

# Understanding the mental health experiences of adult men with intellectual disabilities in Singapore

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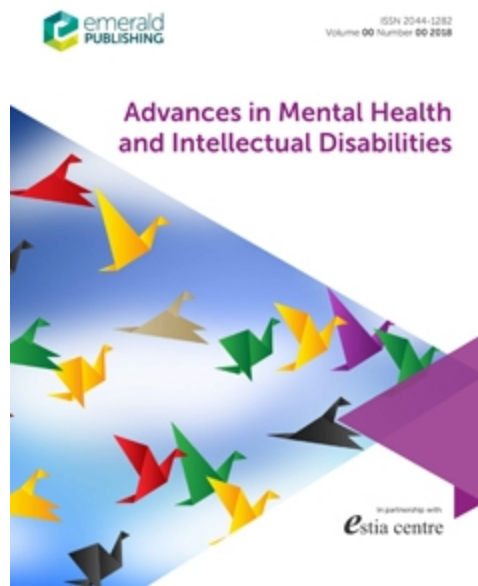
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## Understanding the mental health experiences of adult men with intellectual disabilities in Singapore

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Table 1: Demographics of participants (n = 6)

Participant	Age range	Gender	Ethnicity	Neurodevelopmental and psychiatric labels	Length of inpatient stay
1	20-25	M	Malay	Moderate intellectual disabilities, psychosis inappropriate sexualised behaviours	11 months
2	20-25	M	Chinese	Intellectual disabilities, aggressive behaviours	15 months
3	45-50	M	Chinese	Moderate intellectual disabilities, ASD, schizophrenia, aggressive behaviours	4 months
4	60-65	M	Chinese	Moderate intellectual disabilities, aggressive behaviours	24 months
5	55-60	M	Chinese	Moderate intellectual disabilities, schizophrenia	33 months
6	70-75	M	Indian	Moderate intellectual disabilities, schizophrenia	3 months

**Table 2: Interview Schedule**

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**Example of questions**

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1. What do you know or understand about your mental health condition?
  2. Here is a logo of [hospital's name], can you share with me what it is like?
  3. What do you like/do not like about your stay here?
  4. What kind of things do you like your healthcare worker to help you with?
  5. What do you like/ do not like about your doctors/nurses/healthcare workers?
  6. Are there any things/issues you would like to be different?
  7. What do you like/do not like about your life?
-

Table 3: Master table of themes

Super-ordinate themes	Sub-themes	Participants contributing to the themes
1. Awareness of mental health problems		3, 4, 5, 6
2. Yearn for a life outside the ward		3, 4, 5, 6
3. Interacting with other people	1. Lack of family involvement	1, 3, 4, 5 and 6
	2. The way mental health professionals treat me	1, 2, 3, 4, 5, 6
4. Finding purpose while in hospital		2, 3, 5, 6

# Understanding the mental health experiences of adult men with intellectual disabilities in Singapore

## ABSTRACT

**Background:** This research explores the experiences of people with intellectual disabilities in Singapore receiving inpatient mental health treatment. To date there has not been any research that examines the views and experiences of this population in Singapore. The research examines how the participants view their mental health problems and their experiences of the services they received.

**Method:** A qualitative design was chosen to address the research question. Six adult men with intellectual disabilities were recruited from the tertiary hospital and interviewed. The transcripts of these interviews were analysed using Interpretative Phenomenological Analysis.

**Results:** Four super-ordinate themes were identified; (i) Awareness of mental health problems; (ii) Yearn for a life outside the ward; (iii) Interacting with other people and (iv) Finding purpose.

**Conclusion:** The participants reported that they struggled with being segregated from their families and communities following inpatient admission. They were able to report on the emotional difficulties that they experienced and hoped to find employment after their discharge from hospital. They talked about reconstructing their self-identity and forming friendships to cope with their hospital stay. This research is one of its kind carried out in a non-western society and the findings are discussed in the light of how mental health professionals can best support people with intellectual disabilities during their inpatient treatment.

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**Keywords:** intellectual disabilities, mental health services, interpretative phenomenological analysis, qualitative research

**INTRODUCTION**

There has been an increasing focus on understanding the experiences of people with intellectual disabilities and their views regarding services. A review of disabilities-related research studies over a 20-year period reported a high response rate when invited to

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3 participate in research among people with intellectual disabilities (Cleaver et al., 2010),  
4 suggesting a keen interest in expressing their views regarding various issues such as the  
5 services and treatments they receive (O'Brien & Rose, 2010; Scior & Longo, 2005; Stenfert  
6 Kroese et al., 2013). Most research on people with intellectual disabilities and their  
7 experiences of in-patient psychiatric treatment has been conducted in western countries  
8 (Donner et al., 2010; Longo & Scior, 2004; Scior & Longo, 2005) which identified themes of  
9 disempowerment, lack of meaningful activities and not being informed about treatment  
10 options.  
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14 Given potential cultural differences, there is a need to explore the views and experiences of  
15 people with intellectual disabilities living in non-western countries. Most non-western  
16 research to date has focused on the needs of family caregivers and how they cope with  
17 societal stigma or the challenges associated with taking care of their relatives (Chien & Lee,  
18 2013; Chiu et al., 2015; Yang, 2015). Devapriam et al. (2015) noted that people with  
19 intellectual disabilities with complex needs, for example those who display risky and self-harm  
20 behaviours and commit serious offences, and those who do not respond well to  
21 pharmacological and/or talking therapies continue to receive inpatient care and treatment.  
22 This highlights the importance of consulting inpatients on their views and experiences in order  
23 to further improve services.  
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27 Although there are no official prevalence rates of mental health difficulties among people with  
28 intellectual disabilities in Singapore, specialist mental health services were established in 2011,  
29 which provide both inpatient and outpatient mental health service for adults with intellectual  
30 disabilities and/or neurodevelopmental disorders. Patients are seen by a multidisciplinary  
31 team consisting of a psychiatrist, case manager, psychologist and occupational therapist at  
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the first visit. These mental health professionals have received additional training and experience in working with this population. Adults with intellectual disabilities make up the largest percentage of cases and the majority of them are men who present with challenging behaviours, for example aggression towards others and self-injurious behaviours, as well as mood or psychotic symptoms (Moon et al., 2020). Additionally, they are more likely to have attended special education schools and faced difficulties in obtaining employment.

There has been a recent trend to use a phenomenological perspective to explore the experiences of adults with intellectual disabilities receiving inpatient mental health services (Cookson & Dickson, 2010; Thomson & Johnson, 2017; Tomlinson & Hewitt, 2018). Given that this is a relatively new, unexplored area of research, Interpretative Phenomenological Analysis (IPA) was chosen for this study because it allows participants to explore and make sense of their experiences (Smith et al., 2009). Furthermore, the use of this approach allows participants to develop an awareness of their own personal preconceptions through asking about their feelings and cognitive processes, thus focusing on meaning making (Smith et al., 2009).

The views and experiences of people with intellectual disabilities and mental health issues have yet to be explored in Singapore, particularly of those receiving inpatient services. This study therefore aims to gain an increased understanding of how people with intellectual disabilities in Singapore understand the impact of mental illness on them and their views on inpatient services.

**METHOD**

**Participants**

Participants were eligible to participate if they met the following inclusion criteria:

- 1) Diagnosis of intellectual disabilities (IQ below 70 with impairments in adaptive functioning based on DSM 5 diagnostic criteria (American Psychiatric Association, 2013)
- 2) Adults (aged 21+)
- 3) Had been receiving specialist inpatient mental health services for assessment or treatment for a minimum of three months
- 4) Demonstrated capacity to consent
- 5) Ability to participate in semi-structured one-to-one or focus group interview

Participants were excluded if they presented with acute levels of distress, risk of harm to self or others and/or active psychiatric symptoms. Six participants met the inclusion criteria and agreed to participate in the study. The severity of their cognitive impairment was based on the IQ test. Their demographic information is provided in Table 1.

<<Insert Table 1>>

### **Ethical Considerations**

The study was approved by a University ethics committee in the UK (Ethical Review No: ERN\_17-1730) and the National Healthcare Group Domain Specific Review Board (DSRB Reference No: 2018/00956) in Singapore. Safeguards regarding data storage were implemented and participants have been de-identified in this paper.

Additional considerations were made to determine that participants understood the study and had the capacity to consent. The informed consent form and invitation letter used basic words with large font size (18) and pictures. The text was read aloud to potential participants

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and the study was discussed with each participant by the first author. The first author did not have any involvement in the care of the participants and they were given up to 24 hours to make their decision. Participants were asked questions regarding aspects of their involvement and rights as a research participant (Arscott et al., 1999) which they had to answer correctly before considered suitable to participate. Audio recording was used during the interview and transcribed verbatim, after which they were deleted.

**The interview**

Participants were given the option to share their experiences either one-to-one with the first author or in small focus groups. The use of focus groups is considered suitable for this population as participants may know each other and feel more comfortable to share their experiences and views with familiar others. The data collection process was carried out in a private room in the hospital and took up to 30 minutes. A focus group were carried out with participant 1, 2, 3 and 4. Participant 5 and 6 had individual interviews. The majority of the interviews were conducted in English with some phrases spoken in colloquial local dialect (Hokkien).

The semi-structured interview (Table 2) was enhanced by the use of a range of techniques based on ‘Tools for Talking’ adapted from Unwin et al. (2016). This set of resources was chosen as the foundation for the development of the interview schedule with additions based on previous research with an intellectual disability population as well as a number of discussions between the authors. Participants were given opportunities to communicate their thoughts and preferences in alternative ways, such as choosing images (e.g. thumbs up, sun, heart, smiley face, sad face) to ascribe meaning to their experiences and writing short phrases or words during the session. The ‘Tools for Talking’ resources comprise of exploratory

activities that facilitate participants to discuss issues, namely 1) their level of satisfaction and support they receive, 2) identifying important people in their lives and 3) changes they would like to make in their lives. Additionally, participants were asked about their understanding of their mental health conditions and prompted to share their experiences as described in Table 2. The participants were asked to select from a list of images those that best represented their views of the inpatient services and their interactions with mental health professionals. They elaborated on their choice of images with the first author and discussed what the images meant to them. Participants were also asked about the desirable attributes of mental health professionals. A pilot interview was trialled and changes were made to ensure that the questions were culturally appropriate within a Singapore context.

<<Insert Table 2>>

### Data Analysis

The transcripts were analysed using the IPA guidelines (Smith et al., 2009). The first author read each transcript several times to familiarize himself and made descriptive, linguistic and conceptual comments along the transcripts. Observations regarding the participants' behavioural cues and the language used were recorded as well. Emergent themes were identified and emerging themes were identified and categorized to form super-ordinate and sub-themes which were listed in a table. This process was repeated across all the transcripts. The resulting tables from each transcript were compared and clustered to form the final master table of super-ordinate themes with sub-themes. The focus group transcripts underwent the same process. Additional information about the interactions between the participants were noted down.

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To ensure that the themes remained credible and grounded in the data, the transcripts and themes were discussed and checked by other named authors who have experience in qualitative research. Each stage of the analytic process was carefully reviewed and there were discussions among the members of the research team to triangulate the table of super-ordinate themes and sub-themes. A reflexive journal was used as an audit trail to document the process of conceptualizing the research, changes in subjective feelings and personal reflections of the first author during the duration of the study.

The first author is a qualified clinical psychologist who has worked clinically with people with intellectual disabilities living in a residential institution in Singapore. He was aware of the challenges discussed by the participants and was moved by their experiences of inpatient treatment.

**RESULTS**

Table 3 shows the main themes, sub-themes and the number of participants contributing to each theme.

<<Insert Table 3>>

**Main theme 1: Awareness of mental health problems**

The participants discussed the reasons for being admitted to the hospital, their treatment and experiences of mental health symptoms. For example, participant 6 described having “*alcohol problem*” and identified himself as a troublemaker,

*“I (am) (mah-poh (drunk) Drunk, quarrel with my wife...I just yell, fight with them (friends)...cause trouble.” – Participant 6*

He knew that his family had difficulty dealing with his behaviours and therefore was sent to the hospital for treatment.

Participants 3 and 5 spoke more specifically about their difficulties to manage their emotions that led to frequent fights and eventually admission for treatment,

*"My mum hit me. Then we got into argument, police came... The police brought me here, my mother hit me." – Participant 3*

*"My friend brings me here when I become too angry and can't sleep." – Participant 5*

Participant 5 showed some awareness of his symptoms, *"Because I abit... My brain... craziness...know to fight with gangsters,"* and expressed concerns about the side effects of taking the medication, *"...the body pain...will fall down... don't like it a bit... compulsory to take like that."*

There were mixed responses towards staying in the hospital. The structured setting in the hospital with a routine activity schedule and 24-hour care was appealing to one of the participants who believed that it helped him to manage his behaviours and emotions and he expressed an unwillingness to leave,

*"I like to stay here. I don't want to shift other place. Other place (is) not nice. All patient are new. (What happen if) they fight with me? (What to do if) I get angry? Down here (hospital), doctor checks my problem." –*

*Participant 6*

On the other hand, the hospital environment was uncomfortable for some participants due to the noise level, loss of privacy and lack of autonomy to choose what they like to eat or activities in which to participate.

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3 *"This guy (name of patient) disturbs me every time. ... every time disturb*  
4 *me." – Participant 3*  
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7 *"Outside very noisy in the ward. I don't like the food, makes me want to*  
8 *vomit" – Participant 4*  
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12 **Main theme 2: Yearn for a life outside the ward**  
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14 Many of the participants reminisced about their past lives and one cried when describing the  
15 loss of his past, *"No more job. Closed down already" (Participant 4)*. Another spoke about the  
16 activities that he previously did, *"At outside, I got a bit of this... ah... Baking (activity), cooking",*  
17 viewed his hospital stay as time-limited, *"I think here is a temporary place",* and wanted to  
18 find work, *"Because I want... I want to... to find a bit of work" (Participant 5)*.  
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27 There was a desire to be 'normal' and wanting to be viewed positively by the public,  
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30 *"To I think... apply for study like that...promote to university...want to find*  
31 *job for yourself." – Participant 5*  
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35 Participants expressed a strong desire to leave the hospital, *"I don't like staying here, I want*  
36 *to go home." (Participant 4)*. This was affirmed by another participant in the same focus group,  
37 *"He said he wants to go home" (Participant 3)* who noted he himself was unable to return  
38 home despite his wish, *"I can't go home. Have to come here. I want to but can't go home. Stay*  
39 *here because my mum will hit me" (Participant 3)*.  
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48 **Main theme 3: Interacting with other people**  
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51 Participants reflected on the interactions with their family and mental health professionals in  
52 the hospital, described in the following two sub-themes.  
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56 *Sub-theme 1: Lack of family involvement*  
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Participants experienced a sense of isolation from their family because they had minimal involvement in their lives. One reported a strong sense of loneliness and feelings of loss and grief,

*"Parents are no more already, parents are not here.... mother and father passed away." – Participant 4*

Feelings of sadness and loneliness as well as anger were also endorsed by other participants whilst reflecting on the impact of the absence of family support,

*Participant 6: My family won't come (to) fetch me*

*Interviewer: How come?*

*Participant 6: Hmm. I tell them to come. My daughter also never come*

*Interviewer: How do you feel?*

*Participant 6: Angry.*

There were moments in the interview where participants expressed their affection or love for their family members, such as choosing the image of a heart and expressing feelings of happiness when they were visited by them,

*"Mummy...I have a father too... (picks up the picture of heart) ...close to me...mummy comes and visits me." – Participant 1*

Another talked about his sibling and family members bringing food and spending time with him in the hospital, which helped him to keep in contact with his family,

*"Every Sunday when he's (brother) off (from) work. Go and drink coffee. He buys coffee and popiah (snack) for me every day. My mother comes every time; every time she cooks porridge." – Participant 3*

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Many developed friendships in the hospital to substitute their family and to have a sense of belongingness. Participant 1 chose an image of a sun to represent the friendships he made while another shared how his friend showed care and concern towards him,

*“No. only have one friend only (name of friend)...Buy drink to give me.” – Participant 6*

Another stated he was in the hospital to be with his friend and help him cope with his negative emotions as a result of being unable to return home,

*“I stay with (name of person) in the same ward. I talk to him in the ward” – Participant 3*

*Sub-theme 2: The way mental health professionals treat me*

Several participants identified mental health professionals as figures of authority to whom they raised their concerns, for example informing them that other patients were disturbing them,

*“Important. Like if I got any issue with my body or anything/anyone disturbing me, I can tell the doctor.” – Participant 3*

They viewed mental health professionals as providing a service mostly in relation to their physical health and wanted them to take their concerns seriously,

*“I went to see doctor and doctor gave me cough medicine” – Participant 2*

*“Every time I have problem, I see doctor. Doctor checks problem.” – Participant 6*

*“Important. Like if I got any issue with my body or anything/anyone disturbing me, I can tell the doctor.” – Participant 3*

Some of them shared their satisfaction with being treated well by the mental health professionals, *"Nurse sayang (treat me affectionately) me, very good"* (Participant 1) for example bringing in food, not scolding patients and engaging in activities to build rapport,

Participant 5: *I think... ah... the nurse buy me some curry puff to makan (eat)*

Interviewer: *How she treat you?*

Participant 5: *She is concern about me.*

Interviewer: *How does she show concern for you?*

Participant 5: *She will help me do my best. She is concerned about me.*

Interviewer: *Is there anything you like about her?*

Participant 5: *She don't everyday scold and shout. And don't try to scold vulgarities. And she and I plant some flowers inside the hospital garden.*

The image of a 'thumbs up' or a smiley face was frequently chosen by participants to denote their satisfaction with the services. When asked about the ideal attributes, they wanted mental health professionals to treat them kindly, *"The doctor's kind"* (Participant 6), for example *"show mercy (compassion), Treat me nice. Good heart. Someone that enjoy working with me"* (Participant 5). Others chose the image of the spanner to indicate the support they received in acquiring new skills, *"He taught me how to use a screwdriver."* (Participant 2).

In contrast, one participant had a negative experience and recounted that the mental health professionals were not approachable and lacked empathy,

*"The doctor is very rude to me, very rude, "I don't like the nurse. The nurse makes me cry...scolds me every time."* – Participant 4

Participants valued the advice provided by mental health professionals though some felt they were dismissive and provided superficial advice without understanding their real concerns,

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*“The doctor asked him (his friend) to ignore the patient ...he doesn't want to...so it's not helpful” – Participant 4*

There was strong consensus among the participants regarding the importance of mental health professionals taking time to understand them better and not making decisions on their behalf,

*Interviewer: Would you like the doctor to decide what's best for you?*

*Participant 3: Decide for me?*

*Interviewer: It means like help to make decisions in life for you. Would that be important to you?*

*Participant 3: I don't want that.*

**Main theme 4: Finding purpose while in hospital**

Having some form of activity or work during their inpatient stay was important for the participants. One described learning new skills and expressed hopes about being able to perform tasks in the hospital,

*“I stay here and learn how to play a bit of mahjong. Then after that I think.. I want to... know how to make kite .... help to do a bit of simple jobs.” – Participant 5*

There was a desire among the participants to become more independent, *“They take care of me...I have to take care of myself” (Participant 5).*

Another felt proud of himself for having received an allowance for providing a service to others by carrying out basic chores,

*"I do work operations...little jobs...mop, sweep...Patient, If they pang-sai (defecate), all mah-poh, help them wash backside... Work (for) one month (for a) one time pay..." – Participant 6*

Some of the participants identified their purpose as being a supportive and protective friend,

*"...yeah, he's my friend... I've known (name of friend) for five years...will come to find him when the nurse scolds him every time...joking with him..."*  
– Participant 3

## DISCUSSION

Findings of this study provide a unique insight into the inpatient mental health experiences of adults with intellectual disabilities in Singapore. They demonstrate a clear perspective of how adults with intellectual disabilities ascribe meaning to their experiences and provide feedback about the services they receive in the hospital. Four super-ordinate themes relate to awareness of their mental health problems, the challenges they experienced during their inpatient stay, the quality of interactions with others and redefining their sense of identity following a lack of family involvement. In contrast to a previous study (Cookson & Dickson, 2010) which highlights participants' awareness of their psychotic symptoms and psychiatric diagnoses, the participants in the study did not identify with their psychiatric diagnoses or symptoms. Instead, they mainly describe their emotional difficulties, confirming Robinson et al. (2016) finding that people with intellectual disabilities are aware of their emotional difficulties.

Lack of identification with a psychiatric label and poor awareness of mental health symptoms found in the current study may not be solely due to cognitive deficits. Cultural differences may play a role where family members do not want mental health professionals to inform

their relative with intellectual disabilities about their psychiatric conditions (Bernal, 2008), hence it may be possible that the participants were not told about their psychiatric diagnoses.

Despite the limited awareness of their psychiatric conditions, the participants know they are 'different' and separated from their communities, this was also found in participants of the Robinson et al. (2016) study. Themes of disempowerment and seclusion have commonly been found in western studies of people with intellectual disabilities receiving inpatient mental health services, suggesting that many are dissatisfied with the hospital environment, the treatment process and negative reactions from mental health professionals (Donner et al., 2010; Longo & Scior, 2004). The current study reports on feelings of grief and sadness among hospitalized adults with intellectual disabilities who describe losing ties with their community and being unable to work. This suggests that integration in the community is important for them; they want to interact with others and be a part of the community as reflected by their aspirations, such as wanting opportunities to study, work and have social networks.

A lack of societal acceptance and family members' unwillingness to be involved in their lives may affect the participants' ability to identify positive aspects of themselves. They expressed a belief that their situation would improve if they were allowed to leave the hospital and were provided with opportunities to integrate in their communities. Jahoda and Markova (2004) noted that individuals with intellectual disabilities have to cope with societal stigma when they relocate from the hospital setting to a more independent living arrangement in the communities. Similarly, in non-western culture people with intellectual disabilities have to deal with stigma and process their emotional reactions in relation to their interactions with family members and mental health professionals. This may negatively affect their sense of self and contributed to feelings of loneliness as described by Robinson et al. (2016) and

Mattock et al. (2020) who found the negative impact of stigma on self-esteem and self-identity of individuals with intellectual disabilities in western cultures. The participants in the current study described how they attempt to reconstruct their self-identity through various means, such as being a supportive friend or carrying out acts of service to help others in the hospital, which also helps to alleviate their boredom and improve their self-esteem (Taua et al., 2015).

The findings of the study indicate a strong desire for family members to be involved in the lives of the participants. Other studies have included the voices and perspectives of family carers who acted as advocates for their relatives during the treatment (Donner et al., 2010; Longo & Scior, 2004; Scior & Longo, 2005). Unfortunately, in the current study a lack of family involvement was observed, likely due to high caregiving burden and stress experienced by family members that left them unwilling to continue or resume their caregiving responsibilities (Li et al., 2012).

Participants with intellectual disabilities of qualitative studies conducted in other countries did not talk about their social interactions and friendships during inpatient treatment. Yet, there is an acknowledgement that having friends is important to a person's well-being and research has found that having a social network of friends improves quality of life outcomes for this population (Friedman & Rizzolo, 2017; van Asselt-Goverts et al., 2015). However this is largely neglected by service providers and people with intellectual disabilities are found to have few friendships, lack support in activities with their friends in institutionalized setting and few have non-disabled friends in the community (Emerson & McVilly, 2004). People with intellectual disabilities are capable of making close friendships and enjoying mutual activities together (Knox & Hickson, 2001), which suggest that service providers should work on

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encouraging and supporting them to develop meaningful friendships and provide opportunities for them to interact with others in the community.

The personal qualities of mental health professionals have an impact on the relationships and interactions with this population who prefer mental health professionals who are willing to take time to listen and understand them and help them to promote their competency (Lloyd et al., 2013; Mattock et al., 2020; Stenfert Kroese et al., 2013). This was also found in previous research, people with intellectual disabilities are frustrated with the limited amount of time with their healthcare professionals during which their concerns are not adequately addressed (Wilkinson et al., 2013). Participants in the current study value the involvement of mental health professionals and describe positive reactions when interacting with them, including looking to them for advice and friendship. They would like mental health professionals to support them in decision-making yet allow them to exercise their choices and give them a sense of autonomy. The participants did not recount any experiences where they could exercise their choices which confirms findings of another Asian study that highlighted the challenges that people with intellectual disabilities face when they attempt to exercise their choices during inpatient treatment (Chinn et al., 2011).

The quality of the relationships between participants and mental health professionals has an impact on the coping and adjustment of people with intellectual disabilities in an institutionalized environment. Lloyd et al. (2013) found that a secure attachment relationship between mental health professionals and their service users with intellectual disabilities provides a sense of safety and security which meets their emotional needs. People with intellectual disabilities without the support and involvement of their family may benefit from having a secure attachment and trusting relationships with their mental health professionals

to ameliorate their feelings of loneliness and isolation. Therefore, recommendations are made for training programs to include learning basic counselling techniques, such as active listening and micro-skills to attend and develop rapport with inpatients with intellectual disabilities.

### Implications

The findings of the study may help mental health professionals to understand more about the challenges and emotional difficulties that people with intellectual disabilities face when receiving inpatient mental health treatment. Mental health professionals cited lack of knowledge, low competency and self-confidence as barriers when providing services and treatment to people with intellectual disabilities (Ee et al., 2021b, 2021c). The current findings suggest that mental health professionals would benefit from being equipped with knowledge of behaviour management strategies that focus on avoidance of confrontation and reducing demands or requests so as to de-escalate conflict with the person with intellectual disabilities when they experience emotional distress (McDonnell, 2010).

More efforts are also needed to include family caregivers when their relatives with intellectual disabilities are receiving inpatient mental health services. Family caregivers may feel exasperated and have high emotional distress that can lead to a breakdown in the relationship with their relative and discontinuation of their caregiver responsibilities. This has a detrimental effect on the person with the intellectual disability as they become isolated from their community and efforts to reintegrate them becomes difficult as highlighted in the current study where the majority of the participants did not have strong familial involvement and support. Mental health professionals could work with family caregivers to address emotional issues that arise from their difficulties to manage the behaviours of their relatives

and provide them with resources, including psychological interventions to improve their relationship with their relatives.

The participants in the study lacked opportunities to express their views and the findings of another qualitative study indicate that specialist mental health professionals sometimes act as advocates for their clients with intellectual disabilities, especially when family members are hesitant to integrate them into the community (Ee et al., 2021a). Mental health professionals could focus on working with social service agencies to facilitate discharge from the hospital and integration in the community.

Future research would benefit from involving people with intellectual disabilities as co-researchers during the stages of research development (Strnadova & Walmsley, 2018), to systematically collate their views and feedback about healthcare and mental health services, as well as involve them when planning leisure activities and developing staff training programmes (Billon et al., 2016; Charnley et al., 2019).

Limitations

There were initial concerns that the study may not provide rich and detailed enough data for IPA as this method of analysis requires in-depth descriptive and/or reflective data. Rose et al. (2019) recommend researchers provide additional support when interviewing people with intellectual disabilities, such as having carers or support workers present and (as in the current study) using alternative communication approaches. Resources adapted from Unwin et al. (2016) helped to facilitate the discussion and showed that it is possible to actively engage with service users who have limited verbal communication skills. Having activity-based interactions with the researcher/interviewer can help this client group to express themselves more effectively using pictures and symbols. Some participants were able to

choose symbols such as the heart, sun and spanner to represent the significance of specific people in their lives. In addition, short, fragmented comments made by the participants in the current study were clarified and expanded upon using additional questions, for example using 'how' questions as recommended by Petitmengin (2006) and adapting the questions to be short, clear and concrete (Dagnan et al., 2016). This form of scaffolding joins the short, fragmented comments together to make the data more coherent and richer so that it can be used for IPA. The current findings confirm that IPA (and other qualitative methods) can be usefully applied to adults with intellectual disabilities (Lunsky & Gracey, 2009; Pestana, 2011; Rose et al., 2019).

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#### CONFLICT OF INTEREST

There are no known conflicts of interest.

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