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Organisational impact on the use of restrictive measures: The perspective of Swedish front-line managers

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Abstract

Background: Restrictive measures (RM) are prevalent in services for people with intellectual disabilities. This study investigates managerial awareness of RM and the nature of organisational supports required to reduce their use.

Method: A survey asked front-line managers and staff what (RM) were used, their purpose, impact and importance (10-item Likert scales) and what organisational changes were required (free text). Responses were analysed using descriptive methods and content analysis.

Results: Managers reported a lower use of RM, compared with staff. According to managers, RM were mainly used to keep service users from harm, their use having a significant impact. Opportunities to change practices were limited by a lack of resources and organisational support.

Conclusion: Front-line managers seem to lack the capacity to address the use of RM due to organisational drift; limited manager time and opportunity to allocate resources; inadequate environments; and lack of skilled staff, knowledge and relevant professional input.

KEYWORDS
intellectual disabilities, managers, organisational change, restrictive measures, staff

1 | BACKGROUND

The Swedish constitution protects basic rights and freedoms for people with intellectual disabilities. Restrictive measures and coercive measures (RM) are not allowed in community services. Services are voluntary and applied for under the *Act concerning support and service for persons with certain functional impairments* (Swedish Code of Statutes SFS 1993:387, 1993). They should enable self-determination, integrity and independence. Measures to protect and support the person require express consent, except for occasional emergency situations. Despite a strong legal framework, RM are prevalent in Swedish community services (Björne et al., 2022).

Restrictive and coercive interventions are common in services for people with intellectual disabilities (Büschi et al., 2020; McGill et al., 2009; Merineau-Cote & Morin, 2013). The importance of reducing the use of RM cannot be overstated, since they can have a severe impact on service users' quality of life (Heyvaert et al., 2015; MacDonald et al., 2011; Mérineau-Côté & Morin, 2014). Experiences of being restricted can lead to feelings of panic and fear (Lambrechts et al., 2008; MacDonald et al., 2011; McGill et al., 2009) and may cause trauma (Hughes et al., 2019; Kildahl & Jørstad, 2022; Wigham & Emerson, 2015). Even when used with good intentions, they can be stressful and experienced as abusive by the person (Hughes et al., 2019; Wigham & Emerson, 2015). Once they are

introduced, there is a risk that their use persists (Richardson et al., 2020; Webber et al., 2017) and becomes routine (McGill et al., 2009). Despite their negative impact, staff find RM justified in dangerous situations (Dörenberg et al., 2018) or use them due to lack of organisational support for alternatives (Björne et al., 2022).

It is crucial to reduce the use of RM through a better understanding of the support needs of people with intellectual disabilities (O'Dwyer et al., 2017; Richardson et al., 2020; Webber et al., 2017). While the use of restraints may be considered a necessary last resort for preventing injury, especially severe self-injurious behaviour (Williams, 2010), it is possible to eliminate their use by adopting evidence-based approaches (Craig & Sanders, 2018; Richardson et al., 2020). Adopting trauma-informed treatment methods and reducing the use of restrictive interventions not only affects people with disabilities, making support and treatment safer, but also reduces costs for staff turnover and compensation (Craig & Sanders, 2018) and contributes to a well-functioning organisation that supports staff and service users in trusting relationships (Bloom & Farragher, 2011, 2013).

2 | ORGANISATIONAL IMPACT ON CHANGE

A reduction in RM requires good (Stubbs et al., 2009) and values oriented (Leoni et al., 2018) leadership that supports staff in providing service according to legislation and organisational policies. To achieve this, managers need to know how service is delivered (Deveau & McGill, 2016).

However, a change in practice requires the involvement of management at all organisational levels (Bisschops et al., 2022; Martin et al., 2021; Olivier-Pijpers et al., 2018) and practice leadership (Martin et al., 2021; McGill et al., 2020). Reducing the use of RM entails long-term commitment in an organisation with a clear vision and structured framework (Leoni et al., 2018), and a focus on leadership factors that support change (Larue et al., 2018). It may require structural changes, for example, a reduction in the number of wards a manager had to oversee (Leoni et al., 2018).

Successful implementation also seems to require that participants are able to negotiate various components in the interaction between context and interventions, allowing them to plan and, for example, allocate resources, change the organisation, and adapt the intervention (May et al., 2016). Therefore, to prevent RM, managers must be aware of what is happening in their services and knowledgeable about alternative forms of support.

The aim of this study is to identify what organisational factors impact the use of RM in group homes and daily activity services with a focus on managers' knowledge about RM and ability to effect change. The research questions are:

1. Are managers aware of the use of RM and how do their answers compare to those of staff?
2. How do managers justify these measures and do they think that the use of RM should change?
3. What organisational changes do staff and managers consider necessary for reducing RM?

3 | METHOD

3.1 | Design and ethics

This survey was part of a larger study using data from incident reporting and interviews with staff and managers to identify organisational factors that impact services for people with intellectual disabilities who presented with behaviours perceived as challenging. The study included group homes and daily activity services. This paper focuses on front-line managers, as they are instrumental in effecting change. Staff answers are included where a comparison sheds light on the organisational context.

The project was approved by the Swedish Ethics Review Authority (2018/838).

3.2 | Materials

The survey listed 10 common forms of RM, included in tables, sampled from incident reports and interviews. Staff and managers in group homes and daily activity services were asked if the measures were used and how often, ranging from 'not used' to being used 'every day'. They were further asked the purpose of their use, listing 10 common purposes sampled from incident reports. Two questions were included to explore ethical aspects of the use of RM, one assessing the perceived impact on service users and the other if it were important that the use of RM should be reduced. The respondents were instructed to assess the impact of RM, whether they had experience with these measures or not. These four questions included the opportunity to comment. The last, free text question, asked what was required of the organisation to enable a reduction in RM.

The survey did not ask respondents to specify if service user consent was obtained for the use of RM. Having to consider potential legal implications of their answers could have had a negative impact on their inclination to answer as truthfully as possible.

3.3 | Participants

Managers are usually responsible for two services, that is, two group homes or two daily activity services, with some exceptions. In general, 4–6 service users share a group home, each with his/her own apartment situated around communal areas. Daily activity services vary in size, depending on their aim and design, from ~8 to 25 persons. Staffing will depend on the support needs of the service users.

All managers have a university degree, typically in social work. Staff are required to have a high school diploma, and some will also

TABLE 1 Study responses.

	Group home		Daily activity services		Total	
	Survey recipient (*n*)	Participants (*n*, %)	Survey recipient (*n*)	Participants (*n*, %)	Survey recipient (*n*)	Participants (*n*, %)
Managers	56	34 (61%)	19	18 (95%)	75	52 (69%)
Staff	915	189 (21%)	312	114 (37%)	1227	303 (25%)
Total	971	223 (23%)	331	132 (40%)	1302	355 (27%)

TABLE 2 Percentage of staff and managers reporting any use of sampled RM.

Restrictive measure	Staff (%)	Manager (%)
Locked doors prevent access to communal areas	38	29
The service user can or may not leave the house unless supported by staff	42	31
Locked closets, cupboards, drawers or refrigerators prevent access to private belongings	36	29
Restrictions in use of media, for example, internet, TV, magazines or movies	16	6
Monitoring via camera, babywatch or similar	6	2
Restricted movements through belts, bed rails, 'angel watch' or similar	17	21
Staff hinder the service user physically, by standing in the way or holding back	21	15
The service user is not allowed to meet certain persons	15	12
The service user is given medicine (s)he does not want to take	5	0
Restrictions in amount of allowed food or drink	40	29
Mean percentage reporting use	24	17

have a university degree. However, no university programs specialise in support for people with intellectual disabilities. While some professionals, for example, registered nurses and occupational therapists are available, behavioural consultants, frequently found in other countries, typically are not.

3.4 | Setting and procedure

The survey was open for 19 days, between 15 March and 2 April 2021. As seen in Table 1 response rates varied, being generally higher for managers than staff and in daily activity services.

The research was conducted in one large Swedish municipality responsible for all community services for people with intellectual disabilities.

The HR department provided the first author with e-mail addresses for all staff and front-line managers permanently employed in group homes and daily activity services. An e-mail with information about the research project in general and the survey in particular was then sent together with a personal link to the survey. The answers were not tracked, and therefore one reminder was sent to everyone. Consent to participate in the research project was given through answering the survey.

3.5 | Analysis

Descriptive data, using Excel, on responses regarding use of, purpose, impact and importance for change addressed the first and second research questions.

The third research question on required organisational changes to reduce the use of RM was addressed through conventional content analysis, and compared the answers of staff and managers (Hsieh & Shannon, 2005).

4 | RESULTS

4.1 | Restrictive measures reported

Table 2 shows the percentage of staff/managers reporting any use of the RM included in the survey. A higher percentage of staff than managers reported any use.

Staff reported more use than managers of nine of the 10 RM sampled. Managers reported more use of restricted movements through the use of belts and bed rails.

In respect of the 10 RM included in the survey, staff provided a number of specific examples, including: motion detecting devices or GPS, used for monitoring service users; lying to prevent intake of sugar; wheelchair table; locked door to balcony; denying access to iPad; denying other activities than those scheduled; restricting access to mobile phone during daily activity services; locked windows; coerced hygiene; denying coffee.

Managers did not mention specific examples. However, a few elaborated their answers by noting that risk analyses were made and support plans were in place.

4.2 | Purpose of restrictive measures

Table 3 shows manager assessments of the purposes of the RM in use. The primary purpose identified was to protect service users

TABLE 3 The purpose of the use of RM according to front-line managers (%).

To what purpose are these measures used?	Very common	4	3	2	Not common	No measure used for this purpose
To protect service user from harm	48	10	4	4	4	31
To protect other service users from harm	10	8	4	4	27	48
To protect staff from harm	19	6	6	6	15	48
To protect the public from harm	23	8	4	2	13	50
To support physical health of service user	4	4	14	8	29	41
To protect mental health of service user	6	6	8	8	24	49
To prevent sexual abuse	20	0	2	4	8	67
To prevent self-injurious behaviour	4	8	10	6	22	51
To prevent 'outward' challenging behaviour	6	8	6	8	25	47
To meet wishes of relatives	20	0	8	4	4	65

TABLE 4 The perceived impact on services users, according to front-line managers (%).

Which measures are most restrictive for the service user?	Very restrictive	4	3	2	Not at all restrictive
Locked doors prevent access to communal areas	57	16	16	8	4
The service user can or may not leave the house unless supported by staff	48	25	12	13	2
Locked closets, cupboards, drawers or refrigerators prevent access to private belongings	60	23	10	8	0
Restrictions in use of media, for example, internet, TV, magazines or movies	69	23	8	0	0
Monitoring via camera, babywatch or similar	67	17	10	6	0
Restricted movements through belts, bed rails, 'angel watch' or similar	50	19	21	10	0
Staff hinder the service user physically, by standing in the way or holding back	81	10	6	4	0
The service user is not allowed to meet certain persons	73	17	6	4	0
The service user is given medicine (s)he does not want to take	62	23	10	6	0
Restrictions in amount of allowed food or drink	38	37	23	2	0

from harm, though keeping staff and the public safe were also rated as relatively common. Twenty percent of managers also noted that a very common purpose was to meet the wishes of relatives. Supporting physical or mental health, preventing challenging behaviours, including self-injurious behaviours were not common reasons for using RM.

The question concerning sexual abuse did not differentiate between a service user as offender or as a victim. Thus, these answers could reflect either protecting the service user or others from harm.

This survey was conducted during the COVID-19 pandemic. As it was a follow-up to a previous survey, no extra question about the effect of the pandemic on RM was included. However, some answers also referred to the pandemic as a cause for introducing some restrictions.

4.3 | Ethics

The survey included two questions of a more ethical nature, that is, if measures were perceived as restrictive and if it was important to replace them. The question included an instruction that the answer should be given from a more general perspective, regardless if the measure was used in the services the manager was responsible for.

4.3.1 | Perceived restrictiveness of measure and importance of replacing

Tables 4 and 5 clearly show that managers generally regarded the sampled measures as very restrictive and important to replace with other forms of support, albeit with variation between measures. For

TABLE 5 The importance of reducing the use of RM, according to front-line managers (%).

Which restrictive measures are most important to replace with other support?	Very important	4	3	2	Not at all important
Locked doors prevent access to communal areas	62	13	12	10	4
The service user can or may not leave the house unless supported by staff	50	25	15	10	0
Locked closets, cupboards, drawers or refrigerators prevent access to private belongings	63	17	10	10	0
Restrictions in use of media, for example, internet, TV, magazines or movies	69	19	6	6	0
Monitoring via camera, babywatch or similar	69	12	16	2	2
Restricted movements through belts, bed rails, 'angel watch' or similar	58	15	13	10	4
Staff hinder the service user physically, by standing in the way or holding back	75	13	8	4	0
The service user is not allowed to meet certain persons	71	15	8	6	0
The service user is given medicine (s)he does not want to take	71	12	8	10	0
Restrictions in amount of allowed food or drink	56	21	21	2	0

example, while managers reported that service users were not medicated against their will (see Table 2), they rated this as very intrusive and that such a practice should change if present. However, restricting food and drink was rated as having somewhat less impact and not as important to change, as was preventing a service user from leaving the building (home or day centre) unless supported by staff.

4.4 | Changing practices

The last question of the survey was a free-text question on what was needed to replace RM with other forms of support. Staff answers are included, to incorporate their perceptions of organisational gaps or weaknesses.

Fifty-two percent of staff answered this last question explicitly, with further answers included in previous free text comments, adding approximately 20%. Some responses were very short, for example, 'more staff'. Others were longer and more reflective. Fifty-eight percent of the managers answered this question. Managers' answers generally focused on questions concerning staff, less on their own role as front-line managers. The issues addressed overlapped substantially with those identified by staff and are grouped in content areas below.

4.5 | More and more competent staff

Staff answers were generally concerned with their immediate context, including the need to increase staffing, and how to secure competence. Legal requirements to increase service user independence and self-determination meant that more and better-trained staff were needed. These requirements also created expectations that staff provide more qualified support without an adequate adjustment of resources.

Staff wanted more knowledge about legislation, their duties, disabilities and providing support. Competence would require continuous training and supervision, with opportunities for reflection and exchanging experiences with other services, to find new solutions. Developing competence, however, was perceived as difficult, due to high staff turnover and a job that was not valued.

Managers called for more well-educated staff and continued training provided by the organisation, with access to trainers and supervisors. They agreed with staff on topics for knowledge development, but did not mention staff turnover. A few managers mentioned that they needed to increase their own knowledge on how to support people with intellectual disabilities or how to support staff working in challenging circumstances.

Managers did not always consider RMs avoidable, as some persons with intellectual disabilities engaged in dangerous behaviours.

4.6 | Restrictive measures caused by a lack of resources and inadequate environment

According to staff, the physical environment, when not appropriately designed or carefully located, contributed to the use of RM. Services were located close to roads with heavy traffic, or persons with incompatible needs were placed together in cramped spaces.

While managers did not specify how buildings were inadequate, they mentioned that the environment was not suited. With too little staff, it was not possible to compensate for poorly designed buildings or support someone who wanted to go outside. A lack of staff due to insufficient resources therefore had a direct impact on the use of RM, and on the work environment and intentions to stay. While this was a

recurring theme, the answers were generally short, in the form of 'more resources' and 'more staff'.

4.7 | Organisational requirements and management

The reduction of RM would require a supportive organisation, according to both staff and managers.

Staff reported that required paperwork had increased and was not always worthwhile. The workload left them with reduced opportunities to focus, reflect, be creative and identify alternatives to RM.

While staff called for present and knowledgeable managers who supported and prioritised development towards a reduction of RM, managers mentioned support from senior managers and the HR-department as crucial. Senior management should know more about behaviours that were perceived as challenging and provide support. Front-line managers found it difficult to reduce the use of RM if others in the organisation, for example, healthcare staff, required them.

One manager mentioned that it could be difficult to change the use of RM when coming new to a service and finding measures that had been in place for a long time. Service users felt comfortable with these restrictions, and there was no documentation on what had been tried before.

5 | DISCUSSION

In this study, front-line managers were asked to report the use of RM and to identify organisational changes required to reduce their use. Front-line managers are crucial in supporting staff to work in line with legislation and organisational policies, and therefore in preventing the use of RM. Their knowledge about everyday practices and their role in change is key in service development and implementing evidence based practice (Aarons et al., 2014).

Managers report fewer RM than staff, and seem to find their opportunities for change limited by a lack of resources, inadequate environments and lack of coherent support from the organisation's professionals and senior managers. This might account for the widespread use of RM despite strong legislation aimed at their prevention. That is, managers do not seem to always recognise RM, and when they do, feel powerless to produce change.

However, managers generally rate RM as intrusive and regard a change in practices as important. This is different from staff, who tend to rate the intrusiveness of a measure lower when it is commonly used (Björne et al., 2022; Embregts et al., 2019). Restrictive measures are usually intended to protect persons with intellectual disabilities from harm, or to support their well-being.

The results may be explained by managers not being sufficiently present in service settings, and therefore lacking insight into how support is routinely provided by staff. This is consistent with the view of the HSCI (2021), whose review of mandatory incident reports concluded that managers were responsible for too many services and therefore could not be as present as needed.

It could also be that managers, like staff, lack sufficient knowledge to identify measures as being restrictive or to promote alternatives (Bekkema et al., 2021; Schippers et al., 2018). Both interpretations are further confirmed by staff in their comments on the survey, noting that the presence of knowledgeable front-line managers is required to change practices.

5.1 | Leading change

Managers consider RM to have a substantial impact on service users. This should give them an incentive to work on reducing RM. Transforming a service requires that management supports staff in using knowledge gained through staff training (Aarons et al., 2014; Martin et al., 2021). While the evidence is inconclusive on how this should be done efficiently, training including all levels in the organisation seems to be key according to a review of the literature on how training is transferred into practice (Martin et al., 2021). Olivier-Pijpers et al. (2018) also identify the importance of committed management, with clear directions and communication. Managers must be aware of what is really being done in services, and support learning and transparent exchange (Deveau & McGill, 2016; McGill et al., 2020). Craig and Sanders (2018) raise the concern that managers who do not identify alternative forms of supporting people with intellectual disabilities will not be open to discussing alternatives to RM. If they do not recognise a practice as restrictive, the road to transparency and creativity will be even more difficult, leaving staff to solve the challenges they experience when supporting people with intellectual disabilities whose behaviour is perceived as challenging.

It is possible that managers present ethically 'desirable' answers, as they consider RM intrusive. Still, managers do report a surprisingly high degree of RM in a context where such measures are not legal, which begs the question if these practices are organisationally sanctioned. Furthermore, when managers are asked what is required to change RM, they mainly focus on staff competence and resources, for example, staffing and access to supervision. They do not comment on their own competence or role as practice leaders. We therefore conclude that managers possibly lack awareness of and knowledge about their role in supporting staff in implementing change.

5.2 | Reducing restrictive practices

The use of measures that restrict the fundamental rights and freedoms of a person are not allowed in Swedish community services for people with intellectual disabilities. Safeguards that offer protection are allowed, but only with the express consent of the person him-/herself. Consent should be documented in a support plan and assessed continuously.

While legislation mentions specific interventions as restrictive and potentially illegal, service users may perceive a measure that is

well-intended and supportive as restrictive (Frederiks, 2020). Given that people with intellectual disabilities experience adverse life events, not only as discrete incidents but cumulatively (Hughes et al., 2019; Rittmannsberger et al., 2019), it is crucial to avoid a daily life that is potentially perceived as unfriendly and frustrating in being restrictive. Restrictive measures create oppressive settings, further contributing to the victimisation of people with intellectual disabilities (Sheerin, 2019).

Bloom and Farragher (2011) use the concept of 'sanctuary harm' for contexts where service users are rendered fearful, helpless, humiliated or in distress. Such settings are harmful even when the events as such are not traumatic, but continuously undermine trusting relationships. The use of restrictions tends to surface when a scandal is exposed in the news. However, to prevent the use of RM, attention should be paid less to larger incidents and obvious abuse, and more to routine, daily support as a basis for learning.

This requires open and transparent cultures, with opportunities for learning and change, therefore managers must understand and pay attention to what is happening in services (Deveau & McGill, 2016). Both staff and managers gave contextual factors as a reason for the use of RM, for example, the design and environment of services, knowledge and training, resources, and organisational demands (including the handling of 'systems'). As pointed out by Schippers et al. (2018), consensus on the restrictiveness of measures was limited among staff and professionals. The results in this study show that the multidisciplinary discussions suggested by Schippers et al. (2018) should also include front-line managers, to reach consensus across the organisation, thereby promoting organisational support for a reduction in RM.

5.3 | Implications for services

Therefore, to manage change in the use of restrictive and coercive measures it would benefit managers to not only focus on obvious restrictive interventions, used to control or contain a person. Instead, they should understand the mundane restrictive practices (RP) (Hui, 2017) better, and pay attention to the broader implications of the overall context of an environment including physical aspects as well as dynamics, atmosphere and routines. The concept of RP includes not only discrete measures, but broader contextual factors, directly in the service and in the wider organisation. That is, changing RP will require a broad organisational commitment involving direct care staff and front-line managers as well as policy decisions and a clear vision permeating all levels (Bisschops et al., 2022; May et al., 2016).

Once such steps are taken it may become possible to consider and develop alternatives to RM that emphasise both the prevention of the challenging behaviours towards which they are often directed and the promotion of living and working environments that promote client self-determination. Such approaches are likely to incorporate both systematic improvements in living and working environments (e.g., McGill et al., 2020) and the trauma-informed treatment methods mentioned above (e.g., Craig & Sanders, 2018).

6 | CONCLUSIONS

This study, together with a previous staff survey (Björne et al., 2022), shows that RM are prevalent in Swedish services. Front-line managers seem to lack the capacity to address the use of RM. This reflects organisational drift, limited manager time and opportunity to allocate resources, inadequate physical environments, skill and knowledge, lack of relevant professional input and lack of skilled staff.

The fundamental rights and freedoms of persons with intellectual disabilities are protected in the Swedish constitution, aiming to provide the opportunity for living with dignity. The use of RM is not only a potential breach against vital rights, but rather erodes the opportunity for people with intellectual disabilities to participate meaningfully in the community, as valued members (Treanor, 2020).

6.1 | Limitations to the study

The context of this study is Sweden, with a specific legislation that prohibits the use of RM in community services for persons with intellectual disabilities. The results may therefore not be generalizable to other legal contexts.

The survey was sent to all staff and front-line managers in group homes and daily activity services. Our information on the frequency of RM relies on these informants, that is, the 'true' prevalence is not available. Further, information was provided about the study's focus on supporting people with intellectual disabilities who presented with behaviours perceived as challenging and the use of RM. That is, services were not selected, for example, by directing the survey to staff known to have experience of services where challenging behaviours were known to happen. This might have introduced a bias in the responses. Higher response rates from managers indicate that they answered the survey as representatives of the organisation, while staff possibly were more likely to respond to the survey if they had experienced higher rates of RM in the particular setting where they worked. This is not possible to verify.

The survey represents RM that are recognised by staff and managers. Observations in services would give a deeper understanding of the scope and impact of restrictive practices, that is, including measures that control service users in more mundane, therefore unrecognised forms.

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CONFLICT OF INTEREST STATEMENT

None of the authors has a conflict of interest to declare.

DATA AVAILABILITY STATEMENT

Data can be made available upon request.

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