Behind the Gates of a Gated Community:

Systemic Negligence in Residential Services

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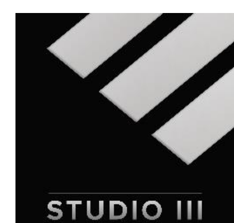
Studio 3 Clinical Services and Training Systems



“The greatest wisdom is seeing through appearances.” - Atisa

Introduction

At Studio 3 Clinical Services and Training Systems, we have worked with a wide range of residential services for autistic adults and young people, as well as those with other conditions and learning differences who may exhibit behaviours of concern. Many of these services have requested our support as they have experienced significant difficulties in managing behaviours that challenge. What we have found when working with such services is that there are often systemic barriers preventing the care provided from being therapeutic. At Studio 3, we employ the Low Arousal Approach which is a person-centred, non-confrontational method of managing behaviour. In this approach, there is a foremost focus on ‘reducing demands that are sources of stress for the individual and enabling individuals to deploy coping mechanisms that support effective self-regulation’ (McDonnell, McCreadie & Dickinson, 2019; p. 454). At Studio 3, we actively campaign against the use of restraint and seclusion and help settings to reduce restrictive practices in order to support individuals using the least aversive approach.

In many settings where elements such as staff training, supervision, regulations, and clear plans are not effectively established by management and staff on the ground, a culture of coercion and control can grow and be very difficult to reverse. On an extreme level, examples such as the abuse scandal at Winterbourne View, as exposed by BBC’s Panorama in 2011, demonstrate what can happen when staff training is neglected and restrictive practices are allowed to flourish. When supporting autistic individuals who may also have an intellectual disability and/or experienced traumatic events, person-centred trauma-informed care is paramount. As

staff members and practitioners in these environments, we have an opportunity to make meaningful changes in the lives of the people we support. However, many factors need to be in place to enable supporters to provide the best possible care.

BBC's Disclosure Locked in the Hospital documentary, which aired on 16th August 2022, unveiled some of the issues we are witnessing in the care sector today, 11 years on from the Winterbourne View exposé. In one example from this documentary, a mother went to visit her son in a high-security psychiatric hospital. After he became very emotional and upset, his mother reported seeing staff pile into his room, take him to the ground and inject him, chemically restraining him. This is not a therapeutic or mindful way to manage stress or stress-related behaviours; it is an overuse of restraint as a means of social control.

In many cases, individuals in crisis are not given the opportunity and space to regulate their emotions themselves. Restrictive environments of coercion and control can grow when the right support and guidance are not in place, particularly behind closed doors and in gated communities. In this article, we will look at some of the issues residential services can face, including toxic working environments, safeguarding violations and abusive practices, and attempt to discuss the wider implications of poor practice for care services across the UK.

Safeguarding Violations

Training

The role of a support worker involves supporting individuals to reach their goals and live with purpose and dignity. In residential services supporting individuals who exhibit distressed behaviour, to keep everyone safe, support workers are required to complete basic training. In many settings, physical intervention (restraint) training is

part of this basic training. These restrictive practices are designed to be used when individuals in crisis are at risk of causing harm to themselves or others. At Studio 3, we believe in teaching physical interventions only on an individualised basis and after a Training Needs Analysis has been carried out. Sometimes physical skills are needed to keep people safe, and when this is the case, physical methods should be taught to a high standard and with clear guidelines around their use.

Though there is a vast range of care settings across the UK where restrictive practices are a part of daily life, many of these settings have staff teams who have not received sufficient, if any, restraint training. Inevitably, occasions arise where some of these staff members find themselves in situations where the use of some form of restraint is unavoidable. This can result in staff resorting to using their own unofficial and unsanctioned restraint techniques in environments where staff training is not closely monitored and prioritised. The use of such techniques greatly increases the risk of injury and harm to both support workers and the individuals involved. In many cases, even those who have received training in physical interventions are taught such a vast range of physical methods in such a short period that they forget these skills as soon as they leave the classroom (McDonnell, 2022).

Staff who are not provided with sufficient de-escalation strategies to avoid a crisis in the first place or taught physical restraint techniques when necessary are left unsupported and defenceless. If staff members do engage in any form of physical restraint while untrained, they will often also be, or feel, unsupported by management. The avoidance and fear that lack of sufficient training can spark in staff members will inevitably be felt by the people they are supporting, as fear can be spread through emotional contagion. In the example to follow, we observe the aftermath of a group of untrained staff who were forced to physically intervene in a potentially life-threatening

altercation without guidance:

One member of staff was targeted and attacked by a person they were supporting. Several other staff members watched this occur and did not help; as is common in crisis situations, they froze. They froze because they were scared, not only of getting hurt themselves but scared, too, of allegations of intervening incorrectly. When one staff member eventually did intervene, they used unsanctioned physical methods as they had not received the appropriate training. Unfortunately, this staff member got injured in the process. It was only after this event that the staff members involved received the physical training they had missed.

This is an example of reactive rather than proactive training that failed to safeguard employees and those they support. For optimal care to be provided, staff need to be trained and supported to provide the standard of care required to safely and confidently support individuals in crisis.

According to Karasek and Theorell's (1990) Job-Demand-Control-Support model, when staff experience high demands at work, have a low sense of control in their role and do not receive appropriate support, their well-being suffers and they experience stress. In short, the demands of work outweigh the staff's inner resources to manage them. If staff do not have the resources they need to manage stressful situations and their stress and arousal levels are continually rising without awareness or support, there is a greater risk of their emotions influencing their behaviours. In environments where staff are permitted to use restraint techniques, this can be especially dangerous. What is being described here is a toxic cycle of 'care,' where staff are not able to support others to regulate their arousal levels if they are not in

control of their own. In response, the arousal levels of the individuals they support will rise in tandem due to emotional contagion, increasing instances of distressed behaviour. This behaviour then affects staff's stress and arousal levels, creating a toxic cycle. Reacting emotively when restraining vulnerable people, especially with untrained staff, can result in avoidable fatal outcomes. This is not therapeutic care. This is harmful and reckless care. In toxic environments such as this, how can we expect the individuals being supported to feel safe or at home?

Avoid Gathering Staff in a Crisis

In most settings where there is a restrictive culture and restraint is often applied, staff are encouraged to call for assistance if restraint is required, usually through alarm systems. When people are running toward someone in crisis to use restraint techniques, fear and anxiety will rise for those in the environment. This example of 'staff behaviour' is all too common in care settings where restrictive practices are taught and may increase the frequency of and duration of crises occurring. Staff must acknowledge that therapeutic support starts with them, and this is at the core of Low Arousal. Generally, it is less often that staff training focuses on attempting to de-escalate and avoid situations where restraint may be needed. At Studio 3, we see many care environments that fit this description and recommend that such services avail of our Low Arousal training. Our de-escalation and crisis management training is informed by Low Arousal Approaches and focuses on non-aversive strategies to reduce stress and tension at the moment, as well as prevent crises from occurring.

At Studio 3, some of the work we conduct involves training staff teams and organisations on how to manage these situations more effectively and efficiently, with the aim of not only reducing the use of restraint techniques but to eradicate them.

What is often seen in care environments that struggle to manage behaviours that challenge is that they are not putting emphasis and focus on de-escalation techniques; staff are reactive to crises, not proactive to preventing crises. In instances where a situation is escalating, we recommend avoiding gathering staff, as more onlookers can escalate the behaviour of distressed individuals, as well as influence the reactions of staff. Staff need to take accountability for how their behaviours influence the behaviours of those they are supporting, as relationships are symbiotic. Removing onlookers is sometimes a simple way to de-escalate a situation without becoming physical. Planned escape is also an excellent solution, particularly in services that have outdoor spaces for distressed people to escape to and learn to self-regulate.

Supervision

Supervision is such an essential component of safeguarding. Due to the ever-evolving safeguarding needs of staff and those they support, supervision for support workers should happen on a set regular basis. Unfortunately, this is an element of safeguarding that is often overlooked by management teams. In homes we have supported, there have been staff members who, on paper, should be receiving supervision, but in reality do not. In some cases, staff teams have not had supervision for 9 or 10 months, while others simply couldn’t remember when they had it last. It is common in situations such as this for accountability for the lack of supervision provided to be passed on from senior team member to senior team member.

This blame culture is inappropriate, and strong leadership and a clear definition of roles are essential in settings such as these, where large staff cohorts are responsible for many individuals. In a recent study (Björne, Deveau, McGill & Nylander, 2021) investigating the use of restrictive measures in community services

for people with intellectual disabilities in Sweden, researchers identified numerous reasons why staff use restrictive practices, including lack of staffing, resources, time, training, and supervision. In the study, staff said that structural changes with engagement from the whole organisation would be required to mitigate the use of, and perceived need for, restrictive practices.

COVID-19 Regulations

For individuals working in residential services throughout 2020 and beyond, the COVID-19 pandemic has presented a new and monumental challenge to safeguarding vulnerable people. Though there were a plethora of government guidelines on how to keep safe and prevent the spread of infection, how these were implemented in residential services varied significantly. It was commonplace in services at this time to have many visible reminder signs relating to these guidelines posted around services, including timed seating schedules for breakfast, lunch, and tea, prompts to wash hands, prompts to use hand sanitiser, prompts to wear face masks, and prompts to do daily temperature checks when entering services. Whilst these signs would suggest compliance with the government guidelines, there was in many settings a distinct and widespread culture of non-compliance. Consider the following example:

One day, after getting particularly frustrated at the scale of this non-compliance culture, a support worker in a residential service wrote a detailed email to their manager, outlining all of their safeguarding concerns. In their reply, the manager said that they were unaware that people weren't wearing masks and thanked them for bringing it to their attention. However, the manager themselves often took walks around the home without a mask, just as the other members of staff had done, leaving

the support worker feeling unsupported and silenced.

In this setting, there had developed a toxic ‘us versus them’ dynamic in the senior and managerial teams, where workplace politics seemed to supersede the importance of creating a safe, welcoming environment for the individuals being supported. This example exemplifies how important it is that staff are transparent in their work and their communication. Toxic dynamics amongst staff members impede the support they will provide to those under their care.

The Issue of the Gated Community

There is a big problem in residential services where a gated community exists. In these settings, staff have radios and are close by to one another, meaning that it is difficult to externally monitor their behaviours and practices, as even a surprise visit from investigators can result in a quick alert to all staff and modified behaviour. The following example demonstrates how difficult these environments can be for staff:

One day, a senior member of staff came to visit one of the homes she helped to run for individuals with intellectual disabilities and autism. Before her visit, staff at the home were told to do a deeper clean than they usually would have and to ensure that everything was as presentable as possible. During this clean, a senior staff member cleaned up a mess in such a way that was known to unsettle a young person they supported. At this time, they kept their belongings in boxes outside of their bedroom. To make the corridors cleaner, however, these boxes were moved back into this individual’s room while they were there still in bed. This young person had a diagnosis of autism, among other comorbid conditions, and did not appreciate it when the staff

did this.

In the end, this staff team were told that they got a positive result from the inspection company for all of the efforts they had made for the people they supported. This example exemplifies the problem with the gated community; coordinated cover-ups can shadow poor practices. What implications does all this have for wider care services across the UK?

Implications for Care Services in the UK

Though there are many positive elements of the work being done in residential services across the UK, there are also a lot of systemically negligent practices occurring, too. These practices need to be called out when witnessed and addressed on a system-wide level. In many toxic environments, staff are living in fear of injury, allegations and suspension as they are put into situations they are not appropriately trained for or sufficiently supported with. This can result in many placements breaking down. It’s upsetting to see young people getting passed on from service to service, and we can do better. Though placements won’t always be successful, there is much that can be done to reduce the frequency of these breakdowns.

The purpose of regulatory bodies like Ofsted and the CQC, for example, is to assess for problematic behaviours, mitigate risk and prevent placement breakdowns. Poor practices will keep happening if they remain unseen, or if there is no accountability. This information should be accessible to the public, too; parents, guardians and caregivers all deserve to have this information when making decisions about the future of those they have a responsibility to protect.

In order for residential services to support individuals and staff teams in the best

possible way, at Studio 3 we recommend:

1. Management and senior staff listen to and support their staff. As outlined earlier in this article, research from 2021 outlined numerous reasons why support staff feel the need to use restraint techniques and seclusion, reasons which can be eradicated with appropriate training and support (see 'Freedom from Restraint and Seclusion: The Studio 3 Approach' by Professor Andrew McDonnell, available exclusively from the Studio 3 website – www.studio3.org/shop).
2. Management and senior staff should consider Low Arousal Approaches to help teach staff how to de-escalate crises. The emphasis in training should be on de-escalation, not unnecessary physical skills that staff will begin to forget as soon as they leave the classroom.
3. All staff should be mindful of the care needs and historical events that have happened in the lives of those they support to provide person-centred, trauma-informed care.
4. According to Professor Martin Seligman's PERMAH model of well-being, there are many facets which contribute to 'the good life.' Consider what is important to the individual and what areas of their lives are, or are not, being fulfilled. What are their aspirations? Explore local supports in the community. What is available to the individual being supported?
5. Finally, transparency and accountability are paramount. If people are transparent about the work that they do, they can be held accountable. This is essential for safeguarding.

References

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