowed for a range of perspectives and information.

3.6 Research Participants

As this research is based on the perspectives of professionals working with adults with an intellectual disability, professionals such as social care workers and healthcare workers who work on the frontline were specifically chosen.

The gender of the participants in this research study is mostly female (90%), this is reflective of the healthcare sector, which is predominantly female (Miyamoto, 2020). According to the HSE National Doctors Training and Planning ‘Medical Workforce Report 2020-2021’, the gender of professionals working within Community Healthcare Organisations in Ireland is, as of 2020-2021, “57% female to 43% male” (HSE National Doctors Training and Planning, 2020-2021, p.40). A Community Healthcare Organisation is according to Brennan *et al.,* (2018, p.6) “the operational delivery system that currently provides services outside of acute hospitals and is made up of four care divisions: Primary Care, Social Care, Mental Health and Health and Wellbeing”. Similarly, Regenold and Vindrola-Padros (2021) state that “globally, females account for 70% of the health and social care sector". However, this study found from the sample that the gender of the employee's working within intellectual disability services for adults was 90% female and 10% male. Although this study did not cover all the intellectual disability services in Ireland, the study did however find, in comparison, a higher percentage of female healthcare professionals to the HSE National Doctors Training and Planning, 2020-2021. Therefore, it was expected from the onset that the gender of the interviewees in this study would be predominantly female, as participants were specifically chosen from twelve intellectual disability services across Munster.

3.7 Rationale for Research Participants

Three groups of interviewees were specifically chosen as they are representative of professionals employed in residential intellectual disability services for adults and day services for adults across Munster. There are over twenty different intellectual disability organisations across Munster, which are either privately funded or funded by the Health Service Executive (HSE) (Freedom of Information, 2022). The three groups of interviewees were chosen from three key intellectual disability organisations, as a representative of health and social care professionals employed in services for adults with an intellectual disability. The three key intellectual disability organisations were selected, as it was determined that such services have a wider range of experienced professionals. The rationale for these groups is reflective on the type of information sought, professionals who work day-to-day and provide personal and intimate care for adults with an intellectual disability. Team leaders and/or managers were also chosen, this was to compare, and contrast with professionals who work day-to-day with adults with an intellectual disability. Although team leaders and managers also work with adults with an intellectual disability daily, they would not generally, provide personal or intimate care for service users. Agency professionals were also selected, for the purpose of a perspective from a professional not directly employed in such organisations of the use of restrictive practices in intellectual disability services for adults. The purpose of selecting such interviewees with different professional roles is to compare levels of responsibility, with regards to assessing, implementing, and reviewing restrictive practices in services for adults with an intellectual disability. Twelve of these interviewees were targeted because they have first-hand knowledge and/or experience working closely with adults with an intellectual disability, they are involved in personal and intimate care on a day-to-day basis, or if agency professional work in different intellectual disability services for adults within Munster. The sample that was chosen was purposive, this was to facilitate a broad collection of knowledge and perspectives from the interviewees.

Table 2: Details of Interviewees

	Qualification	Employed Role	Added Role	Date of Interview	Number of Years' Experience	Duration (minutes)
Interviewee 1	Social Care	Social Care Team Leader	Key Worker	23/06/2021	5	46:03
Interviewee 2	Social Care	Healthcare Worker		23/06/2021	3	40:27
Interviewee 3	Health Care Assistant	Healthcare Worker	Key Worker	04/07/2021	11	17:00
Interviewee 4	Health Care Assistant	Healthcare Worker	Key Worker	05/07/2021	15	19:03
Interviewee 5	Health Care Assistant	Healthcare Worker		06/07/2021	1	38:20
Interviewee 6	Social Care	Social Care Worker		07/07/2021	2	36:36
Interviewee 7	Social Care	Social Care Worker		09/07/2021	2	29:02
Interviewee 8	Health Care Assistant	Manager		12/07/2021	11	26:13
Interviewee 9	Social Care	Social Care Worker	Key Worker	03/08/2021	7	28:55
Interviewee 10	Social Care	Healthcare Worker		03/08/2021	3	32:44
Interviewee 11	Social Care	Social Care Worker	Key Worker	26/08/2021	2	22:37
Interviewee 12	Social Care	Social Care Team Leader		01/10/2021	5	19:08

It is evident from Table 2, that there were three distinct professions identified, Social Care Worker, Healthcare Worker and a Manager. It was identified that five interviewees with a Social Care Work degree are employed as their qualified profession, three Healthcare Workers are employed as their qualified profession and three are employed in a profession that is not their specific qualification. This suggests that professionals with a Social Care Worker qualification can be employed as Healthcare Workers, as the roles/responsibilities may be interchangeable. Similarly, interviewee 8 (manager), deemed to have most relevant experience does not specifically have a qualification in management, but has completed internal trainings within the organisation to attain such position. It is also evident that four interviewees have an added title of 'Key Worker', the roles of the professions identified will be further discussed in section *4.4.1 Social Care Profession within Services for Adults with an Intellectual Disability.*

Table 3: Employment Background of Interviewees

	Type of Intellectual Disability Service
Interviewee 1	Residential Service for Adults Day Service for Adults
Interviewee 2	Residential Service for Adults Residential Respite Service
Interviewee 3	Residential Service for Adults Residential Respite Service
Interviewee 4	Residential Service for Adults
Interviewee 5	Residential Service for Adults Day Service for Adults
Interviewee 6	Residential Service for Adults
Interviewee 7	Residential Service for Adults
Interviewee 8	Residential Service for Adults Residential Service for Children
Interviewee 9	Residential Service for Adults
Interviewee 10	Residential Service for Adults
Interviewee 11	Residential Service for Adults
Interviewee 12	Residential Service for Adults

3.8 Ethical Considerations

The nature of the key research question may generate potential issues. This is due to the overall nature of restrictive practices whether it is safe, ethical or legal. Therefore, when undergoing interviews with professionals and those involved in the care of adults with an intellectual disability, ethical considerations are of most importance (Edwards and Mauthner, 2002).

Ethics is "a branch of philosophy which addresses issues of human conduct related to a sense of what is right and what is wrong and as such it may be regarded as a society's code of moral conduct" (Remenyi *et al.,* 2011, p.1). Throughout any research process, ethical considerations must be accounted for. As ethics is the study of "what are good, right or virtuous courses of action" it was a significant part of this research study as ethics concerns the morality of human conduct (Oancea, 2014, p.36) (Edwards and Mauthner, 2002).

This study focuses on experiences and knowledge of human participants therefore, respect must be afforded to them. When setting out the research design it was determined that ethical considerations were paramount due to the sensitive nature of the study and the vulnerability of the individuals' experiences. The concept of 'do no harm' regarding ethics in research is reiterated throughout the research process. The core purpose of this research procedure was to 'do no harm', this was addressed by considering key factors associated with a 'do no harm' concept as stated by Favaretto *et al.,* (2020) which include consent, confidentiality, using appropriate communication methods and of social media platforms. The use of appropriate communication was a key feature in ensuring that potential interviewees were minimised from harm as this study was carried out during the Covid-19 Pandemic, whereby individuals relied heavily on technology and social media platforms to communicate with others and to possibly work from home. Therefore, strict measures were used to communicate with potential interviewees, email to invite potential interviewees to participate in this research study and Zoom, as the virtual communication platform. Byrne (2014, p.226) argues that it should be clear that “research should not inflict harm on interviewees but in some cases the subject matter may be such that it is difficult to predict what is going to cause distress”. This means that there should be no purposeful intention of harm when conducting interviews. This was ensured by engaging with interviewees in a respectful and caring matter, but also by informing interviewees of the nature of the interviewee before beginning and reiterating that they were free to stop and take a break, or refuse, to answer any question without having to give an explanation in relation to why they may wish to leave the interview at any stage (Allmark *et al.,* 2009). As mentioned previously, due to the sensitive nature of this research topic, once each interview was concluded, interviewees were referred to a relevant counselling service or support service (see Appendix G).

As this research study was carried out during the Covid-19 pandemic, the “traditional data collection methods became unfeasible during physical distancing” (Sy *et al.,* 2020, p.600). Therefore, modifications were made regarding the data collection procedure and most important, ethical considerations. As previously mentioned, adaptations were made regarding ethical concerns when using a webcam for conducting online interviews. Lobe *et al.,* (2020, p.7) argue that “most of the fundamental ethical issues in online interviewing are the same as in face-to-face contexts”. Another ethical consideration that was accounted for was the use of the Zoom waiting room feature, this was used to prevent any uninvited persons’ from joining and to protect the interviewee’s privacy. In addition, Zoom’s built-in recording feature records both audio and visual, however it does not allow audio recording without visual (Roberts *et al.,* 2021). Interviewees consented to audio-recording of their interviews, this meant that the use of Zooms recording feature was not feasible. Therefore, interviewees were audio-recorded through a mobile phone whilst using Zoom as the main platform of virtual communication. In comparison to a face-to-face interview, it was found that the modifications that were made regarding ethical considerations for a virtual interview were minor.

Additionally, because of the nature of this research topic, it was important throughout this research process that the researcher remained non-biased. Bias is, according to

Pannucci and Wilkins (2010, p. 1) "any tendency which prevents unprejudiced consideration of a question". Therefore, it was critical that the researcher remained conscious of their own inherent bias throughout the research process, in order for an objective viewpoint of the findings.

Another important aspect of ethical considerations is that of sustaining confidentiality and privacy. Ali and Kelly (2014) state that most research studies involve an invasion of privacy at some level. Confidentiality "arises from respect for the right to privacy and functions as a pre-cautionary principle" (Punch, 2014, p.27). Moreover, for this study interviewees were assured at an early stage that personal information provided will remain confidential, and utmost care will be taken to ensure that they will not be identified in the study. This was achieved by clearly stating on the consent form given to all interviewees, that all personal information provided will not be used in the research study. Additionally, interviewee's names, and names of organisations will be anonymous, this is to ensure that the data within the research cannot be used to identify the interviewee's names or places of work. These components are for the purpose of protection of individuals partaking within the research and to overcome obstacles and challenges that may be faced. One of these challenges included keeping record of interviews. According to The Munster Technology University, Code of Good Practice in Research (2019, p.11), Article 11.2.1.3 "Data generated in the course of research (including electronic data) must be recorded in a durable and appropriately referenced form and must be held for a sufficient period of time to allow for legitimate reference and review". Similarly, the CORU, Social Care Workers Registration Board Code of Professional Conduct and Ethics (2019, p.21) Article 18 highlights the responsibility of keeping accurate records which includes "store and use records according to data protection legislation, and other relevant legislation and policies governing your practice and protect information in records against loss, damage or access by anyone who is not allowed to access them". The Munster Technology University, Code of Good Practice in Research (2019) and the CORU, Social Care Workers Registration Board Code of Professional Conduct and Ethics (2019) were followed throughout this research process to ensure that participants were reassured and protected under this.

Once each interview was finished it was transferred immediately after to a USB storage device and transcribed. The interviewees were all issued a transcription of the interview *via* email to ensure that it was captured appropriately and allow for any changes prior to further analysis. When this task was completed, all original recordings, or primary data, were destroyed/deleted from the mobile phone permanently, in-keeping with GDPR and confidentiality of the interviewees.

3.8.1 Informed Voluntary Consent (see Appendix A)

As the data for this study was collected it was crucial that the interviewees gave their signed consent in the form of a ‘consent form’ including ethical consideration. It was important for this research study that interviewees understood to who they were giving their consent to and to what, which must always be considered (Miller and Bell, 2002). Voluntary informed consent is where interviewees agree freely to be part of the research study and understand what their participation entails, that they are free to withdraw their agreement at any stage throughout the research process (Oancea, 2014). This means that they can stop participation in the research process at any point. Consent was gained for the purpose of this research through a signed consent form. In addition, The Munster Technology University, Code of Good Practice in Research (2019) outlines a series of guiding principles and standards for good research practice and applies to all disciplines including, Article 11.1.10.5 which states that “Informed consent needs to be sought of human participants (including minors), with the freedom to withdraw at any time during the research process”, which is included in Appendix A. Twelve interviewees provided a signed and dated consent form, this confirmed that all interviewees consented to take part in the interview.

3.9 Interview Guide (see Appendix B)

All interview guides are developed iteratively - questions are developed, tested, and then refined based on what one learns from asking people these questions (Cohen and Crabtree, 2006, p.1).

The interview guide was based on grounded theory analysis which offers flexibility, however keeping systemic methodological strategies that demystifies the research process (Charmaz, 2000 cited in Bryman, 2016). The interview guide design went through many stages of development such as formulating questions that would engage information-rich perspectives. The first stage of carrying out the interview guide process began with twenty questions. However, the number of questions was condensed to fourteen through relating back to the key research question. In addition, the pilot-interview highlighted structural challenges faced by the interview guide, which further developed the interview guide and the flow of the questions asked. This allowed for an in-depth perspective of the views and observations of the interviewee. As the interview schedule was semi-structured, there was an allowance for a flow between questions and themes. Gubrium and Holstein (1997, p. 114) argue that "within the interview itself, the subject is fleshed out – rationally, emotionally, in combination, or otherwise". This means that the researcher asks open-ended questions which allows for the interviewees to reflect on their experiences or perspectives. The interview guide design also included open-ended questions. Open-ended qualitative data, according to Punch (2014, p.87) "are appealing to researchers who are keen to capture directly the 'lived experience' of people". As part of the inquiry was to investigate what restrictive practices are in services for adults with an intellectual disability this design allowed for early- stage collection of qualitative data from which relevant theory became increasingly apparent or emerged. This means that the questions within the interview guide were informed by the gaps that were apparent in past and current research and/or literature. The gaps that were noticed included: an operational definition of what restrictive practices are, in services for adults with an intellectual disability, the effectiveness of current training regarding the use of restrictive practices in services for adults with an intellectual disability and the impact of current terminology regarding restrictive practices i.e. challenging behaviours. Therefore, the interview guide sought to investigate and interpret these gaps.

Borrowing elements of a grounded theory allowed for an in-depth analysis, which formulated concepts or codes which led to emerging themes. Furthermore, the flexible nature of grounded theory permitted the researcher to probe with further questions to gain a better understanding of their perspectives regarding the research topic.

3.10 Interview Procedure

Before carrying out the interviews, a pilot interview was carried out. The pilot interview was crucial to this study as it allowed for a practice-run of the interview schedule and corrections were made prior to conducting research interviews. According to Bryman (2016, p.261) the purpose of an interview pilot or pre-testing questions regarding the qualitative method takes into consideration "how well the questions flow and whether it is necessary to move some of them around to improve this feature". The pilot interview for this study was conducted *via* an online Zoom meeting with a staff member working within the disability sector known to the researcher. This was a benefit to the study as it allowed for non-biased, critical analysis feedback. The pilot revealed the need to re-iterate and ensure confidentiality, due to the sensitive nature of the topic interviewees may not be willing to disclose information. This was addressed by re-iterating, verbally, prior to the commencement of each interview and within the consent form. The pilot interview outlined issues that arose regarding the structure and flow of the interview schedule, of which allowed for changes to occur in time before the interviews began. The changes that were outlined during the pilot interview allowed for the researcher to gain experience and take appropriate action on the gaps identified within the interview procedure.

An interview invitation (see Appendix C) was issued to thirty potential interviewees *via* email which, outlined the purpose of the research, explained what the interview process would entail and also outlined ethical considerations. This assisted the researcher to establish a rapport with potential interviewees and provide an overview of what the research study entailed. Thirteen interviewees accepted, however, one dropped-out during the recruitment process, four refused to take part, as they did not see their participation as valuable in this study, and the remaining thirteen did not reply. Once a reply was received, either rejecting or confirming participation, a follow up email was sent to those who rejected thanking them for their reply. A further email was issued to those that confirmed interest in participating in the research study, which included the consent form (see Appendix A) and the interview guide (see Appendix B). Once the consent form was returned to the researcher (signed) by the participants, a suitable time and date for each interview was identified and agreed upon. To ensure that the interviewees did not feel under time pressure, interviewees were encouraged to propose a suitable time and date for their own convenience, the initial proposed date was facilitated as much as practicable by the researcher. Once a time and date was agreed upon, a Zoom link was sent to the interviewee *via* email.

There are a variety of different methods of interviews according to Seale (2018, p.p 178-179) such as: “Face-to-face, Telephone, Skype, or equivalent and Computer assisted”. Traditionally, semi-structured or in-depth interviews are completed face-to-face (Carter, 2019). However, due to the Global Covid-19 Pandemic the interview procedure for this research study was adapted. The nation-wide lockdown, caused by the Covid-19 Pandemic has made the world rely on technology for work (Stanko and Richter, 2015). The interviews were, at first to be carried out face-to- face, in a neutral setting, but due to the circumstances of the lockdown, limiting contact with individuals, the interviews were carried out through Zoom. In-keeping with the framework of grounded theory analysis the interview guide informed each interview (Hesse-Biber and Leavy, 2008). Similarly, the grounded theory approach involved continual coding to identify concepts as ongoing rather than left to a discrete data analysis phase (Charmaz, 2016).

Interviewees were given the option to turn off their webcam for any reason they saw fit, this was to allow for the privacy of participants if they were taking part in interview from their home or if the internet connection was not strong enough on either end to facilitate the camera being turned on. Ten interviewees decided to keep their webcams on, whereas two interviewees chose to keep their webcams turned off. This was due to a poor internet connection.

3.11 Data Analysis

The data analysis for this research study is based on a grounded theory approach. Knigge and Cope (2006, p.2024) state that regarding data analysis in qualitative research, “grounded theory involves the collection, coding, and categorization of qualitative data (transcribed text from interviews, focus groups, and researchers' notes, photographs, and other images, etc) toward enabling themes to emerge through iterations of ‘constant comparison’”. Utilising Strauss and Corbin’s grounded theory approach and Charmaz’s grounded theory approach, analysis was ongoing and consisted of three rounds of coding. The first stage was transcribing all information gathered from the interviews and highlighting salient words or phrases or open-coding. Open- coding as pioneered by Strauss and Corbin, “constitutes a first level of conceptual analysis of data, the analyst begins fracturing or breaking open the data” (Punch, 2014, p. 180). Punch (2014) also argues that using codes or labels generates categories or themes which can then be used for building theories. This early stage of analysis allowed key points to be acknowledged and therefore, allowed further experiences or perspectives to be gained throughout the interviews. This process allowed for the identification of re-occurring phrases and key points. According to Seale (2018, p. 277) “the modification of emerging theory is done during the collection of data as well as during analysis”. Therefore, the data analysis was ongoing throughout the research process.

The second stage of the data analysis was coding the information, more specifically focused coding, in identifying recurring ideas or concepts. Focused coding is based on Charmaz’s approach to grounded theory analysis and “entails emphasizing the most common codes and those that are not seen as most revealing about the data” (Bryman, 2016, p. 575). Focused codes “cut across multiple interviews and, thus, represent recurrent themes” (Charmaz and Belgrave cited in Gubrium *et al.,* 2012, p.357). According to Punch (2014) and Knigge and Cope (2006), coding is the most important aspect of grounded theory analysis. Coding is, regarding grounded theory analysis “a way of evaluating and organizing data in an effort to understand meanings in the text (or images) and helps the researcher to identify categories and patterns, which can in turn be investigated through additional data collection and/or analysis" (Knigge and Cope, 2006, p.2025). The coding process is the "starting activity in qualitative analysis and the foundation for what comes later" (Punch, 2014, p.173). The coding process was carried out by critically analysing the interview transcripts by re-reading and physically highlighting key points throughout the transcribed interviews.

The third stage was grouping the analysis into categories or theoretical coding (Appendix E). Theoretical coding is again based on Charmaz's approach to grounded theory analysis, which is where "theoretical codes specify possible relationships between categories that have developed through focused coding" (Charmaz, 2006, p.63). Applying a grounded theory approach of theoretical sampling which was first introduced by Glaser and Strauss (1967) the study sought to re-examine, rather than verify, existing theory and remain open to inducing theory from the data. Theoretical sampling is, according to Glaser and Strauss (1967, p.45-47) "the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses the data and decides what data to collect next and where to find them". Moreover, "theoretical sampling shapes further data collection as the researcher pursues developing conceptual ideas rather than amassing general information" (Charmaz, 1990, p.1163). This method of data analysis used for this research study allowed more room for discovery in the interviewing process. This occurred as each interview informed the next, however sticking to the interview guide, probing questions were asked to gain more of an insight.

Theoretical saturation was not claimed; however, it is indeed widely acknowledged that the process is potentially limitless (Seale, 2018, pp 278 - 279), but theoretical sampling was carried out throughout the analysis of the data that was collected. The interviews were transcribed, and recurrent words or open coding were highlighted throughout. The groupings of concepts into categories then occurred once the first stage was complete. Finally, selective or theory emergence occurred, whereby the final themes emerged from the primary data. Through the analysis of the interviews recurring categories with shared properties and, thereafter, inter-related themes became evident. Glaser and Strauss describe this as constant comparison – the properties of certain categories interacted with others and a core category became apparent.

One code that was used throughout the analysis process relates back to the main research question, *What defines restrictive practices within services for adults with an intellectual disability?* This involved combing through each transcribed interview and highlighting key viewpoints of what restrictive practices are within services for adults with an intellectual disability. This code provided as an 'umbrella', whereby the second code emerged, the definition of restrictive practices. This code allowed for analysis throughout the transcribed interviews whereby different views were gathered and analysed under the *Definition of restrictive practice* heading. The second stage of coding and further analysis of the data collected provided a concrete theme, which emerged *Defining Restrictive Practices in Intellectual Disability Services.* Through ongoing analysis of the professional's perspectives, it was evident that this theme was significant as it paved the way for further emerging themes. The four themes that emerged are outlined in Figure 2:

Figure 2: *Thematic areas emerging from the research*

3.12 Conclusion

In conclusion, the purpose of this research design was to gather in-depth, perspectives of professionals working within services for adults with an intellectual disability. The qualitative research method, which included semi-structured interviews allowed for the collection of information-rich data. The qualitative methodological approach was also the most suitable approach in relation to presenting the findings, in a way that explores restrictive practices from professionals who have first-hand, practical knowledge. The adaptations made to the interview procedure, because of the Covid-19 global pandemic, brought to light alternative methods of data collection.

4. ANALYSIS AND DISCUSSION

4.1 Introduction

Data was gathered for this research study by conducting twelve semi-structured interviews with health and social care professionals who work day-to-day with adults with an intellectual disability. Overall, the data gathered from the interviews confirmed that restrictive practices, both in terms of definition and in current applications identified on adults with an intellectual disability, have a variety of meanings and present in many different forms for social care and allied professionals. The interviewees agreed that stereotypical restrictive practices such as physical restraints, environmental, mechanical and chemical are still in use. However, the findings presented suggest that there is a much deeper sense and awareness of the use of restrictive practices and the elements that are associated with them on adults with an intellectual disability. From the analysis of the data collected, four themes emerged: Defining Restrictive Practices in Intellectual Disability Services, Effectiveness of Trainings regarding Implementing Restrictive Practices, Barriers to a Least Restrictive Environment within Services for Adults with an Intellectual Disability and Safeguarding Professionals and Adults with an Intellectual Disability.

4.2 Defining Restrictive Practices in Intellectual Disability Services

It was evident that all interviewees were able to provide a definition of what restrictive practices are, and particularly, regarding their use on adults with an intellectual disability. Eight interviewees had similar responses regarding their definition of restrictive practices. According to the majority, restrictive practices are measures put in place to stop, prevent, disable, or restrict an individual from movement or doing something that they wish to do. The terminology used to define restrictive practices suggests negative connotations as individuals are prevented to use their mobility. Investigating the implementation of restrictive practices, provides further understanding in defining what restrictive practices are.

> *"Anything that would prevent them from having full reign and independence, so anything stopping them, preventing ... their mobility and freedoms"* (Interviewee 11, Social Care Worker).

> *"Include safeguarding due to health and safety concerns"* (Interviewee 1, Social Care Team Leader).

This finding aligns with the definition of restrictive practices mentioned in the extant review, "the actions by which one person restricts the movement of another" (Harris, 1996, p. 20). The use of the term *anything* poses a query to the types of restrictive practices as mentioned in the literature review include "Physical, Chemical, Mechanical, Environmental, Seclusion, Electronic Surveillance" (The Health Information and Quality Authority, 2017, p. 3-4). This finding suggests that restrictive practices include, are not limited to the types of restrictive practices listed above.

> *"Restrictive practices are used to try to prevent behaviours that would be harmful towards either services users or anyone around them"* (Interviewee 7, Social Care Worker).

This highlights that any type of restrictive practice used, is to prevent behavioural outbursts and potential harm to either the service user or those around them. This definition of restrictive practices suggests that there are benefits to the use of restrictive practices, such as ensuring the physical safety of those within the service.

However, such restrictive practices used in services for adults with an intellectual disability may also employ negative connotations whereby adults with an intellectual disability are not afforded the same freedom as a neurotypical adult within society has, as suggested by five interviewees.

> *"Restrictions are in place for the safety of the people we support*"
> (Interviewee 3, Healthcare Worker).

As previously discussed within the literature review, Patrick *et al.,* (2021, p. 2) stated that adults with an intellectual disability have “functional limitations, including language development, social interaction, motor skills, and self-care”. It was found that all services catered for individuals with a mild intellectual disability to those with a profound intellectual disability. It was also evident from the definitions provided, that restrictive practices are used in all services for adults with an intellectual disability regardless of the level of intellectual disability such as mild, moderate, severe or profound.

> *“It's very hard to manage and get everyone's individual needs, to the best standard of care that we can because someone may need a restrictive practice put in place for their own health”* (Interviewee 2, Healthcare Worker).

This is an interesting finding, as it indicates that regardless of the level of cognition an adult with an intellectual disability has, restrictive practices are in place. Additionally, The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations, (2013, p.3) in Ireland, state that the use of restrictive practices is “the intentional restriction of a person’s voluntary movement or behaviour”. The current research found that staff employed within services for adults with an intellectual disability intentionally implement restrictive practices for various reasons which will be discussed further throughout this chapter.

Moreover, five interviewees revealed that restrictive practices often take away a person’s freedom.

> *“Any practice that would alter that person's liberty, freedom and rights or movement”* (Interviewee 5, Healthcare Worker).

> *“Is to impede on the rights of any adult with a disability from doing what they wish to do at any particular time”* (Interviewee 4, Healthcare Worker).

This suggests that restrictive practices are a form of a deprivation of liberty. This finding indicates that restrictive practices not only prevents or stops a person from movement or doing something freely but also impedes on their human rights. This is striking, as it provides a more in-depth perspective of restrictive practices currently being used in services for adults with an intellectual disability. This underlines the severity of the use of restrictive practices within services for adults with an intellectual disability, as restrictive practices hinder human rights. This also highlights the term *alter*, this suggests that a restrictive practice not only stops or prevents an individual from doing something they wish to do, but changes how an individual may move, or do something this wish to do. This finding further engages the understanding of what restrictive practices are within services for adults with an intellectual disability. This further indicates that there may be other forms of restrictions evident within services for adults with an intellectual disability that are not included within the HIQA 'Guidance on promoting a care environment that is free from restrictive practice' (2019).

The suggestion that restrictive practices are a positive attribute within services for adults with an intellectual disability is interesting as eight of twelve interviewees noted negative connotations associated with the use of restrictive practices.

> *"Measures that are put in place to ensure the person's safety and to improve their quality of life"* (Interviewee 8, Manager).

This highlights the perceived positive outcome of the use of restrictive practices, however, does not provide an insight to the measures used to achieve this outcome. The outcomes of restrictive practices will be further discussed in section 4.5 Safeguarding Professionals and Adults with an Intellectual Disability. Four interviewees noted that restrictive practices provide positive attributes within services for adults with an intellectual disability.

> *"You're restricting their movements in what they can do as such... they might not realise but it's necessarily for the benefit of them"* (Interviewee 6, Social Care Worker).

This finding regarding restrictive practices provided here in comparison to previous findings indicates a positive undertone. This may indicate a proactive approach to the use of restrictive practices, as the definition emphasizes an individual's quality of life. Moreover, as interviewee 8 is a manager within a service for adults with an intellectual disability, it is evident that the definition of restrictive practices included elements of person-centred terminology in comparison to professionals who work day-to-day with adults with an intellectual disability. This viewpoint contradicts with the majority opinion of staff working 'on the floor' description of restrictive practices.

> *"Restrictive practices should be avoided at all costs"* (Interviewee 1, Social Care Team Leader).

Arguably, interviewee 8 (manager) may be less exposed to the implications of restrictive practices as they may not be implementing or experiencing the use of restrictive practices daily. Another description of restrictive practices reinforces the ideology that restrictive practices stops or prevents an individual from movement or doing something they wish to do:

> *"You are limiting more so than anything else the person from doing something that may or may not cause them harm or cause us harm"* (Interviewee 9, Social Care Worker).

This statement highlights that professionals are limiting 'a person' rather than implementing an overall restrictive practice that may affect each individual living within the service. This suggests that restrictive practices are tailored specifically to prevent harm. Moreover, the use of the term 'harm' in the context of adults with an intellectual disability suggests an individual may display challenging behaviours. As previously found in the literature review, restrictive practices are generally associated with individuals who present challenging behaviours or aggressive behaviour, therefore, would be present in intellectual disability services (Clarke *et al.,* 2017). However, in the context of the description of restrictive practices, interviewees suggested that the purpose of restrictive practices is not only to prevent harm, or risk, to a service user but also protects professionals who provide their care.

> *"Because of minimal use of restrictive practices... there's more aggression towards staff, more violence towards staff"* (Interviewee 11, Social Care Worker).

This description specifically indicates that restrictive practices are only used in the context of an individual who displays challenging behaviours, which may or may not cause harm to either themselves or to staff. However, this finding also suggests that the lack of restrictive practices involves a greater risk to the safety of professionals. This description of restrictive practices indicates that restrictive practices not only provide governance on adults with an intellectual disability but also professionals involved with their care.

Interviewees' responses regarding whether restrictive practices are necessary within services for adults with an intellectual disability were mixed. Eight interviewees agreed that restrictive practices are necessary within services for adults with an intellectual disability.

> *"As a whole, I do believe they're necessary for the safety of the individual and for the safety of the staff, I think it has to be broken down to the individual... you can't bracket everybody with intellectual disability as somebody with an intellectual disability, it's so individualised"* (Interviewee 4, Healthcare Worker).

This finding indicates, that whilst restrictive practices may be necessary for the safety of those within the service, such practices may also be imposed on other service users when there may be no individual need for such restrictive practice to be implemented specifically for them. This point highlights that person-centred care may not always be achieved, possibly due to the risk involved by one individuals behavioural outburst or safety concern.

> *"Restrictive practices have a knock-on effect on the others who don't need it"* (Interviewee 2, Healthcare Worker).

In summary, it is evident from the findings, that there was no one, fixed operational definition of the term restrictive practices, however interviewees provided insights into key aspects of defining restrictive practice as commonalities were identified from their professional perspectives. From the definitions provided by interviewees a common theme on the definition of restrictive practices was taking away or preventing an individual's movement. However, it is also suggested by the interviewees that the use of restrictive practices involves much more than taking away a person's liberty or freedom but also impedes on their human rights. This was mentioned by eight interviewees, thereby, suggesting that restrictive practices have negative connotations associated with their use but also a stigma attached to restrictive practices. However, four interviewees provided an opposite perspective whereby restrictive practices improve an individual's quality of life. Therefore, exploring the process of how restrictive practices are implemented within services for adults with an intellectual disability may provide further insight.

4.2.1 Implementation of Restrictive Practices by Practitioners in Services for Adults with an Intellectual Disability

Findings from this research study revealed, that measures must be taken prior to the implementation of restrictive practices, to assess the potential outcome and whether the behaviour would escalate or de-escalate following the use of a restrictive practice, this involved assessing the level of risk involved. Along with the definitions provided, interviewees noted their personal perspectives the necessity of restrictive practices. This point was highlighted by three of the interviewees.

> *"We'd all love if restrictive practices weren't 'a thing' in the disability sector but it's always going to be a 'thing'"* (Interviewee 2, Healthcare Worker).

This suggests that restrictive practices are viewed negatively by the majority who are involved within the intellectual disability sector. Deveau and McDonnell (2009) and The Health Information and Quality Authority (2016) both argue that the use of a restrictive practice should be a 'last resort'. Findings from this research suggest that professionals employed within services for adults with an intellectual disability are aware of the negative connotations associated with restrictive practices and would *prefer* not to use them, however they perceive that they are often left with few alternatives. This may be because the level of cognition of an adult with an intellectual disability may lead them to be unaware of their actions to ensure their safety and the safety of those within the service. It was the view of interviewees that restrictive practices will always be required in some form, however service users and should not be restricted because of their level of cognition.

> *"Treated differently than others, because of his experiences...because of what he has done in the past"* (Interviewee 1, Social Care Team Leader).

This relates to whether restrictive practices are implemented based on the cognitive level of an individual and, how the restrictive practice for an individual is assessed. This suggests that restrictive practices are assessed but it is the level of risk posed by an individual that is not. Factors such as training regarding restrictive practices and challenging behaviours may influence the implementation of restrictive practices within services for adults with an intellectual disability. The manner in which restrictive practices are implemented may also be a key component of why restrictive practices are implemented. Measures that were found, that are involved in the implementation of a restrictive practice:

> *"Looking at situations seeing what risk is involved if that service user wants to do something, is there going to be a high risk, low risk, medium risk and all about deciding"* (Interviewee 12, Social Care Team Leader).

This highlights that, risk is a key factor regarding the implementation of a restrictive practice and managing a potential risk that may occur. This means that for a restrictive practice to be implemented, there must be a risk involved, as mentioned by all interviewees. Additionally, factors associated with risk management were evident from the definitions of restrictive practices provided by the interviewees: that they are measures put in place to prevent an individual from movement but also to prevent harm.

> *"You definitely have to assess the situation...you'd have to look at if there's physical restraint the likelihood is it going to make her worse or is it going to make her better"* (Interviewee 6, Social Care Worker).

It was apparent that measures must also be taken prior to the implementation of restrictive practices, to assess the potential outcome and whether the behaviour would escalate or de-escalate following the use of a restrictive practice, this involved assessing the level of risk involved. It is the risk that is assessed and not the capacity and cognitive ability of an individual. All twelve interviewees noted that risk assessments are carried out within their services regarding the use of restrictive practices. A risk assessment examines risk prior to the implementation of a restrictive practice.

> *"Risk could be eliminated due to a potential restrictive practice"* (Interviewee 1, Social Care Team Leader).

> *"Foreseeing and being able to predict the potential hazards or potential risk to service users, physical, emotional, mental state and their vulnerabilities in that sense in relation with restrictive practices"* (Interviewee 11, Social Care Worker).

The purpose of a risk assessment is to determine the level, or what type of restrictive practice should be put in place to reduce a risk. This is interesting as the Assisted Decision Making (Capacity) Act (2015) involves that all health and social care services must support an individual in decision-making and maximising an individuals' capacity in making decisions relating to their care. However, only three of the interviewees noted that, within their services an individuals' capacity in risk assessments is included. Therefore, it may be interpreted from the interviewees that not all services are operating under this Act, as interviewees have not mentioned this as a factor when implementing or considering a particular type of restrictive practice. Moreover, three interviewees reinforced aspects of the Assisted Decision Making (Capacity) Act (2015). This highlighted the importance placed on individuals' physical, emotional, mental state regarding the use of a restrictive practice.

> *"One of the things that we do every now and again is to assess the service users' capabilities"* (Interviewee 7, Social Care Worker).

This highlights that the role of professionals working day-to-day with adults with an intellectual disability is important to determine what is best for an individual when carrying out risk assessments.

> *"Key workers would do our risk assessments ... because we would know the residents best"* (Interviewee 9, Social Care Worker).

Of the participants in this study, only three interviewees were involved in writing and carrying out risk assessments. According to Douglas and Skeem (2005 in Lofthouse *et al.,* 2020, p.703) risk management "enable professionals to be better informed about when to intervene to reduce risk, how much individuals respond to treatment and whether modification to supervision levels is required". However, the other seven interviewees noted that risk assessments are mainly carried out by those is management positions as training regarding risk management is not readily available or accessible for professionals working in healthcare assistant positions. It was also noted by all interviewees, that professionals working day-to-day with adults with an intellectual disability, who were not involved in the risk assessment process, were able to view and access such risk assessments for their understanding.

> *“I follow whatever they have written up and told me”* (Interviewee 7, Social Care Worker).

> *“It was brought to us, and we were then explained what we were allowed to do”* (Interviewee 5, Healthcare Worker).

These findings suggest that regarding the implementation of a restrictive practice, professionals who were not involved directly in the risk assessment process, are instructed by professionals in managerial roles, about the implementation of risk assessments.

> *“We weren't really taught how to do them in the unit...It's the manager does them”* (Interviewee 2, Healthcare Worker).

Training and education regarding restrictive practices, was found to be important when carrying out risk assessments. However, it was clear that those who work closely with adults with an intellectual disability on a daily basis were not afforded such trainings, this may be because, as suggested by the point above that only professionals in managerial positions are offered such trainings. Even though professionals who work day-to-day with adults with an intellectual disability would know the service users best and be better able to determine their capacity and abilities.

> *“I read them (risk assessments) I don't agree what she(manager) says because she(manager) doesn't ask us our opinions even though we'd be working closely to the clients”* (Interviewee 2, Healthcare Worker)

This finding indicates that professionals working with adults with an intellectual disability daily, may not be included in how restrictive practices are implemented; only three interviewees noted their participation in the process. Additionally, this may lead to a conflict of interest, between managers and frontline professionals, regarding the care provided for service users, as professionals working day-to-day with adults with an intellectual disability would know the service users best as previously found.

It may also be interpreted that those professionals may not have the experience in carrying out risk assessments as they may have not had the opportunity to do so. It was also clear from the interviewees that when carrying out a risk assessment, it is the person in charge or a manager who carries out this task. The supervisor, or manager, may discuss the risk assessment with the professionals working daily with adults with an intellectual disability such as key workers, social care workers, and healthcare assistants. Similarly, the findings highlighted that the current practice is that, only professionals in managerial roles have the authority to complete risk assessments and approve risk management plans. It may also be interpreted from the findings that, professionals who work day-to-day are not meant to be involved with the risk assessment process or the implementation of restrictive practices. Roscigno (2013) found in their study that health care professionals have a significant amount of power over individuals with an intellectual disability, and the relationship between health care professionals and service users is personable. Therefore, it may be interpreted that the purpose of management implementing restrictive practices and carrying out risk assessments, is to establish a boundary between professional roles, in such a way, professionals who work closely with individuals with an intellectual disability do not hold all the power.

Arguably, restrictive practices may be implemented because of past incidents of behavioural outbursts. This may be because of safety concerns for the service user, peers and staff. However, one key factor that was indicated throughout the interviews was those who carry out the risk assessments. The level of input from frontline professionals working attentively with adults with an intellectual disability in relation to the types and use of restrictive practice appears inconsistent. It was suggested that frontline professionals know the service users best and their cognitive capabilities, however, have limited input to the risk management plan as it is at the discretion of the manager/team leader. Connolly (2018) argued that staff working within intellectual disability services lack training for the use of restrictive practices and associated trainings. However, all professionals interviewed received some form of training regarding restrictive practices, therefore, the effectiveness of such trainings is queried, this theme is explored further in *Section 4.3 Effectiveness of Trainings regarding Implementing Restrictive Practices*.

Furthermore, the current findings suggest that measures, such as risk assessments, are carried out prior to the implementation of a restrictive practice. A restrictive practice is not implemented if there is not a risk to the safety of a service user, this means that there must be an antecedent behaviour, or potential risk involved whereby professionals determine whether a restrictive practice needs to be implemented or not. However, the professionals involved in the carrying out of risk assessments, notably professionals in managerial positions, suggest that they may not accurately represent the capabilities of adults with an intellectual disability. As professionals who work day-to-day with adults with an intellectual disability may have a better insight to an individual's development and understanding. The availability, and effectiveness of trainings regarding restrictive practices appears to be an indicator as to the reason why professionals who work day-to-day with adults with an intellectual may not be involved with the risk assessment process. Therefore, accentuating the evaluation of other trainings associated with restrictive practices and challenging behaviours.

4.3 Effectiveness of Trainings regarding Implementing Restrictive Practices

All interviewees received some form of training regarding restrictive practices such as Managing Actual and Potential Aggression training (MAPA), Positive Behaviour Support (PBS), Advanced MAPA, Multi-Elemental Behavioural Support and Challenging Behaviour Training. This suggests that training regarding restrictive practices and challenging behaviour is deemed important within services for adults with an intellectual disability, as all interviewees received either proactive trainings, reactive trainings or both.

Of the twelve interviewees, four received Positive Behaviour Support; two received Multi- Elemental Behavioural Support; one received Challenging Behaviour Training; one received Advanced MAPA and eleven received MAPA training. It was clear that the most common training that professionals received was MAPA training, eleven interviewees. Interviewees revealed that MAPA is the most common training for professionals working within services for adults with an intellectual disability as it focuses on managing challenging behaviours, which as discussed within the literature review are prevalent within intellectual disability services.

> *"I have used MAPA ... for aggressive behaviour, towards staff and for the safety of myself and the safety of my colleague"* (Interviewee 3, Healthcare Worker).

> *"You need MAPA before you step foot in a door, in any house with disability"* (Interviewee 6, Social Care Worker).

The findings highlighted that MAPA training is viewed as essential, to ensure the safety of staff and service users when restrictive practices are implemented within services for adults with an intellectual disability. Therefore, as it was also the most common training received by the interviewees, it was determined that MAPA would be one of the key trainings regarding the analysis of its effectiveness. There were conflicting responses found by the interviewees regarding whether the effectiveness of trainings has been evaluated, more specifically regarding MAPA training. According to the New South Wales Department of Education (2019, p. 1) the purpose of MAPA training is to "prevent behaviour escalation through non-physical interventions". Seven interviewees revealed that the effectiveness of MAPA training has not been evaluated within their specific service, whereas four noted that MAPA was evaluated, however, not in their service specifically.

> *"No, it hasn't* (been evaluated) *because that's all we'll get...maybe in the company it has been evaluated, but definitely not in our service"* (Interviewee 11, Social Care Worker).

This response suggests that MAPA training is used widely within services for adults with an intellectual disability, however the effectiveness of MAPA training is not evaluated in specific services. This is an interesting point, as MAPA training is used by professionals who work day-to-day with adults with an intellectual disability and would therefore have the most experience and first-hand knowledge using MAPA training in a day-to-day scenario.

> *"No, it has never been evaluated... I did my MAPA training on a zoom call and it was never tested, but I am signed off to practice"* (Interviewee 5, Healthcare Worker).

Throughout the global Covid-19 pandemic, alternative methods were used to provide trainings for professionals. This finding suggests that trainings were provided, however, professionals were not examined on the training regardless of the effectiveness of the training and can practice without any practical examination. This highlights that, professionals may be signed off on trainings for being present within a training and without any examination. This may lead to unsafe practice and professionals unaware of how to implement such trainings.

Another finding was that just under half (five) of the interviewees had not received MAPA training prior to beginning their employment. According to the National

Health and Safety Function, Workplace Health and Wellbeing Unit (2017, p.9) Training in the Management of Violence and Aggression and/or MAPA is a mandatory training for “all employees who work in an environment where a risk assessment has identified there is a risk of exposure to verbal or physical aggression”.

> *“I was in the house nearly a year before I got MAPA training, and I was in a challenging behaviour house”* (Interviewee 10, Healthcare Worker).

This highlights that staff are employed in services with challenging behaviours, without receiving adequate MAPA training or any alternative. It could be argued on this basis that organisations are putting the safety of staff at risk by not providing or preparing staff for day-to-day incidents that may occur. Arguably, there is also an added risk to services users, if the staff are unsure how to respond, there may be a higher risk for both themselves and the service user as an individual’s behaviour may escalate instead of de- escalate. An additional risk factor that may occur is that staff may follow practices that are carried out by pre-existing staff rather than the official training.

> *“What if someone puts a knife in my leg, but what do I do now? There is no training for that ... because that could happen”* (Interviewee 1, Social Care Team Leader)

This finding accentuates the idea, whereby professionals believe they are underprepared for incidents that can or may occur. This also brings to light the level of risk involved and the position staff may find themselves in, endangered to such violent outbursts. If professionals are underprepared for incidents that can and may occur within services for adults with an intellectual disability, they may resort to using their own initiative. This implies that there may be a culture that has developed within the workplace, whereby staff have accepted that they may not need training as they have been employed so long without it.

> *"I'm trying to get my MAPA training done... they've allowed me to work without it"* (Interviewee 7, Social Care Worker).

MAPA training is considered a mandatory training, by the HSE Education and Training Needs of Registered Nurses Intellectual Disability and Registered Psychiatric Nurses in Cork and Kerry (2020), for health and social care professionals working in an environment that involves risk. However, the findings suggest that the training perceived as mandatory, but in reality, there is no consistency to the training being completed, nor the effectiveness of its implementation evaluated. As previously discussed, risk assessments are a key factor in the implementation of restrictive practices. Therefore, this finding indicates that managing risks in a reactive approach may prove to be ineffective if trainings are not completed/received prior to employment. Additionally, this may have a negative impact on service provision as professionals within the service, are unable to respond to challenging behaviours. It may also be interpreted that, organisations for adults with an intellectual disability are not following standards set out by the Health Service Executive. This also implies that the effectiveness of MAPA training cannot be evaluated accurately, as some professionals working closely with adults with an intellectual disability have not completed the training. Additionally, four interviewees raised an interesting point, whereby the trainings received are given only to satisfy government standards and guidelines and are not provided effectively regarding the use of restrictive practices. Findings presented that, two interviewees did not receive MAPA until six months after the commencement of their employment, one interviewee did not receive MAPA training until one year after the commencement of their employment, one interviewee did not receive MAPA training until two years after the commencement of their employment and one interviewee (interviewee 7 Social Care Worker) was at the time when this research was conducted, trying to get MAPA certified.

> *"It's just kind of a tick the box thing for management and HR to do so if an incident does occur or if a restrictive practice is put in place, they'll say that we had the training for this so it's just backing themselves up"* (Interviewee 2, Healthcare Worker)

The concept of ‘tokenism’, or ‘ticking the box’, is apparent within this research study. This means that training is only provided professionals to meet regulation standards (Smith and Dransfield, 2019). This finding also implies that organisations are only providing the necessary trainings to protect themselves legally. This means that if a claim is made by an individual regarding an injury that occurred during the time of employment, the organisation can provide evidence that this training was given and that they are not liable. This highlights that the trainings received are not given for the benefit of professionals working closely with service users but are to ensure organisations are not liable for injuries that may occur. This suggests that the trainings received are not effective and put professionals and services users’ safety at risk as the training may not suit day-to-day scenarios that can occur.

In addition, as mentioned by Interviewee 2 (Healthcare Worker), management view training as a ‘tick the box’ exercise, however, not only disregards the impact of the staff, but also the welfare of the adults with an intellectual disability.

As mentioned in the literature review, adults with an intellectual disability are often pushed aside or disregarded in society, this point mentioned by Interviewee 2 (Healthcare Worker) denotes connotations of ableism. This suggests that managers within services for adults with an intellectual disability with regards to training for professionals look at an individual’s disability and behaviour rather than looking at the individual themselves. Therefore, it may be interpreted, with regards to training for professionals within intellectual disability services for adults, that training is provided for the purpose of benefit to policy and procedures, rather than adults with an intellectual disability.

> *“It's almost that culture of doing what you do to get by. You adapt to it then maybe write it up as if you've done it completely, as it's been trained to you to do but in reality, a lot of times it doesn’t work and it's putting services and staff at risk”* (Interviewee 11, Social Care Worker).

This is an interesting point as it implies that professionals who have received trainings regarding restrictive practices do not use the practical elements of these trainings in daily routines, however, they only use the theoretical elements when recording incidents. It may also be determined that if such trainings were used as demonstrated by the training facilitator, the training would provide more risk to staff and service users rather than professionals taking their own initiative. Although the documentation may indicate that the correct measures have been implemented, the findings suggests that this is not the day-to-day reality. This indicates that in practice there is no standard approach to implementing restrictive practices when staff are responding to challenging behaviours, which may leave both service users and staff in a vulnerable position, and at risk of injury. It appears that organisations have on paper, signed-off on staff having completed this training and have paperwork which suggests the correct measures have been implemented successfully, which indicates that staff are adequately equipped and competent to implement such practices when responding to challenging behaviours. However, the start finding from this research study revealed that current practices is not represented or recorded accurately, the challenges faced by staff in responding to challenging behaviour, and the risks both staff and service users are exposed to.

Furthermore, injuries that may occur, because of staff implementing a restrictive practice as directed in a training or by their own initiative, may not be covered by the organisation. It is interesting that those who have not completed training face the same exposure to violence, however, are not personally responsible as training was not provided for them. This suggests that regardless of whether a training was received or not, staff are subjected to workplace violence, and that training regarding restrictive practices and challenging behaviours focuses on protocol rather than staff and service user safety and welfare. It may be difficult to predict an incident that may occur, and therefore, difficult to predict an individual's reaction. This further highlights the importance of professional's involvement in the evaluation process of trainings received, as professionals working day-to-day with adults with an intellectual disability have a better insight of day-to-day scenarios and incidents that may occur, instead of a generalised approach.

Another factor regarding the effectiveness of MAPA training was a non-physical approach. The Crisis Prevention Institute (2021), the main organisational body that provide MAPA training in health and social care services in Ireland, highlighted that the use of physical holds is to be used as a last resort. However, two interviewees suggested that this is not always the case.

> *"The training that we receive is a hands-off approach, which can't happen. It's impossible in some situations"* (Interviewee 10, Healthcare Worker).

This highlights that the training received has not prepared professionals for day-to-day incidents that may occur. Each individual is different and may react differently to scenarios. However, there may also be a reluctance from the staff here, as the findings suggest they may feel the lack of physical intervention or restraints are insufficient. This reinforces the perceived 'need' or lack of alternatives when responding to behavioural outbursts and that the traditional physical restraint is the only option. Additionally, this finding also suggests that MAPA training does not cover all situations that may occur within services for adults with an intellectual disability. The mentioning of the term *impossible* suggests that professionals may have no other option but to restrain an individual if their own safety and the safety of those around them are at risk. Therefore, indicating that the purpose of such trainings and restrictive practices is to provide a safe environment for staff and service users.

One interviewee received Advanced MAPA training: therefore, it is difficult to exactly determine the effectiveness. However, as the response from interviewee 9 (Social Care Worker) included positive feedback regarding the effectiveness of the training the feedback was included. Advanced MAPA is not a mandatory training and, as previously found if a training is not mandatory, it is difficult to receive. Additionally, it may be argued that, whether a training is mandatory or not, it is difficult to access such trainings. As previously found, professionals were waiting over a year to receive MAPA, a mandatory training, regardless of additional trainings. This may be a reason why only one interviewee received this training. According to the Crisis Prevention

Institution (2021, p.1) Advanced MAPA, although like MAPA training, "enables staff to identify higher risks and intervene appropriately, without putting themselves or the patient/service user at unnecessary risk".

> *"Advanced MAPA is actually beneficial compared to a regular two person MAPA hold...Advanced MAPA is a four- person restraint on the floor...we found that there's actually a lot less staff injuries and service user injuries with advanced MAPA"* (Interviewee 9, Social Care Worker).

Interestingly, this point not only highlights specific procedures regarding Advanced MAPA but also *regular* MAPA. Although Advanced MAPA is a reactive strategy regarding restrictive practice, it may be determined that it is safer for staff to use in comparison to MAPA. This is because Advanced MAPA requires four staff to engage in the restraint, whereas MAPA requires two staff. The number of staff engaging in a *hold*[9] appears to have an impact on the effectiveness of a reactive training, as there is extra support from staff and less of a risk for an injury to occur. This finding also includes that Advanced MAPA is a restraint on the floor, this may also be safer for both staff and the service user. This indicates that Advanced MAPA may be better suited for services with extreme challenging behaviours and may also be the reason why only one interviewee has had this training. In addition, this finding also suggests that there is a risk to the safety of both staff and service users expected by professionals, regardless of the type of training used which is discussed further is section 2.5 Safeguarding Professionals and Adults with an Intellectual Disability. These findings explore and allow for a better understanding of the use of reactive trainings within intellectual disability services for adults with challenging behaviours.

Findings indicate that the focal point of MAPA training is generalised interventions for managing challenging behaviours. MAPA appears to have been evaluated within organisations, but not within specific services. However, the evaluation of a training

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[9] A hold is "holding a person's body and extremities to limit voluntary movement, either to control a crisis situation (emergency PR) or as a procedure specified in a behaviour support plan (planned PR)" (Luiselli *et al.,* 2011, p.93)

does not indicate that a training is in fact effective, rather assesses the outcomes and goals of a training (Poth *et al.,* 2014). This inconsistency in evaluating the effectiveness of training which is relied upon to ensure the safety of the staff and service users, appears to be insufficient and is impacting service provision. Personal risk is increased to both staff implementing interventions and restrictive practices and services users who are imperilled by it. MAPA training may be determined from these findings as non-effective as it was found that professionals chose to use their own initiative responding to challenging behaviours over directed training.

It can be determined from the findings that the current trainings regarding restrictive practices and challenging behaviours lack practical day-to-day knowledge when being used in services for adults with an intellectual disability. This suggests that in practice, staff are reliant on their own experiences to manage challenging behaviours and implement restrictive practices. This may pose as an issue, as trainings are provided in line, with HIQA Standards and Guidelines. Therefore, if HIQA Standards and Guidelines are not followed, the quality of care provided may suffer. Additionally, interviewees suggest that the factors which relate to the ineffectiveness of such trainings include professionals not receiving MAPA training in a sufficient period, tokenism and overall application of MAPA training. The ineffectiveness of such trainings found by the interviewees highlighted there is a risk to the safety of not only the service users but also to staff. Additionally, findings also highlight, that the trainings received by the interviewees, regarding restrictive practices and challenging behaviours, are based on strategies on how to use physical interventions to stop or prevent a behavioural outburst, rather than understanding an individual's behaviours and why such behaviours may occur.

Six interviewees received Positive Behaviour Support or Multi-Elemental Behavioural Support Training. It was found that proactive trainings, encountered positive responses from the interviewees, in comparison to reactive trainings. This may be because, proactive trainings are less, physically invasive intervention.

> *"Positive behaviour support is a good training... I think staff should have to do it every six months, so we're re-educated"* (Interviewee 2, Healthcare Worker).

Positive Behaviour Support (PBS) is an alternative, proactive approach to manage challenging behaviours (Strydom *et al.,* 2020). As PBS and MEBS trainings are proactive and use non-physical, invasive interventions, it may be interpreted that professionals prefer to use such strategies in comparison to reactive trainings such as MAPA. This may be due to PBS being a safe alternative to MAPA and provide a lesser risk to both staff and service users. In addition, this also highlights the timeframe of which PBS should be reintroduced to professionals. This suggests that although PBS is effective, a refresher course should be frequent to ensure the effectiveness of the training.

> *"The measures that have been implemented are as a result of PBS, you can see them working even in terms of behaviour support plans"* (Interviewee 8, Manager).

This indicates evidence that PBS and MEBS are effective regarding being used in services for adults with an intellectual disability. However, interviewee 8 is a manager within an intellectual disability service, they would generally carry out behaviour support plans. In comparison one interviewee mentioned:

> *"We have a positive behaviour support team, they're just psychologists, behaviour support... They tell us what to do, but they don't work on the floor"* (Interviewee 10, Healthcare Worker).

This finding highlight that, professionals, who work day-to-day are not involved in the process of PBS, it is external professionals who deliver and undertaken behavioural support plans. As previously highlighted, it is the professionals who work daily with adults with an intellectual disability who carry out such trainings and would therefore know the service users best.

Although the person-centred relationship is not a training *per se*, seven interviewees highlighted that this concept proves significant in its effectiveness when de-escalating a behavioural outburst. According to Dowling *et al.,* (2006, p.28) the person-centred relationship is a “positive relationship between service users and staff and are needed to make person-centred planning a possibility”.

> *“Staff should be able to see what is that individual’s triggers, and you can tell sometimes when your clients are about to engage in a behavioural outburst because you'd be working so closely with them...you really need to know the clients you are working with when you're in a unit”* (Interviewee 2, Healthcare Worker).

This implies that staff who are familiar with service users are better able to provide person-centred care. This may be because staff are working day-to-day with service users and are able to identify specific triggers that may cause a behavioural outburst and be able to prevent it from occurring. This also relates to the implementation of restrictive practices and the need for staff working with service users on a day-to-day basis to be involved in the risk management plan. Additionally, Britten *et al.,* (2017) highlight that the person-centred relationship between staff and service users, enhances the workplace environment. As indicated above, if staff can prevent a behavioural outburst by noticing specific triggers and behavioural trends, this would inadvertently provide a safer and positive environment as reactive interventions, such as MAPA are not needed. Therefore, highlighting the importance and the effectiveness of a person-centred relationship.

Furthermore, the use of proactive strategies, appear to be more effective than the reactive, as proactive trainings provide less risk to both staff and service user. In summary, the findings suggest that intellectual disability services adopt person-centred approaches in responding to challenging behaviours, such as proactive strategies rather than reactive strategies, this ultimately supports the shift from the medical model to a social model of care and reflects connotations of the United

Nations Convention on the Rights of a Person with a Disability. Finally, the findings from this study suggest that there are other factors that contribute to the slow movement of intellectual disability services moving towards a least restrictive environment.

4.4 Barriers to a Least Restrictive Environment within Services for Adults with an Intellectual Disability

All interviewees understood and were aware of the concept of a least restrictive environment. However, factors that suppress a least restrictive environment were made significantly clear. A least restrictive environment is, as mentioned in the literature review, “is a human rights claim, for individuals with disabilities that goes beyond its literal role in eliminating physical or notional barriers in placements.” (Lim, 2020, p.582). Additionally, key aspects of a least restrictive environment are in-keeping with the United Nations Convention on the Rights of a Person with a Disability framework (Shogren and Turnbull, 2014). Each interviewee provided their perspectives on how intellectual disability services in Ireland would be able to foster and move towards this concept.

> *“Training and the teaching of the clients and that would take them away from...the luring them in of having a fight or throwing something that their mind would be occupied on something positive, something they enjoy”* (Interviewee 3, Healthcare Worker).

This suggests that services, for adults with an intellectual disability to provide a least restrictive setting, there must be ongoing involvement of the service users development and education. This means that staff should be able to provide ongoing opportunities for adults with an intellectual disability to learn and develop their skills, motor or emotional. Additionally, eight interviewees suggested for a least restrictive setting to occur, professionals should be teaching services users how learn from previous behavioural outbursts and how to live with risk but without restrictive practices.

> *“Foster new mindsets, and learning for the individuals so that they don't have to live with restrictions forever*” (Interviewee 1, Social Care Team Leader).

This point suggests that ableism is a key driver as a barrier for a least restrictive environment. Bias is a significant factor regarding ableism, therefore this point highlights that within intellectual disability services for adults, professionals' biases contribute to barriers regarding a least restrictive environment (Dhanani *et al.,* 2022).

> *"Doing things to a person's needs and their wants and wishes"* (Interviewee 12, Social Care Team Leader).

This suggests that professionals, who work day-to-day with adults with an intellectual disability should take on an educator role rather than a carer role to provide a least restrictive setting. It is evident from the findings, that services for adults with an intellectual disability are person-centred, as interviewees highlighted that by teaching, educating, and supporting service users daily rather than professionals doing everything for services it may create independence for the service users. In agreement, Mackay *et al.,* (2009) argue that health and social care practitioners in an educator/teacher role is vital for the education and development of skills for individuals with an intellectual disability through the use of combined personal, lived experiences and professional evidence. This piece of literature supports the interviewees argument, whereby, the health and social care profession is more than supporting adults with an intellectual disability by providing personal and intimate care, but also educating and teaching to further adults with an intellectual disability's' skills and independence. However, interviewees also highlighted aspects that deter services from a least restrictive setting.

> *"There is a lot of things ... being swept under the carpet, not being dealt with"* (Interviewee 6, Social Care Worker).

One issue raised was the lack of incidents being reported to HIQA and matters regarding challenging behaviours being disregarded suggesting that there is something to hide. Although there is no direct mentioning of abuse within services for adults with an intellectual disability, matters that are *"swept under the carpet"* denote connotations of the possible misuse of restrictive practices. However, incidents of any kind of maltreatment, abuse or reports of malpractice are required to be reported to either, HIQA or the HSE Independent Confidentiality Recipient, Leigh Gath. This finding and the finding below highlight the disregard and neglectful attitude of management, denoting connotations of ableism. This may imply that there may be an issue of malpractice involved or, the potential overuse of restrictive practices. This point is reiterated below:

> *"Management do not want to hear it because it's just more paperwork for them and they don't want to get HIQA involved so sometimes they take the lazy approach"* (Interviewee 2, Healthcare Worker).

This point additionally highlights ableism within services for adults with an intellectual disability, managers that "*take the lazy approach*" display disregard not only for the adults with an intellectual disability but also staff working closely with adults with an intellectual disability. Ableism provides clarity on aspects as to why managers disregard individuals with an intellectual disability such as predisposed biases gained from society. Through the lens of social justice, it is evident from these findings that ableism is apparent throughout services for adults with an intellectual disability, as both staff and service users are disregarded which enables a restrictive environment and creates power imbalances between staff and management but also staff and service users which will be discussed further in Section 4.4.1. In addition, this point contravenes the Health Information and Quality Authority (HIQA) (2021) which mandates that all incidents that occur within social and healthcare services must be reported to the National Incident Management System (NIMS). This implies that, although incidents of challenging behaviours are occurring or have occurred, the response may not be fully compliant with standards and guidelines. This indicates that some intellectual disability services in Ireland, more specifically services whereby this study was conducted, are not providing a least restrictive environment as measures that may have been implemented from reports by HIQA are absent.

> *"A lot of the of the restrictive practices are just there so HIQA are 'happy' when they come in"* (Interviewee 2, Healthcare Worker).

This indicates that although this research specially investigates services for adults with an intellectual disability, HIQA, standards and guidelines govern other services such as older person’s services. Therefore, it may be interpreted that this issue may not be sector specific.

An additional factor found to be a barrier to a least restrictive environment was funding. Funding for services for adults with an intellectual disability appeared to be a significant factor regarding a least restrictive environment. All interviewees provided that the lack of funding received can be noticed by the type of service that is provided.

> *“The things that they need for to introduce different things more often aren't readily available to the people we support which comes down to money, there is none”* (Interviewee 3, Healthcare Worker).

Interestingly, it appears that services for adults with an intellectual disability rely heavily on funding for day-to-day operations. This highlights that although funding for services for adults with an intellectual disability is sufficient to ensure HIQA standards and guidelines are met, the funding is also limited regarding development and adaptation of services and service provision. This means that the level of care provided by professionals is affected by the lack of funding, as professionals are unable to develop or change according to the service user’s needs or wishes. This implies that although professionals may have the adequate training whilst employed within services for adults with an intellectual disability, the lack of adequate resources contributes to a restrictive environment and, a lack of consistency in the use of restrictive practices and/or engaging in service provision development.

Eight interviewees suggested that the service user to staff ratio is too high, which leads to further issues such as increased use of restrictive practices and challenging behaviours escalating. However, according to HIQA (2021, p.7) there is no exact mandated staffing ratio within services for adults with an intellectual disability, only that "the number and skill mix of staff are recruited to meet the needs of the number of residents you are applying to register". Therefore, it is the organisations prerogative and judgement, regarding how many staff are on duty. However, it was determined from the perspectives of the professionals interviewed that the number of staff on duty, is insufficient. This means that although, according to the organisations policies and HIQA National Standards, there is enough staff, however, it was found that staff working day-to-day with adults with an intellectual disability are under pressure managing challenging behaviours. This finding also suggests that services for adults with an intellectual disability employ the minimum number staff to provide personal and intimate care for adults with an intellectual disability, which indicates a profit driven model of care. Dillard-Wight and Shields-Haas (2021) state that healthcare providers that prioritise profit over the well-being of service users and staff, discriminates and disregards individuals with an intellectual disability.

> *"There's such a shortage of staff often... restrictions definitely go up because it's almost, it's near impossible to manage some of our service users and outbursts one-on-one"* (Interviewee 11, Social Care Worker).

It is evident from the findings that the shortage of staff contributes to the use of restrictive practices. This may be due to the number of staff on duty are unable to manage the number of service users or the behaviours they present, as according to policies determined by organisation's they do have enough staff, however the reality of the matter differs.

> *"The rotation of staff also needs to happen... if I'm one-to-one with my SIB girl I'm with her 12 hours, it's a long time"* (Interviewee 5, Healthcare Worker).

According to Casey *et al.,* (2020, p.16) from their study of 7,046 adults with an intellectual disability living within a residential care setting, only "6% of individuals had one-to-one support and 2% had greater than one to one support". This correlates with the findings from this research as it is evident that the lack of staff impacts negatively on service users. This finding also suggests that the use of restrictive practices replace the role of staff within services for adults with an intellectual disability. This means that restrictive practices may be used as a ‘safety net’ when there are staff shortages, as staff may be unable to manage behavioural outbursts alone. This finding also highlights that when staff shortages occur, trainings such as MAPA may be ineffective, as MAPA is a two- person hold. Therefore, the lack of staff increases the risk of harm to both staff, service users and service provision, staff are unable to manage behavioural outbursts if there is no available staff to support them. An interesting point made by one interviewee highlights that there is a significant need for support greater than on-to-one.

> *“It's near impossible to manage some of our service uses and outbursts one-on-one”* (Interviewee 11, Social Care Worker).

This reinforces that, those professionals working with adults with an intellectual disability need support from other staff regarding managing challenging behaviours. It is evident that the professionals are left with few alternatives when there are staff shortages within services for adults with an intellectual disability. Additionally, this reinforces that the use of restrictive practices is one of the main alternatives to support staff when there are staff shortages.

> *“Not enough staff to actually support that person in the right way and reduce those restrictions”* (Interviewee 8, Manager)

An additional factor suggested by this research highlights that the lack of staff within services for adults with an intellectual disability impacts on the care provided. It may also be interpreted that because of staff shortages, there may not be the correct number of staff to support an individual as stated in a care plan, and, therefore, may lead to malpractice. This suggests, in conjunction with previous findings regarding staff shortages, that the level of care provided is decreased when there is a lack of staff. This indicates that if there is a high number of service users, they may not receive focused one- to- one attention, as there is an inadequate number of staff to provide any more than basic personal and intimate care. This indicates that when professionals encounter staff shortages, they are only able to provide the minimum standard of care.

It is evident from the findings that the issue surrounding staff shortages means that restrictive practices are more likely to be used to replace work that may be carried out by staff. However, this hinders the freedom and independence of adults with an intellectual disability as previously discussed. It appears that the issue surrounding staff shortages is one domino effect that contributes to a least restrictive environment, if there was funding available, organisations may be better able to provide incentives for staff which would increase employment uptake and staff retention. Therefore, it is apparent that funding appears to be key barrier to a least restrictive environment. By contrast, interviewees noted that United Nations Convention on the Rights of a Person with a Disability was a factor that contributed to a least restrictive environment.

4.4.1 United Nations Convention on the Rights of a Person with a Disability

Eight interviewees were aware of what UNCRPD is, whereas four were unaware.

> *"I actually had to go look this up... there's something about more rights for ID and something about housing as well for people with an intellectual disability regarding the policies and all that would be higher up levels. It wouldn't be us on the ground"* (Interviewee 9, Social Care Worker).

This finding suggests that because the UNCRPD is a piece of legislation that would mainly be dealt with at management level. This also suggests that the UNCRPD does not govern professionals who work day-to-day with adults with an intellectual disability. However, Article 25 of the UNCRPD (2006) clearly highlights that healthcare professionals must provide quality care to individuals with a disability. This means that regardless of a professional's role within services for adults with an intellectual disability, the rights of an individual with an intellectual disability must be maintained by all who provide their care. This may have an impact on service provision, as it may be interpreted that it is the role of management to inform frontline professionals of legislation such as the UNCRPD. This may lead to a breakdown in the quality of care provided as professionals working day-to-day with adults with an intellectual disability are not informed. An additional finding regarding the implementation of the UNCRPD was:

> *"I'm not sure even in this modern day and age is a lot of it being adhered to"* (Interviewee 5, Healthcare Worker).

This finding indicates that UNCRPD has not been fully introduced within all services for adults with an intellectual disability. However, this also indicates that if professionals are unaware of the UNCRPD, they are unable to implement or follow guidelines and standards. This suggests that it is the professional in a managerial role responsibility to inform professionals who work day-to-day with adults with an intellectual disability of such guidelines.

> *"It's going to be very difficult for people to get their heads around it (UNCRPD)"* (Interviewee 8, Manager).

Additionally, the Human Rights Based approach are a set of guidelines, developed from the UNCRPD and HIQA National Standards, directed at health and social care professionals. The purpose of a Human Rights Based approach "ensures your ability to protect the human rights of people using the service you work in. It also promotes professional accountability within the service" (Health Information and Quality Authority 2019, p.9). As suggested by interviewees, professionals in managerial roles would be more aware of the UNCRPD. Therefore, the Human-Rights Based Approach was adapted to fulfil this gap for professionals who work day-to-day with adults with an intellectual disability. Although, the Human-Rights Based Approach wasn't mentioned *verbatim*, all interviewees noted principles of it.

> *"It's about promoting wellbeing for service users... promoting their independence, wellbeing... treating people with respect and dignity"* (Interviewee 12, Social Care Team Leader).

Arguably, this means that the UNCRPD involves all health and social care professionals working with adults with an intellectual disability, not just management. Although it appears that it may be management's responsibility to make employees aware of the UNCRPD, the UNCRPD governs everyone within services for adults with an intellectual disability.

> *"It's (UNCRPD) not just for the residents, but the staff may have issues trying to get rid of restrictive practices that have been put in place because it's just easier for them to deal with the behaviour being nipped in the bud"* (Interviewee 2, Healthcare Worker).

This implies that professionals working within services for adults with an intellectual disability would rather keep restrictive practices in place, rather than implement proactive interventions that may reduce behavioural outbursts and decrease the use of restrictive practices. This finding suggests that some services may be 'old fashioned' in terms of the model of care followed.

> *"(Name of organisation) they would still be kind of in the medical model instead of being person centred"* (Interviewee 7, Social Care Worker).

According to Finkelestein (1998 cited in Bunbury 2019, p. 28) the medical model "reinforces the disabled person's dependency and sick role". This is interesting as some services within Ireland are still following the medical model in comparison to the social model of care, as it does not afford adults with an intellectual disability independence or development.

> *"The older staff, they might not be as interested in the social model because I suppose they've been doing things the old way for so long"* (Interviewee 6, Social Care Worker).

This finding denotes a long legacy of ableism. Professionals employed in services for adults with an intellectual disability inherited ideologies and biases over a vast period of time within such services. This finding suggests that the attitudes of *"the older staff"* reflect on the discriminatory perspectives and disregard towards adults with an intellectual disability. This highlights that, culturally, services for adults with an intellectual disability, remain in the past, whereby adults with an intellectual disability are not meant to be seen or heard (O'Doherty, 2019). This also implies a power imbalance between staff and service user. Henderson (2003) found in their study that the beliefs' of healthcare professionals suggested that they know what is best for the patient/service user, also the lack of cognitive ability and/or capacity of service users allowed for healthcare professionals to hold onto the power and maintain control. The ideology of power imbalance is was also suggested below:

> *"The older staff who have been there so long are institutionalised themselves... they don't want to deal with the outcome"* (Interviewee 2, Healthcare Worker).

The power imbalance between staff and service user is evident within this finding, the *"older staff"* demonstrate disregard towards adults with an intellectual disability as staff have the power to decide what they want to do or what not to in any scenario. Moreover, this finding also distinctly highlights ableism, such as the staffs' own attitudes towards individuals with an intellectual disability. The institutionalisation of staff themselves also highlights an old model of care, the medical model of care. It may be determined that some services may be slowly moving away from the medical model of care to the social model, however, efforts must be made to ensure the rights of an individual with an intellectual disability are being followed. This finding provides significance as Ireland has ratified the UNCRPD, making it a legally binding contract and all disability services must therefore follow, protect and promote the rights of individuals with a disability.

In summary, the findings suggest that services for adults with an intellectual disability in Ireland are slowly moving towards a least restrictive environment. One of the reasons for this, is some services for adults with an intellectual disability are currently still following the medical model of care. However, it may also be determined that professionals working with adults with an intellectual disability may not want to change, regarding day-to-day roles. Finally, the findings highlight that professionals are aware of the factors that contribute to a least restrictive environment, but also identified why they are currently necessary within services for adults with an intellectual disability.

4.5 Safeguarding Professionals and Adults with an Intellectual Disability

It was agreed by all interviewees that the outcome of restrictive practices *should* be to provide safety for service users. According to Søndenaa *et al.,* (2015) one of the core purposes of restrictive practices is to provide safety for adults with an intellectual disability. Additionally, the findings suggested that restrictive practices are also to provide safety for professionals. Whilst regarding the outcome of restrictive practices, the findings also provide a better understanding of what restrictive practices are in services for adults with an intellectual disability.

> *"Restrictive practices are to keep the people who we support safe... sometimes staff will have to put themselves in the firing line"* (Interviewee 10, Healthcare Worker).

This finding indicates that professionals risk their own safety to maintain the safety of service users. In addition, it appears that the main risk factor regarding the safety of professionals and those living within a service is challenging behaviours. Challenging behaviour can be defined as abnormal and puts the safety of themselves or others at risk (Kinney *et al.,* 2020). This finding also highlights that, restrictive practices alone, are not enough to keep staff and service users safe. However, the findings from the current study suggest that challenging behaviours provides that the safety of staff is treated as less important than the safety of service users.

> *"I've been groped by residents and said it to my manager, but nothing was done about it because they had dementia"* (Interviewee 2, Healthcare Worker).

This type of challenging behaviour can be classed as sexual challenging behaviour as it contributes to negative implications for staff such as stress, depression, and other negative psychological outcomes (Clari *et al.,* 2020). This may also be classed as sexual assault. It appears, from this finding, that the severity of incidents regarding inappropriate sexual behaviour is not taken seriously by management due to the nature of the case, as individuals with an intellectual disability are cognitively impaired. Therefore, it may be determined that the individual did not know what they were doing. Interestingly, incidents such as this have been reported to management, but perhaps may not have been fully resolved. This provides an insight that the safety of staff has been ignored due to the nature of the disability sector.

> *"There are some female service users could be getting up and personal with the male staff and then vice versa with male service users"* (Interviewee 7, Social Care Worker).

This indicates that boundaries, regarding the services user and staff relationships, can be problematic regarding inappropriate sexual challenging behaviour. This highlights that, although the person-centred relationship may be beneficial regarding managing challenging behaviours, as previously established, it may also lead to issues regarding the safety of staff. However, this suggests that in some cases, it may be inappropriate and non-consensual, if boundaries have not been recognised, specifically, professionals working with service users of the opposite gender. This may lead to further issues of inappropriate sexual challenging behaviour, and jeopardise the safety and welfare of staff, leading to burnout and professionals leaving their profession.

> *"When people are really seriously injured, and people are bruised and have potentially black eyes or are so traumatised by the event that they don't want to work in the sector anymore"* (Interviewee 1, Social Care Team Leader).

According to the Safety, Health and Welfare at Work Act (2005) section 8.1 states that "Every employer shall ensure, so far as is reasonably practicable, the safety, health and welfare at work of his or her employees". It is evident that professionals are subjected to injuries and incidents of challenging behaviours regardless of their safety. This proposes that an intervention such as a restrictive practice should be in place, to prevent injuries from occurring as the purpose of restrictive practices as agreed on by all interviewees is to keep service users and professionals safe. Interviewees, however, highlighted, this is not the case. It appears that the use of restrictive practices is limited as injuries to staff are still occurring because of behavioural outbursts. This implies that the restrictive practice is unsuitable for a specific incident or behaviour, restrictive practices are not being used at all or professionals themselves are acting as a restrictive practice and are taking the outcome of a behavioural outburst. Also, the lack of training available as indicated by interviewees to implement restrictive practices in a safe way may increase the risk of professionals' safety. This implies that restrictive practices are necessary for the safety of both, service users and professionals.

Eight interviewees believe restrictive practices are necessary for the purpose of providing personal and environmental safety for service users and professionals. Additionally, the idea that the implementation of restrictive practices should be specific to an individual is evident here. This promotes a person-centred approach but also appears to limit the use of restrictive practices as they would be specific to an individual. Moreover, this also demonstrates that for a restrictive practice to be put in place it must be deemed necessary for the individual regarding their safety and the safety of others. In comparison, four interviewees were conflicted and could not provide a conclusive yes or no regarding whether restrictive practices are necessary or not.

> *"Yes and no, it depends if an individual is living with other residents...I don't think it ever should be if a person is living by themselves, it depends on the person because of some individuals past and due to what they've done"* (Interviewee 1, Social Care Team Leader).

This provides evidence that, restrictive practices may be eliminated in certain circumstances. In addition, this also highlights that, a restrictive practice may indirectly impact on not just the individual that the restrictive practice is meant for but also those living within the service. It is also evident that an individual behaviour contributes to the use of a restrictive practice, however, it may also be determined that an individual's living circumstances depends on whether a restrictive practice is implemented or not, this may be for the safety of themselves and others.

> *"If you just have to do it, you have to, if you've no choice, if you're in danger or another person we support are in danger, there's no question about it, you have to do it"* (Interviewee 6, Social Care Worker).

The safety of adults with an intellectual disability is highlighted within this research as connotations of urgency are suggested regarding the implementation of a restrictive practice. Interestingly, this provides an insight that in certain circumstances, when there are no restrictive practices in place, however, when the safety of individuals was at risk a restrictive practice was implemented. When professionals believe they have *no choice* but to implement a restrictive practice, this suggests that they are used as a last resort which is according to The Health Information and Quality Authority (2016) is the intended purpose of a restrictive practice. This highlights that restrictive practices are necessary regarding the safety of service users and others that are present. However, this finding also demonstrates that restrictive practices are circumstantial, an incident or behavioural outburst that endangered the safety of themselves or others occurred prior to the implementation of a restrictive practice.

Furthermore, the findings suggest that the purpose of restrictive practices is to keep both service users and professionals safe. The main finding was that the safety of service users is prioritised over professionals providing their care. As previously mentioned within the literature review, the rate of staff turnover in health and social care professions are high (Health Service Executive, 2019). Therefore, it may be interpreted that, if professionals were afforded the same level of safety as service users, there may be less staff turnover and less workplace injuries. Within services for adults with an intellectual disability the most significant risk to any individual's physical and emotional safety is challenging behaviours.

Challenging behaviour was found to be the main cause of violence against staff and indicated that although incidents have been reported to management, appropriate measures were not taken due to the nature of the intellectual disability sector. It was found from this study that the nature of the intellectual disability sector, professionals who work day-to-day with adults with an intellectual disability expect some level of harm towards staff.

> *"Challenging behaviour can be a thing that staff endure...but I've left my last job due to high levels of challenging behaviour"* (Interviewee 1, Social Care Team Leader).

This indicates that professionals are aware of the risks implied when working with challenging behaviours. Interestingly, this finding implies that staff working with challenging behaviours can work with challenging behaviours, however, only for a period. This implies that, challenging behaviours not only risks the safety of individuals but impacts on an individual's professional career. The term *endure*, suggests that professionals suffer working with challenging behaviours.

> *"It's actually exhausting to work with, I find challenging behaviour a lot harder to work with"* (Interviewee 6, Social Care Worker).

Because of this the safety of professionals is at risk and may, therefore lead to burnout and staff retention issues. This highlights the necessity of restrictive practices as agreed by all professionals interviewed, as they are to provide personal and environmental safety. Therefore, factors that contribute to behavioural outbursts is a key indicator of determining the safety of themselves and others, moreover, it follows that if incidents of challenging behaviour are limited, the safety of professionals and service users increases.

Six interviewees mentioned that in relation to challenging behaviours and restrictive practices, the environment in which the service users live can be a key indicator of whether incidents of challenging behaviour occur, or whether challenging behaviours escalate. In addition, interviewees provided an insight that the dynamic between service users is also an indicator of challenging behaviours and restrictive practices.

> *"Not all the clients that live together get on with each other, they're put into houses together just because of need for their family situation or there's not enough beds throughout the organisation"* (Interviewee 2, Healthcare Worker).

It is evident that adults with an intellectual disability are placed in houses based on availability rather than compatibility. This may be a case of urgency for a bed. However, it appears that individuals have been living with peers they do not like or have not got on with for a while, therefore, it is evident that it is not a case of urgency rather than a matter with prioritising this issue.

> *"He would be like "new house new house new house" ... he has no interest being there...but it's not a priority to try and get him a new house"* (Interviewee 6, Social Care Worker).

Adults who are neurotypical are afforded a choice of who they live with or who they choose to see on a day-to-day basis, however adults with an intellectual disability are not afforded this choice as articulated by the interviewees. This is important, as many services claim to be person-centred and prioritise the needs and wants of adults with an intellectual disability. However, this finding implies that services are not availing to the needs and wants of service users which means that they are not person-centred. This again, highlights that the environment and the dynamics of individuals living with a service is not considered a priority even though it may suggest that behavioural outbursts may decrease whereby the use of restrictive practices would be reduced and would result in less workplace injuries. This idea correlates with the concept of a least restrictive environment, whereby if the environment is suitable, restrictive practices would be reduced. Findings suggest that the use of restrictive practices in services for adults with an intellectual disability are more favourable towards service users and management. It was evident from the findings that management and/or team leaders carry out risk assessments, therefore, are responsible for who the restriction is implemented for. As previously found restrictive practices are implemented to prevent harm from occurring to service users and staff, however, the findings suggest that the restrictive practices that are implemented are more focused on the safety of service users rather than staff. The findings also suggests that restrictive practices do not keep staff safe, this may be because professionals who work day-to-day with adults with an intellectual disability are not involved in the risk assessment process. This reiterates the point whereby the safety of service users is prioritised over staff, outcomes of this may enhance an unsafe workplace environment, if professionals are injured and/or traumatised from a behavioural outburst incident and are unable to work. Although service users have little to no input into such practices, it was found that they are implemented specifically for the safety of service users and therefore, to some extent gain bias. Therefore, restrictive practices should be favourable towards both service users and staff ensuring safety for both groups of individuals.

Moreover, it was evident that restrictive practices are biased towards intellectual disability organisations. This was found as the categories of restrictive practices listed previously (Chemical, Physical, Seclusion, Mechanical, Environmental) are evident only in services for adults with an intellectual disability and not in everyday society, and therefore, biased in favour of intellectual disability organisations. This suggests that intellectual disability services may be considered restrictive environments as services users are restricted within the service itself but not in society.

In summary, the findings highlight that in relation to the safety of professionals and service users, restrictive practices are necessary. However, the findings also highlighted that the safety of service users is prioritised over the safety of professionals. Due to the vulnerable nature of adults with an intellectual disability, it may be suggested that their safety is more important that professionals who provide their daily personal and intimate care. However, it appears that, if the safety of staff is at risk because of behavioural outbursts, there is more likely higher rates of staff turnover and therefore, staff shortages. This may indirectly lead to higher levels of restrictive practices being implemented within services for adults with an intellectual disability as staff are unable to manage the levels of challenging behaviours.

4.6 Conclusion

This chapter discussed and analysed professional's perspectives of restrictive practices within services for adults with an intellectual disability. The comparison and contrasts are evident in findings between professionals who work closely with adults with an intellectual disability and a professional in a managerial role. The findings highlighted that although there was no one fixed operational definition of the term restrictive practices, professionals provided that restrictive practices are measures/interventions put in place to provide safety for service users and staff, they are measures put in place to stop/prevent an individual from doing something they wish to do and, restrictive practices impede on the rights of an adult with an intellectual disability. Factors that are associated with restrictive practices such as challenging behaviours, trainings and safeguarding provided an in-depth exploration to the use of restrictive practices within services for adults with an intellectual disability.

It was agreed by the majority of interviewees that restrictive practices are necessary for the safety of both staff and service users, trainings regarding restrictive practices and challenging behaviour are not effective in day-to-day scenarios. This indicates that reactive strategies regarding, responding to challenging behaviours will always be required. Finally, it is evident that there are gaps regarding the use of restrictive practices in responding to challenging behaviour, the training provided for professionals in services for adults with an intellectual disability. Finally, to define restrictive practices it may be determined that there are a variety of factors to be considered with regards to the human-rights of an adult with an intellectual disability, the type of restriction, the safety of the service users and staff, but most importantly how restrictive practices are implemented in services for adults with an intellectual disability.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

This research set out to define restrictive practices in services for adults with an intellectual disability from the perspectives of professionals. In summary, it was evident that each interviewee had a different perspective of what restrictive practices encompass regarding adults with an intellectual disability. In addition, this research provides a wider understanding of why restrictive practices are implemented, and contradicts a variety of the negative connotations associated with restrictive practices.

5.1.1 Defining Restrictive Practices

In relation to defining restrictive practices, the results of this study determined that there is no one fixed operational definition recognised by professionals that describes restrictive practices in the context of services for adults with an intellectual disability. This was a key finding from this research, as although no one clear operational definition of restrictive practices was evidenced, interviewees provided specific characteristics of what restrictive practices entail within their specific service. Characteristics of restrictive practices found, include:

- Stop or prevent an individual from doing something they wish to do freely,
- Takes away a persons' freedom and rights.

The findings highlight that where an overall definition of restrictive practice is highlighted by organisations such as HIQA, the interviewees did not agree on one specific definition of restrictive practices, and the definition of restrictive practices is dependent on the type of population within a service.

The findings from this research highlighted that, operational definitions of restrictive practices vary and reflect the type of service and the service users within an organisation. This emphasises the complexity of restrictive practices, which may require more than one definition depending on the context. Similar, to the finding whereby restrictive practices are not a ‘one size fits all’ intervention, the definition of restrictive practice is also currently individualised at an operational level.

5.1.2 Moving towards a least restrictive environment

A key finding of this study was that restrictive practices were deemed necessary to provide safety for service users and staff. It was agreed by all professionals interviewed that, the intended use of restrictive practices, are indeed necessary for the safety of the service users and staff and to prevent harm from occurring. This means that the presence of restrictive practices in services for adults with an intellectual disability may not be completely eradicated due to their agreed necessity. However, it may be possible to eradicate restrictive practices that are not deemed necessary through risk assessments, which would promote a least restrictive environment. The limitations in determining whether restrictive practices are appropriate, or not, is determined by the capacity of the service user, the policies of an organisation, and the type of training professionals receive.

An additional finding was that staff to service user ratio is a key factor in determining whether the use of restrictive practices either increase or decrease. Staff shortages was highlighted to be to a key indicator which increased the use of restrictive practices in services for adults with an intellectual disability, whereby restrictive practices were used in place of staff. One of the main issues that emerged from the findings, was that there was no exact, mandated number of staff to service user ratio for intellectual disability services in Ireland. This also highlights the issue whereby, if there is an insufficient number of staff present, restrictive practices are no longer a last resort, as restrictions often replace staff. This was apparent, as restrictive practices are necessary for the safety of everyone involved, the professionals agreed that to either implement or engage in a restrictive practice incurs negative connotations.

Eight interviewees noted negative connotations associated with restrictive practices. The remaining four interviewees highlighted that, although restrictive practices are beneficial to service users and staff, they are used with caution because of the negative connotations associated with their use. The stigma surrounding restrictive practices is still evident, due to Ireland's precarious history on the misuse of restrictive practices, however, the results of this research show, that a lack of restrictive practices, leads to workplace violence towards professionals.

The concept of ableism was expressed widely throughout the interviews. Ableism was found to be a barrier towards a least restrictive environment within services for adults with an intellectual disability, with factors such as predisposed biases from society, professionals' attitudes, and perspectives of adults with an intellectual disability and power imbalances between staff and service users but also staff and managers. Through the lens of societal justice, ableism awareness offers and educates professionals on personal and societal biases, attitudes and discriminatory behaviour that occurs towards adults with an intellectual disability. Moreover, ableism awareness within services for adults with an intellectual disability promotes an accessible, least restrictive environment and a human-rights based approach.

The practical, action -oriented alternatives were also found to enable a least restrictive environment, such as professionals as educators/teachers, professionals recognising internalised ableism and proactive responses to incidents of challenging behaviour. An additional aspect that proved significant regarding a least restrictive environment was the practical application of staff training. The findings highlighted that, trainings regarding restrictive practices and managing challenging behaviours are not practically effective in services for adults with an intellectual disability.

The accepting culture of challenging behaviour and violence against staff contributes to staff turnover. The impact of challenging behaviour on staff was found to be negative as interviewees suggested that this is an aspect of working in the disability sector is concerning. It is interesting however, that it was also determined that, professionals within services for adults with an intellectual disability, have a better understanding of a behavioural outburst, rather than understanding the functions and causes of challenging behaviours. Additionally, it was found that the safety of service users is prioritised over the safety of professionals. However, since the ratification of the UNCRPD, adults with an intellectual disability are legally afforded the same rights as a neurotypical individual and therefore, the level of safety provided to both professionals and service users should be equal.

5.1.3 The impact of varied terminology used in conjunction with restrictive practices.

It was clear that terminology such as challenging behaviour does have an impact when used in conjunction with restrictive practices. This research found challenging behaviours to be a determining factor, whether a restriction is put in place or not. There were many forms of challenging behaviour found throughout this research. However, it was agreed by all interviewees that working with challenging behaviours is the most common reason for staff shortages and staff turnover. This is because challenging behaviours pose a risk to the individual themselves, staff and other service users. To use the term restrictive practice on its own lends to misconception of the intended outcome of the practice, such as restricting an individual from freedom or, movement, for the intended purpose of safety. However, a key finding suggested that the lack of the use of restrictive practices has led to an increased risk of harm to staff and service users. It was evident from the findings that the term challenging behaviour in services for adults with an intellectual disability is at all times associated with safeguarding and risk assessment. It was agreed by all interviewees that risk management is essential for implementation of restrictive practices. However, the lack of involvement of professionals working day-to-day with adults with an intellectual disability in the risk assessment process proved challenging. This is because professionals working day-to-day with adults with an intellectual disability would know the service users best and would be better able to determine whether a restrictive practice is or is not necessary for their safety.

It was also evident that the concept of ableism, although not mentioned directly, was evident throughout the findings. The discrimination, inequality, power imbalance and disregard for adults with an intellectual disability was apparent. Ableism was also apparent from the onset as, historically in Ireland, individuals with an intellectual disability were not meant to be seen or heard. Therefore, individuals with an intellectual disability faced lifelong discrimination and inequality, which then leads to internalised ableism. Elements of internalised ableism were apparent through the use of restrictive practices, whereby adults with an intellectual disability were aware of the restrictions placed on them, for the purpose of safety or the management of challenging behaviours. Therefore, it is evident that the term *ableism* denotes negative connotations and impacts on adults with an intellectual disability negatively.

5.1.4 Effectiveness of Trainings regarding Restrictive Practices responding to Challenging Behaviours

A further finding from this study highlighted that, professionals employed in services for adults with an intellectual disability choose to use their own initiative in relation to implementing restrictive practices and managing challenging behaviours regarding the trainings provided. This was due to the perspectives of the professionals interviewed highlighted that the trainings received regarding restrictive practices and managing challenging behaviours lack practical, day-to-day knowledge regarding behavioural outbursts. Moreover, the findings highlighted that there is a lack of involvement by professionals who work day-to-day with adults with an intellectual disability in the evaluation of the trainings. This highlights that the trainings are not tailored to facilitate daily occurrences within services for adults with an intellectual disability, as the trainings are set out by professionals in managerial or external roles, who would not be familiar with the daily operations or dynamics of a specific service. In addition, in relation to trainings, professionals employed in organisations in the current study, have not received any training regarding restrictive practices and challenging behaviours prior to their employment. Although it is common to receive training within a short period of time after beginning employment, the findings highlighted an issue whereby professionals were employed in high challenging behaviour services without any form of training for a year or more. The findings also suggest that proactive trainings such as PBS, are more suitable for staff and service users, rather than reactive trainings such as MAPA. This is because proactive trainings provide less risk to staff and service users, are less invasive practices and focus on the preventative practices such as de-escalation. The findings may also be interpreted that the lack of adequate trainings for health and social care professionals is due to the corporate culture.

5.2 Recommendations for Practice, Policy and Future Research

The following recommendations emerging from this research address factors that contribute to practice, policy and furture research. This research recommends that the entire concept of restrictive practice is viewed in a wider manner, as restrictive practice has unintended, but nevertheless still highly pejorative connotations. Whilst restrictive practices are still viewed as inherently impinging on the rights and freedoms of adults with an intellectual disability, such actions were deemed necessary for the safety of staff and service users. Therefore, the recommendations of this research address areas whereby, restrictive practices can be appropriately used, provide the necessary safety for services users and staff and also to promote a least restrictive environment.

Additionally, it can be recommended that, specifically in the Irish context, in order for services for adults with an intellectual disability to move towards a least restrictive environment, professionals should be provided with ablesim awareness, services should be person-centred, following a human-rights based approach, a mandated staff to service user ratio and appropriate trainings. The mandated staff to service ratio may be achieved if services for adults with an intellectual disability are no longer following a profit driven model of care, similarly, ableism was found to be a key indicator of a restrictive environment. Moreover, professionals employed within services for adults with an intellecctual disability should be educated on the history of abuse within health and social care services in Ireland such as, Aras Attracta, Industrial Schools and Magdalene Laundries, whereby vulnerable individuals where mistreated and abused (McAlinden, 2012). Therefore, ableism awareness, should challenge professionals attitudes and biases towards adults with an intellectual disability, to allow for a better understanding and consideration towards adults with an intellectual disability.

5.2.1 Inclusion of Adults with an Intellectual Disability in their Care.

It can be recommended that adults with an intellectual disability should be included in the process of the implementation of restrictive practices. This may be achieved by assessing an individual's capacity, involving service users in the risk assessment process. Adults with an intellectual disability, since the ratification of the UNCRPD, are encouraged to be involved in their own personal care, therefore, their opinions/ needs/ wants should be included in measures that will have an impact on their day-to-day lives. Furthermore, the involvement of service users in their own personal care may alleviate responsibility of staff and further the independence of service users. This may then, indirectly decrease the use of restrictive practices.

5.2.2 Introduction of Effective Trainings for daily use in services for Adults with an Intellectual Disability

It can be recommended that professionals working with adults with an intellectual disability who display challenging behaviours should be provided with trainings that are effective in day-to-day scenarios that can and may occur. Effective trainings should include trainers who have practical day-to-day knowledge of what can or may occur within services for adults with an intellectual disability, following and adapting to the needs of service users, an individualised approach and identifying specific requirements for service users. Alternative trainings should be emphasised, in-keeping with the UNCRPD and following a baseline of a person-centred approach. Alternative trainings should include looking at antecedent behaviour, and also understanding why challenging behaviours occur. In addition to effective trainings, managers should also provide an appropriate support system for professionals who have been effected/ injured from a behavioural outburst. This may include incident specific supervision, to debrief with staff and provide any support for staff that is deemed necessary.

5.2.3 Evaluation of Trainings regarding Restrictive Practices and Challenging Behaviours

Trainings regarding restrictive practices and challenging behaviours should be evaluated to establish the effectiveness of such trainings being used on adults with an intellectual disability. Evaluation should happen as soon as possible after the training is received. However, it is important to consider the findings of this research as it was viewed that, ‘tick the box’ exercises have proven to be non-effective in determining the effectiveness of trainings. A qualitative approach, such as focus groups, to evaluate trainings is recommended. It is also recommended that the training facilitator is not involved in the evaluation process, as it may lead to bias. Therefore, an independent body is recommended to carry out the evaluation process of trainings and provide feedback and recommendations to the facilitator.

5.2.4 Health Information and Quality Authority Policies

It is the descretion of the organisation to employ the number of staff dependent on the number of service users, regardless of the needs of individuals within services for adults with an intellectual disability. This recommendation is for HIQA to establish a mandated ratio of staff to service users to avoid the use of restrictive practices to increase and staff shortages. The recommendation also includes that the mandated ratio of staff to service user, should be specific and focus on the type of service for adults with an intellectual disability such as: services with high levels of challenging behaviour, services for young adults, services for an older population and respite services.

It is also recommended that HIQA, should adjust their standards and guidelines for services for adults with an intellectual disability to reflect the UNCRPD, ableism aware and a least restrictive environment. This research found that the current guidelines and standards set out by HIQA creates a restrictive environment, whereby a culture of managerialism is present. The corporate culture and culture of managerialism inhibits the training and education of professionals working with adults with an intellectual disability to establish a least restrictive setting, this is because the resources that are needed are not readily available to frontline professionals, only to those who are in management and corporate employements.

An additional recommendation is to date, there is only one mandatory, training regarding restrictive practices and challenging behaviours, MAPA. This research recommends that the HSE and/or HIQA should mandate trainings such as Positive Behaviour Support Training and other proactive trainings in accordance with a human-rights based approach and the UNCRPD.

5.2.5 Recommendations for Future Research

A future research study could consider expanding to include a larger scale of participants, including professionals employed in services for adults with an intellectual disability who provide personal and intimate care, but also, professionals who provide trainings in relation to restrictive practices and challenging behaviours. This larger scale of participants should provide better comparison and contrasts of perspectives regarding restrictive practices. Participants may also include adults with an intellectual disability. A mixed method approach, such as a questionnaire, may better suit adults with an intellectual disability, depending on the capacity of an individual. Included in the mixed method approach, the qualitative research approach may better suit professionals.

An additional recommendation for future research relating to this topic, could include an investigation to alternative methods to restrictive practices within services for adults with an intellectual disability. The current types and methods of restrictive practices are widely known, however, there is little known as to what may be implemented instead of restrictive practices. As intellectual disability services in Ireland are moving towards a person-centred approach and a social model of care, future research should look at alternatives to restrictive practices and how they can be achieved.

5.3 Strengths and Limitations of Research

As with any empirical based research approach, there are strengths and limitations associated with it (Punch, 2014). Qualitative research in the form of in-depth interview was a key strength for the gathering of findings regarding the use of restrictive practices in services for adults with an intellectual disability. This approach allowed for the perspectives of professionals to be presented in a way that captured information-rich data. From a methodology viewpoint, an additional strength to this research study was the design of the interview guide. The interview guide was semi-structured, this meant that additional, probing questions could be asked. This allowed for an in-depth exploration of the professionals perspectives' of restrictive practices in services for adults with an intellectual disability.

All interviewees were, at the time of this research, working in services for adults with an intellectual disability, and had experience working with challenging behaviours and restrictive practices. This allowed for an extensive insight into the day-to-day use of restrictive practices and the realities of how restrictive practices impact on services for adults with an intellectual disability. Additionally, one professional at a managerial level was included within this study, and this allowed for comparison with professionals who work day-to-day with adults with an intellectual disability. The inclusion of a professional at managerial level also allowed for an insight to the within intellectual disability services.

The sample size of the interviewees and the geographical location of this study was small. The findings of this study does not represent every professionals' perspectives and intellectual disability service for adults within Ireland. However, the viewpoints represent an in-depth sample of a specific location. All interviews were conducted through Zoom, therefore, provided strengths regarding the interview procedure as it may be further investigated on a larger scale.

A strength of this research was the completion of a pilot interview. The pilot stage of the interview procedure was important, it allowed for challenges to be encountered and adapt accordingly, which lead to increasing the strengths of this study. During the pilot stage of the interview procedure, the professional indicated that they did not feel confident speaking openly on the topic of restrictive practices, as it can be a sensitive subject regarding its uses. Specific questions within the interview guide were identified and it was suggested that further acknowledgement of anonymity may empower interviewees to speak openly as part of this research study. As a result, interviewees were reassured that anonymity would be guaranteed, this was acknowledged in the consent form, and interviewees were also reassured prior to the beginning of each interview, that no identifying information would be included throughout this study. Anonymity provided further reassurance for interviewees to speak open and freely without judgement.

The Covid-19 pandemic proved to be the most significant challenge this study faced. As previously mentioned due to the global Covid19 pandemic, interviews could not take place in a natural environment, therefore, interviews took place over Zoom. Although there were benefits to the use of Zoom for qualitative interviews as discussed previously, one limitation that was encountered was the quality of the recorded interviews. Interviews were recorded by a mobile phone, with the consent of the interviewees. The limitation of the quality of the audio-recorded interviews was overcome throughout the pilot interview, whereby trials of placing the phone in different positions and changing the volume would increase the quality of the audio-recording. Following the transcription of each interview, the audio recording was permanently deleted. As the interview was not face-to-face and was recorded through laptop speakers, the audio recordings of the interviews were obscured. This impacted the write-up of the transcripts, as extensive time was taken to listen accurately to the audio-recordings of each interview to ensure preciseness.

Due to the Covid-19 pandemic contacting professionals working within services for adults with an intellectual disability provided a challenge, In conjunction with GDPR, personal data of persons must be protected (Irwin, 2021). This meant that the point of contact was through phone and email, which hindered the process of getting in contact with professionals, as there was many unaswered phonecalls and emails. Although, securing a representative sample provided its difficulties, the snowball sampling technique, as previously discussed within the methodology chapter, allowed for further connections with professionals to be secured. Therefore, a strength of this study emerged from gaining access to professionals in the first instance.

In conclusion, it was evident that this research study encountered strengths and limitations associated with any type of research. The limitations faced by this study, not only provided an insight in to carrying out research in an unnatural setting but also further developed strengths, that assisted the research process. The strengths of this study focus heavily on empirical-based research as it allowed for an in-depth exploration of restrictive practices within services for adults with an intellectual disability from the perspectives of professionals who are involved with day-to day care.

5.4 Concluding Remarks

This research study explored the definition of restrictive practices, used within services for adults with an intellectual disability. The perspectives of professionals employed in services for adults with an intellectual disability provided an, in-depth insight to what is meant by the term restrictive practices and associated terminology, such as challenging behaviours, risk management and safeguarding.

The ambiguity and precarious nature surrounding the term restrictive practice within services for adults with an intellectual disability was highlighted from the outset of this research. The definitions provided by organisations such as HIQA, noted negative connotations associated with their use and the use of restrictive practices are viewed as the ‘last resort’ when responding to challenging behaviours. The ratification of the UNCRPD in 2018, in Ireland and, the establishment of the Assisted Decision-Making (Capacity) Act (2015) spearheaded the movement on the rights of individuals with an intellectual disability and the movement of intellectual disability services towards a least restrictive environment.

The objective of this research study was to define restrictive practices in services for adults with an intellectual disability. Through the exploration of professionals' perspectives, there was no one operational definition of restrictive practices identified, however, it was evident that restrictive practices are indeed necessary regarding responding to challenging behaviours and providing safety for service users and staff. This highlighted that a restraint-free environment would not be possible, however, intellectual disability services in Ireland have an opportunity and obligation to move towards a least restrictive environment, which uphold the rights of adults with an intellectual disability, in conjunction with HIQA National Standards and Guidelines for Disability Services and the UNCRPD.

This research study contributed a deeper understanding of restrictive practices in services for adults with an intellectual disability, by examining staff training regarding restrictive practices and challenging behaviours, and highlighted how services for adults with an intellectual disability can move towards a least restrictive environment whilst considering the safety of service users and staff. This research study also brought additional light to key issues within intellectual disability services for adults such as workplace violence, lack of funding for intellectual disability services, and the need for alternative trainings responding to challenging behaviours. Furthermore, the history of misuse of restrictive practices in intellectual disability services in Ireland that contribute to the stigma and negative mindsets surrounding restrictive practices were outlined. Fundamentally, this research study highlighted that restrictive practices are always going to be necessary in intellectual disability services, where incidents of challenging behaviours are present, for the safety of service users and staff, however, the human-rights of adults with an intellectual disability must always be paramount.

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7. APPENDICES

APPENDIX A Consent Form

I ________________________ agree to take part in the research study "An Investigation of 'Restrictive Practices' within Services for Adults with an Intellectual Disability: Perspectives of Professionals and those involved with their care".

I understand that participation in voluntary and I have the freedom to withdraw at any stage of the interview or refuse to answer any question without giving any reason.

I understand that once the interview has been transcribed, all recordings of the interview will be deleted/destroyed.

I understand the information may be later published and presented at conferences but no identifying information will be disclosed.

I understand that all personal names and organisations and services will be kept confidential.

Please tick one;

I consent to this interview being recorded by a mobile phone through the zoom call:

No ☐ Yes ☐

Participant Signature:__________________________ Date:______________

Researcher Signature:__________________________ Date:______________

Nature of the Research Study

The ambiguity which is apparent around the form restrictive practices in services for adults with an intellectual disability is reflected in the variety of terms/jargon employed both in practice and in academic courses leading to social care degrees. In exploring the meaning of restrictive practices and associated terms it allows for the investigation of meanings rather than an application of definition. The aim of this study is to gain the perspectives of professionals who are currently working or have previous experience working with adults with an intellectual disability regarding the use of restrictive practices.

Ethics

All names of organisations and those involved will remain confidential and will not be included within this research study. In regards to the interview, all information that is collected throughout will be securely held on a USB which is transferred from the mobile device immediately following the interview (which may be used for recording). In line with the General Data Protection Regulation (GDPR) (EU) 2016/679, all information will be held until such time, the researcher has sufficiently transcribed the interviews. Once transcribed all data that has been collected will be destroyed accordingly.

A transcript of the interview will be sent to you for approval before it is analysed as part of this research.

If there are any queries or questions relating that you may have regarding this interview feel free to contact me through emai[redacted]r by phone : [redacted]

Participation is voluntary and you may withdraw at any point.

APPENDIX B Interview Guide

1. What is your understanding of the term restrictive practices in relation to adults with an intellectual disability?
2. What restrictive practices are currently in place within your service?
3. What is the outcome for both staff and service users, if or when using these practices?
4. Is there a threshold point at which these practices are deemed appropriate to use?
5. Are restrictive practices necessary within intellectual disability services?
6. What (if any) preventative practices are currently in place within your service?
7. What does risk management mean in conjunction with restrictive practices within your service?
8. What does the term 'challenging behaviour' mean for service provision within your service?
9. Is there value in specific additional training (such as MAPA / PBS /Other) for staff regarding the use of restrictive practices?
10. Has the effectiveness of this training ever been evaluated in anyway?
11. Is there any alternative training you would like to see introduced in responding to behaviours that challenge in pro-active way?
12. What does the ratification of the United Nations Convention on the Rights of a Person with a Disability mean for disability services in Ireland?
13. How can disability services further foster a culture of least restrictive practices?
14. Is there anything else you would like to add, or any other comments on the research?

APPENDIX C Interview Invitation

Dear

My name is Rebecca Donovan, I am a Social Care Work Graduate and currently an MA postgraduate student of Munster Technological University (formerly Cork Institute of Technology). As part of my MA degree, I am undertaking research entitled: 'An Investigation of 'Restrictive Practices' within Services for Adults with an Intellectual Disability: Perspectives of Professionals and those involved with their care" under the supervision of Professor Margaret Linehan and Ms Sandra Conroy.

As part of this research I hope to interview professional experts who have a wide range of professional experience and knowledge in this area. The purpose of this message is to invite you to partake in an interview as part of this research.

Participation is voluntary and as the interviewee, you have the freedom to withdraw from participation at any stage of the interview. Confidentiality is also of high importance, all names of individuals, organisations and service providers will be kept confidential and interviewees will be anonymised. The information gathered will be used only for the purpose of this research. Transcripts will be sent to the interviewee to ensure a fair reflection of the discussion is agreed.

Due to the Covid-19 restrictions, adaptations have been made in the research process by changing the format of interviews to take place though an online zoom meeting. Interviews will take approximately forty-five minutes at your convenience. I am happy to forward a copy of the questions I propose to ask in advance of the interview.

If you have any questions or queries please feel free to contact me on the details provided below.

Kind regards
Rebecca Donovan, BA(Hons)
MA Student
Email: [redacted]
Tel: [redacted]

APPENDIX D Thank You Letter (E-mail) to Interviewees

Dear____________________

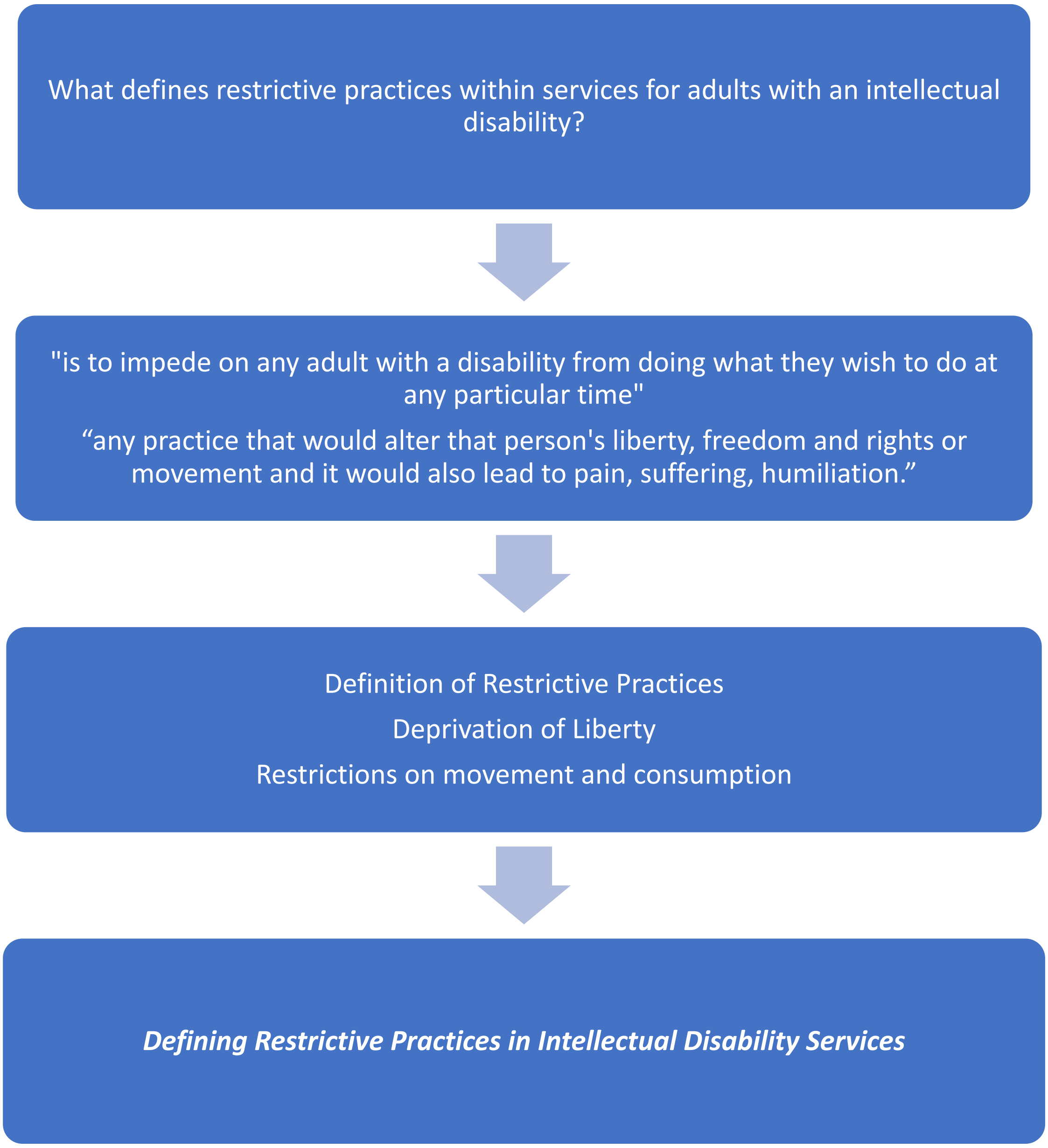
I would like to thank you personally for taking part in this interview which will provide huge support to my research study with your knowledge and experience surrounding this topic.

Once the information is transcribed, I plan to send a copy some-time in the near future. If you have any further questions of queries regarding this interview, please feel free to contact me.

Kind regards
Rebecca Donovan, BA(Hons)
MA Student
Email: [redacted]
Tel: [redacted]

APPENDIX E Thematic Analysis

Theme 1.



What defines restrictive practices within services for adults with an intellectual disability?

"is to impede on any adult with a disability from doing what they wish to do at any particular time"

"any practice that would alter that person's liberty, freedom and rights or movement and it would also lead to pain, suffering, humiliation."

Definition of Restrictive Practices

Deprivation of Liberty

Restrictions on movement and consumption

Defining Restrictive Practices in Intellectual Disability Services

Theme 2.

How effective is current training for professionals working within disability services, in implementing restrictive practices and responding to challenging behaviours?

“it's just kind of a tick the box thing for management and HR to do so if an incident does occur or if a restrictive practice is put in case, they’ll say that we had the training for this so it’s just backing themselves up.”

“I don't think we should just be ticking ‘Excellent’ just because we liked the instructor. It's important that we are actually learning something and to ask the questions.”

Effectiveness of education, training and Support

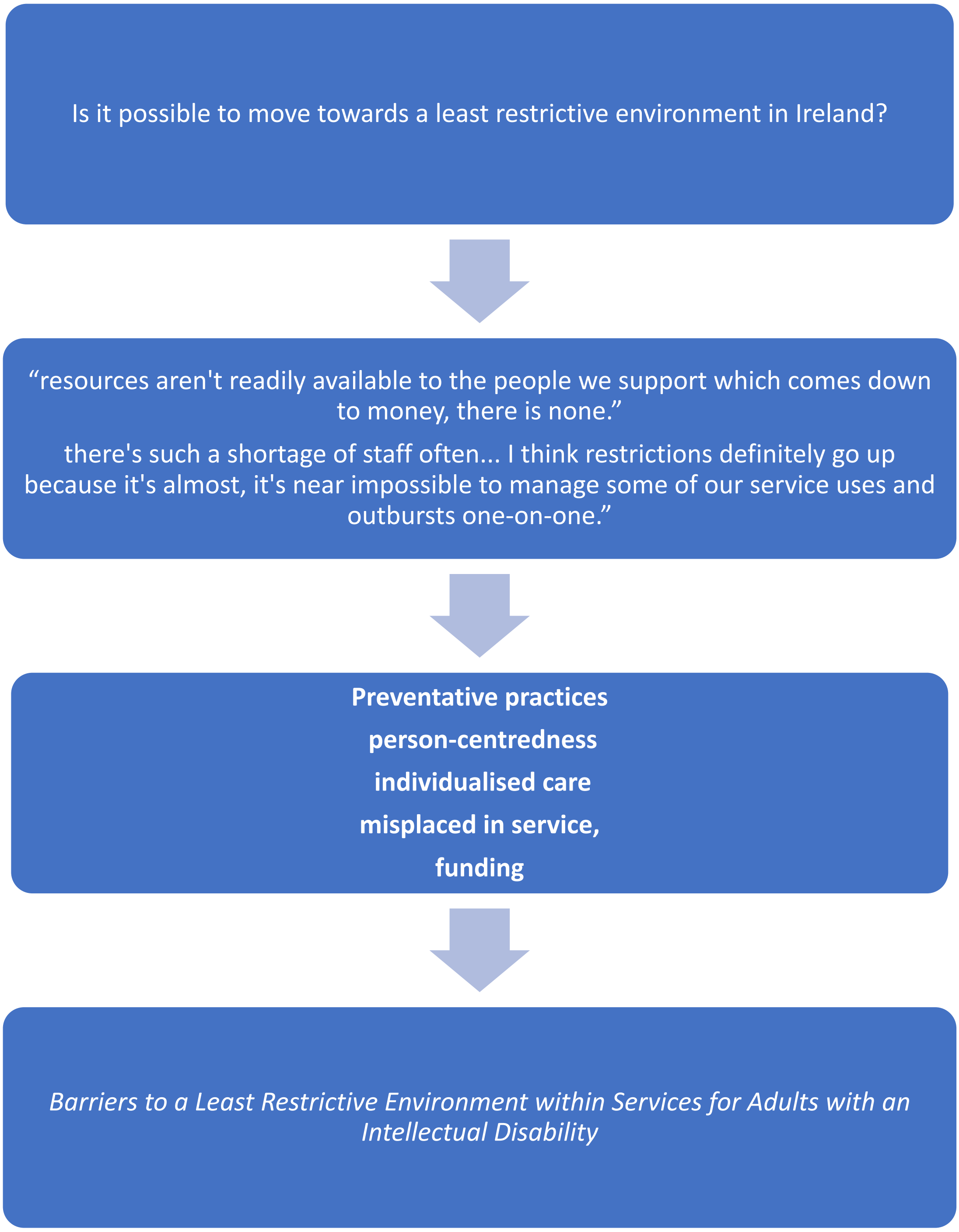
Limitations of a training

Alternative training

Social Care Profession

Effectiveness of Trainings regarding Implementing Restrictive Practices

Theme 3.



Is it possible to move towards a least restrictive environment in Ireland?

“resources aren't readily available to the people we support which comes down to money, there is none.”

there's such a shortage of staff often... I think restrictions definitely go up because it's almost, it's near impossible to manage some of our service uses and outbursts one-on-one.”

Preventative practices
person-centredness
individualised care
misplaced in service,
funding

Barriers to a Least Restrictive Environment within Services for Adults with an Intellectual Disability

Theme 4.

Does the varied terminology used in conjunction with restrictive practices, such as challenging behaviours, have any impact on practice/s used?

"(Necessary) As a whole, I do believe they're necessary for the safety of the individual and for the safety of the staff, it has to be broken down to the individual... you can't bracket everybody with intellectual disability as somebody with an intellectual disability, it's so individualized"

"if you just have to do it, you have to, if you've no choice, if you're in danger or another person we support are in danger, there's no question about it, you have to, you actually have to just do it"

Appropriate use of restrictive practices, (un)necessary use

Workplace violence

Challenging behaviour

Safeguarding

Safeguarding Professionals and Adults with an Intellectual Disability

APPENDIX F Ethics Form

Email sent to Interviewee’s post Interview.

Dear ______________

The concept of ‘do no harm’ is highly regarded throughout the interview process and therefore all measures to minimise harm to interviewees are applied. Therefore, if required, names and numbers of support services are listed below if you have been affected by this research topic or material that was discussed within your interview.

Relevant Counselling or Support Services
Pieta House: 24hr Service Phone 1800 247 247 or Text HELP to 51444
Cork Counselling Service: Phone (021) 4274951
Shine: Phone (021) 4226064