The Slippery Slope to Abuse

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Summary

The abuse of people with autism and learning disabilities by their paid carers is a difficult subject. It is the contention of this article that there is a “slippery slope” in most cases of abuse, leading to negative, sometimes tragic consequences. The ‘slippery slope’ suggests a complex of interacting behaviours, attitudes and values (i.e. cultures) that individually and mutually reinforce abusive behaviours by those exercising control over those unable to. Early stage slippery slopes i.e. at the margins of abusive are probably commonplace, well developed abusive cultures appear too frequently to be complacent. This article examines a recent example of abuse in the UK and discusses how practitioners and managers might recognise and act to prevent slippery slopes developing into abuse.
The Winterbourne View Experience

In June 2011 the UK media spot light focused on the abuse of some of society’s most vulnerable individuals. A documentary “Undercover care: The abuse exposed” (BBC Panorama, 2011) gave a snapshot of the multiple abuses that some individuals with autism and learning disabilities suffer. These abuses took place at the Winterbourne View Hospital in Bristol, a facility intended to support such individuals to live meaningful and fulfilled lives. However, a group of staff were seen to subject their clients to what has been described as torture (McDonnell, 2011). Verbal and physical assaults, fraudulent incident reporting and prolonged targeting of certain clients were filmed and appeared to be routine staff behaviours. Whilst the staff undertaking these behaviours may be represented as a ‘few bad apples’ at the frontline, the lack of action by frontline managers (apart from one) to intervene and the actions of an ‘accredited’ trainer in physical interventions appeared to support this systematically abusive culture. The events at Winterbourne View are not isolated incidents. Recurring episodes of systematic abuse occur, from the Ely hospital scandal of the late nineteen sixties to the Longcare scandals of the late nineties (Community care, 2007). Some surveys have shown prevalence rates for abuse and maltreatment of people with learning disabilities as high as 53 percent (Sullivan & Knutson, 2000). Services intended to safeguard and support such vulnerable individuals are noted as being the most likely places for abuse to occur (Sobsey, 1988). It was hoped that as institutional care was replaced with care in the community, cases of abuse would diminish. However, the cultures which allowed abuse to occur in institutions have found new homes in the wider community (Clement & Bigby, 2010; Fyson & Kitson, 2010).
Social psychological evidence

Previous commentaries on this subject pointed to abusers as callous individuals with few morals (Martin, 1984), but social psychology research indicates that most people are capable of acting abusively if certain factors create the right context. Bandura (1999) described this “slippery slope” as ‘gradualistic moral disengagement’ (Bandura, 1999), where otherwise healthy and typical individuals behaved inhumanely. The Stanford prison experiment illustrated this process. The experiment created a “total situation” (Zimbardo et al., 2000) where those in power became ‘deindividuated’ (their individuality subordinated to their role as a group member) and those they had power over became dehumanized and subjected to abusive control. These individuals were punished and had their control over their lives removed. They were seen as undeserving of empathy or compassion; an essential premise for humanity (Bandura, 1999). Similar situations have been observed in a psychiatric hospital, an example of a ‘total institution’ (Goffman, 1961) and in services for people with intellectual disabilities (Wolfenberger, 1975; Cambridge, 1999) designed to control ‘inmates’ lives and create social distance between staff and patients. Winterbourne View residents were often denied private or easy access to family members.
Organisational influences

Abuse in services is rarely purely the result of “bad apples” (Martin, 1984) but rather a gradual deterioration of behaviours to become a dominant, malign, abusive organisational culture. A clear understanding of the “slippery slope” to abusive cultures is vital to developing preventative and reactive strategies (Cambridge, 1999). Organisational culture refers to the shared beliefs, practices, goals, work systems etc. among staff that are passed on to new staff, or more simply “how things are done around here… the grown up pattern of expected and accepted behaviours” (Drennan, 1992). Despite receiving limited attention in the learning disability sector, organisational culture is very important to staff practice. Hastings et al. (1995) first proposed the importance of differentiating and analysing the impact of both informal and formal cultures, yet little is known about how these interact and effect staff behaviour (Felce et al., 2002). Broadly, formal culture can be equated with policy maker’s requirements from services; for example, the regulatory/legal and inspection standards, procedure and policy manuals and expert advice given to services from a variety of professionals. Informal cultures develop within a group of staff working together to ‘give life to’ the formal culture, within relationships with service users, who often have little power/influence over how they want to be supported. Factors likely associated with early stages of the slippery slope are relatively commonplace and are associated with organisational culture. For example, staff experience of stress and high turnover are increased by or ameliorated by organisational culture (Hatton et al., 1999) and service user quality of life is associated with staff performance and organisational culture (Gillett & Sternfert-Kroese, 2003). White et al.
(2003) argue that specific aspects of organisational cultures may promote abuse.
Organisational cultures that lack good management, staff training and support, staff boundaries or that are isolated or poorly planned are particularly prone to the normalisation of restrictive practices and the development of abuse. Lack of support or protection for whistle-blowers, as seen at Winterbourne View is also likely within a negative culture (Cambridge, 1999).

However, society and organisations expect frontline staff and managers to control people’s unsafe behaviour, when they are in ‘care’. The combination of disempowered frontline staff, with low social status and esteem, supporting a similar group, and having the burden of expectation of control placed upon them, have the ever present potential to create ‘corrupted cultures of care’ (Wardhaugh & Wilding, 1993). The development and enactment of numerous daily activities, that staff control, emphasises the powerlessness of people needing care. Organisational forums for staff and managers to explore these complex, contentious issues are required to provide the emotional and therapeutic containment needed for positive carer/client relationships to develop (Cambridge, 1999; Wardhaugh & Wilding, 1993). It was noted at Winterbourne View that the main carer ‘leading’ abusive practices and culture was able to ‘control’ his shift, the other shift being characterised as ‘chaotic’. Such powerful informal leaders can be seen as competent, useful staff members by senior staff, who do not look to deeply into how they achieve these results. Relatively minor abuses of power (e.g. unreasonably locked doors or withdrawal of scheduled activities) and restrictive physical interventions applied without thoughtful review are likely to be at the top of the “slippery slope”. Factors that may ameliorate the development of the slippery slope are considered below.
Towards better practice - The case for restraint reduction

Deveau and McDonnell (2009) argue that physical restraint should be a last resort, however, evidence on prevalence of physical intervention use suggests these are used as routine (McGill et al., 2009). Research suggests that staff believe physical aggression would be the most likely reason for restraining someone (McDonnell, et al., 1994; McGill et al., 2009). However, (Ryan et al., 2007) found two thirds of restraints in a USA day school had been recorded as a response to noncompliance. In England a 15 year old boy held in secure custody died in 2004 whilst held in a ‘double seated embrace’ after a confrontation about cleaning the unit toaster. Some workers may find restraint in itself reinforcing (Harris, 1996) and a minority of workers may be responsible for the majority of restraints (McGuirk, 1999). Paterson et al. (2012) have argued that services developing processes of seeking and achieving restraint reduction is an ameliorating factor for preventing corrupted cultures of care and the slippery slope developing. The primary component of a successful restraint reduction strategy is leadership and organisational change (Deveau & McGill, 2007; Colton, 2004; Huckshorn, 2004). Other components suggested are: data use to inform practice, workforce development, consumer roles/participation, staff debriefing and external review.

A Special issue Journal of Applied Research in Intellectual Disabilities on (reducing) restrictive practices suggests that the use of restrictive behavioural procedures demonstrates service providers may not have implemented effective preventative and treatment strategies at the individual and organisation levels (Sturmey, 2009). Interventions associated with reduced physical interventions are: mindfulness training for staff (Singh et al., 2009) organizational leadership, action planning and monitoring of
restraint (Sanders et al., 2009). One literature review on successful restraint reduction, suggested that applied behavioural approaches e.g. functional analysis, altering setting conditions, combined in a thorough behaviour support plan which is monitored, is crucial to enable restraint use to reduce (Luiselli, 2009). Sturmey (2009) concluded successful interventions possess a number of components in common. The accurate and comprehensive documentation of all incidents of restrictive practice, concentrate on high risk situations which encompass accurate functional assessments of target behaviours, staff training and support to implement positive behavioural interventions based on functional assessments and teaching replacement skills so that individuals have alternatives to challenging behaviour (Sturmey, 2009).

Practitioner experience suggests the following may help to reduce exposure to restrictive practices and the slippery slope to abuse of people with learning and other disabilities:

1.  *Being aware that minor restrictions can lead to more intrusive deprivations.*

As practitioners it is noticeable that people who are described as “challenging” appear to have high levels of rules and boundaries within their support plans. Treating an individual in such a way may, in practice, escalate “challenging” behaviour rather than support its reduction.

2.  *Practice from a human rights perspective.*

Chan et al. (2011) argued that “Increasingly, practitioners will be called upon to justify their interventions in terms of upholding human rights and may expect that there will be areas where practice will be found wanting.” In practice we should always question whether we have the right to impose specific rules or boundaries. The pragmatic
approach would suggest that there are times that individuals may require interventions such as restraint to keep them safe. However there are also many circumstances where individuals are restricted access to food, drink or preferred objects where the consequences of allowing access is unlikely to lead to increased harm to the person or their carers.

3. Creating a positive risk taking culture.

Mc Donnell (2010) argues that a positive approach to risk taking requires the acceptance that risk minimisation rather than risk eradication is the goal. Some risk taking is likely to be necessary for individuals to learn adaptive coping strategies and may increase the likelihood of living a full and meaningful life. It is important to avoid the traditional “near miss” culture. Consider this example

‘John is a 30 year old man with autism, whilst on a walk he becomes very distressed. The staff member has to physically guide him away from a road and distracts him with a drink. When he returns to the service the staff member is asked to fill out a near miss form.’ This could be reframed; John’s carer demonstrated successful diversion.

Managing risk positively requires analyses of situations where incidents were prevented due to positive staff practice, as well as actual incidents.


Leaders should focus organisations and services upon the reduction of restrictive practices by attending to daily staff practice, “The most effective way to reduce these practices is to challenge their use and set organisational goals for their reduction” (Webber et al., 2011).
5. **Supporting reflective staff practice.**

   It is often the case that there can be too strong a focus on the behaviour of service users at the expense of staff reflecting on their own contribution to challenging behaviours (McDonnell, 2010). In essence, good behaviour support requires taking the perspective of the person who is challenging; ‘try to walk a mile in the person’s shoes’. Developing positive relationships with people is the key approach to managing behaviours (Pitonyak, 2005). Staff based approaches to develop self awareness and self management e.g. through developing mindfulness (Singh et al., 2009; Brooker et al., 2012) is suggested.

6. **Developing a culture of low arousal.**

   Arousal regulation is a significant factor in reducing challenging behaviours (McDonnell et al., 2012). Creating environments that reduce arousal requires a reflective approach and a stress management perspective (McDonnell, 2010).

**Conclusion**

It is unlikely that abuse will ever be fully eradicated from care settings. This suggests that reducing abuse and the opportunities for it to occur is of utmost importance. McDonnell (2011) argues that services are often on a slippery slope, where relatively minor infringements of people’s liberties and rights may deteriorate to systematic abusive practices. Reducing potential abuse requires practitioners to be reflective and vigilant of the subtle ways in which restrictive practices control and dehumanise people. Good practice should ensure that restrictions are used minimally, legitimately and only as a last resort (Deveau & McDonnell, 2009). Abuse is likely to emerge in settings where people are devalued, unreasonably restricted, denied freedom and choice and where staff and
cultures are unreflective, poorly led, afraid of risk and lacking in perspective. Restrictions should not infringe on basic freedoms or human rights and staff and service users should be supported and facilitated in positive risk taking. Positive organisational cultures which promote reflective practice, human rights and choice are essential in working against the slippery slope to abuse.
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