Managing stressors in a detention facility – a response

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This article is a personal reflection on a research paper entitled "Managing Stressors in a Detention Facility" previously published in the journal. The paper considered the emotional impact of their work on a small group of staff who had worked in an immigration detention facility in Australia through a series of face-to-face semi-structured interviews. The group of interviewees numbered only nine but were both female and male and aged between their late 20s and early 60s. They had a range of previous work experiences.

There are obvious limitations to the research; in that, the sample was small and was identified by "passive snowballing", whereby one interviewee would provide the contact details of other former staff who had worked in a detention facility and who might be of interest to and interested in the study, and the interviewees were not directly recorded to allay any concerns that what they said would get back to their former employers.

The author recognised that it was not a comprehensive study but considered that it did provide "a snapshot of the experiences of a small group who had significantly been impacted by the stressors of the workplace". By definition, the impact had been sufficient to cause the interviewees to terminate their employment.

The study identified a number of stressors that all or some of the interviewees reported, a number of coping mechanisms/strategies that they had used or developed and five recommendations for employers to implement to help staff manage the stressors.

This article will consider the relevance of the study and its findings for adult health and social care services and safeguarding adults in particular.

At first glance, there may appear to be little linking an immigration detention centre to health and social care settings. In many cases, this may be true, but there are settings where the links can be very strong. As the paper points out, while immigration detention facilities used to "cater for people who are visa overstayers such as students and people working illegally, as well as asylum seekers who came by boat", however, recent changes in Australian immigration policy has led to non-Australian citizens who have received a prison sentence of more than 12 months being stripped of their Australian residency and placed in an immigration detention facility pending possible removal from Australia to a country they left as small children. They had work rights or permanent residency in Australia but not citizenship. They are therefore potentially fighting both their conviction and sentence and the change in their human rights that could lead to their repatriation to a country they do not know, with obvious implications for their mental health.

There are, therefore, links to those prisoners in English prisons who also have care and support needs and even more so to those people with care and support needs who have

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been placed in care homes and other institutions against their wishes or who lack the capacity to agree to their placement. The position of adults with mental health needs, a learning disability or who are on the autistic spectrum and who are placed in care homes or hospitals such as Winterbourne View is also potentially similar to that of those in the immigration detention facilities.

There might also appear to be little linking of the study with safeguarding adults, and indeed the study does not identify any such links; however, I would suggest that there are themes that can be identified within the study that can equally apply to health and social care settings with direct implications for safeguarding adults. This paper will consider some of those themes, their implications and possible means for limiting their impact on adults with care and support needs.

The themes to be considered are:

- the disengagement of staff from the service and the service users;
- services moving towards becoming "total institutions";
- a lack of specialist services and staff to meet specific needs of the service users;
- pressure of accountability beyond capability;
- staff recruitment and retention strategy;
- supervision/workload management/reflective practice; and
- distance of senior managers with different priorities – bottom line of budget.

Disengagement of staff from service and service users

The study identifies a number of factors that can lead to staff disengaging from the service, in particular the service being under-resourced, preventative work being lost, the service being resistant to change, whether deliberately or not, and service users situations either not changing or deteriorating, whether in their own view or in reality. These can be exacerbated by staff having to implement arbitrary rules and regulations without the opportunity to explain them to service users or the ability or chance to inform their development.

The under-resourcing of care and support services, particularly over the past decade, is well-known and documented; here is not the place to repeat those arguments though it is perhaps relevant to point out that additional funding or resources will not, in themselves, resolve all the issues identified in the study. The issue of preventative work being lost is a relevant one for this paper; I am including in the term "preventative work" support that is aimed at re-enabling or developing the service user's independence skills. The interface between the proactive and the reactive aspects of safeguarding adults is a complex one; in reality, it is a permeable membrane where any interaction with the service user may move between the two aspects.

The lack of this important aspect of care and support services and therefore safeguarding services can reinforce the disengagement of staff from their service users. The lack of any "improvement" or development in the service user's situation must impact on the job satisfaction of the staff and therefore, in the longer term, on their motivation and commitment to their work and hence their service users. This may, I suspect almost inevitably, result in the reification of the service users, their being seen as "other", which will raise the likelihood of their being abused or neglected, as they are not treated as individuals with their own unique needs and wishes. This will further reinforce the lack of any "improvement" or change in the service user's situation which will, in turn, reduce any expectation of any change in the future – a self-fulfilling prophesy of stagnation for both service user and staff.

At its worst, this could lead to service users' situations actually deteriorating. This may be inevitable: someone with a degenerative physical condition, whether it impacts on their physical or mental health, or a chronic mental health issue might be bound to have their situation worsen over time, but the lack of appropriate support and stimulation can either accelerate their decline or prevent its delay. On the assumption that most care and support staff are motivated by a desire to help people in some way or other, this "failure" to meet that motivation can only further their disengagement from their service and their service users. Again, this can only increase the likelihood of poor practice becoming entrenched into service cultures with a similar increased likelihood of escalating into abuse or neglect.

Services moving towards becoming "total institutions"

Linked to the above theme is that of health and social care services sliding towards becoming "total institutions". A "total institution" can be defined as "a highly ordered and restrictive social institution which keeps up a high level of management over the activities of those people who are members of, or confined to, it". It is often considered to have been first identified by Goffman and described in his collection of essays "Asylums" (Goffman, 1961). A distinction can be drawn between an institution or organisation that is established with the intention of being a total institution – for example, prisons, military bases and, at one time, certain health institutions for those with a learning disability or chronic mental health issue – and those health or social care settings that, over time become so rigid in their procedures and practices that they take on many of the aspects of a total institution.

The motivation or causation for this change from what could be described as a therapeutic model to a more restrictive one can vary from a variation or permutation of the factors identified above to the isolation of the service by its geography. For example, a service in an urban setting is likely to have greater turn-over of staff or interaction with other similar services than a service in a rural or more remote area. A more isolated service, in the sense of less contact with other similar services either through common staff development opportunities services or with less staff turn-over, is more likely to become entrenched in its policies and less reflective in its practices.

The introduction of the Deprivation of Liberty Safeguards (DoLS) was meant to safeguard those lacking the capacity to decide whether or not to agree to being admitted or remaining in residential or hospital care against the illegal or inappropriate violation of their human rights. However, the reality for many of those people is that the safeguards are ineffective and are not being implemented due to a lack of resources, including trained staff to complete and authorise the necessary assessments. As a result, there are bound to be a number of individuals being illegally deprived of their liberty to some degree or other, a number that is likely to be increasing, as local authorities have to prioritise which assessments to complete, and the implementation of the successor to the DoLS, the Liberty Protection Safeguards, is delayed. In practice, this means those institutions where DoLS assessments have not been completed appropriately are moving closer, for those particular residents, to being a "total institution". While the DoLS in themselves do not come under Safeguarding Adults, in my view, as they *are* the safeguards, any failure to implement them appropriately *does* become a safeguarding issue.

Lack of specialist services and staff to meet specific needs of service users

From my experience both as an Independent Author of Safeguarding Adult Reviews and as the Independent Chair of a Safeguarding Panel for a housing and support provider, I am aware of the lack of access to specialist resources and staff to support service users with specific care and support needs. This is linked, obviously, to the under-resourcing of health and social care services over the past decade but has particular relevance to safeguarding adults whose behaviour puts them at particular risk of abuse or neglect. For example, I am

aware of a young man with a learning disability, and who is on the autistic spectrum, who has been targeted by local vigilante groups as a paedophile because of his inappropriate use of social media to try to have a heterosexual relationship. The combination of his learning disability and his autism makes him unable to understand that he should not be contacting girls/young women under a certain age. Although he is living in the community, it is very difficult to manage his access to the internet, to ensure his safety at all times or to provide the specialist input and support to enable him to develop that understanding; it is also impossible to find or finance a residential placement for him that would make the aforementioned easier to achieve – that is without considering the morality of both what he is doing or restricting his liberty by such a placement. The reality is that his identified needs are not being met – some might argue cannot be currently met – and he is at risk of further abuse by vigilantes as are staff working with him and other tenants in the block of flats where he lives.

Pressure of accountability beyond capability

The aforementioned example also demonstrates the additional pressure that can be placed on un- or under-qualified staff to manage situations and care and support service users with needs beyond their professional abilities or their job description. This puts not only the service user at risk of harm but also the member of staff at risk of accusations of neglect should the service user come to any harm. I am aware of situations where support staff have been accused of neglect when other professionals – in both cases nursing staff – did not carry out appropriate assessments but relied on the support staff's judgement and assessments.

Being placed in such a situation can only exacerbate the disengagement of staff from their service and their service users, particularly when they are expected to work with service users' families and significant others. I am aware of a number of cases where families have unrealistic expectations of their rights to be involved in decision-making about service users. This may not be such a major issue in residential or hospital settings but can be in the community where managers are not so immediately available to speak to the family or have the same degree of knowledge of the service user. Often the above has been caused by the family not being advised of or misunderstanding the Mental Capacity Act 2005.

Staff recruitment and retention strategy

The study refers to staff who "had not expected to deal with the types of issues that emerged [. . .] and then had little power to take the action they felt was needed". This again links to the issues of the disengagement of staff raised above but matches the concerns I have had about newly recruited support staff not being effectively inducted into the posts they have been appointed to. This is not due, in my experience, to a cavalier attitude by employers but by the reality of staff shortages, the increased demand of services and the increasing dependency of service users.

The study also identifies a lack of appropriate training being provided to staff to enable them to work with detainees with "either mental health and/or behavioural problems". Given the difficulties some services are having ensuring newly recruited staff are properly inducted, it is hardly surprising if they are having similar difficulties providing ongoing staff development opportunities to enable staff to meet more specialised needs of their service users. This can only be compounded by difficulties in releasing staff because of issues of "back-filling" to ensure services continue to be delivered. The position of rural or isolated services referred to above will also be more difficult. This theme also links to the lack of access to specialist services – see 3 above.

Supervision/workload management/reflective practice

The study identifies an issue around the lack of appropriate support to assist staff manage or cope with the stress they were working under. In particular, it refers to a lack of support to deal with specific detainees who caused problems for staff. Reference is made to an excessive workload with insufficient time off duty and to feeling that their experience was not sufficiently validated by upper management. If staff are to manage the above stressors and therefore avoid disengagement from the service and their service users, then the role of supervision, combining both workload management and reflective practice, is paramount.

The pressures referred to above about increased demand for support services combined with reduced funding and the resulting focus on more dependent service users make the provision of effective supervision more difficult. This situation may be further exacerbated by cutbacks in managerial posts, as has happened in a number of agencies as a means of achieving the economies necessary to meet the funding shortage. Again, the position is likely to be more complicated in rural or isolated services.

It is interesting that the study draws attention to staff creating their own support systems but not accessing community-based support systems; this is ascribed to the need to retain confidentiality of information. What is not spelt out is whether this confidentiality relates to the detainees or the service itself; the study does also refer to a fear of its subjects of their actual or previous employers becoming aware of their participation in the study. If it is the later, this could be related to differences in the legal position of whistle-blowers in Australia, but I am not able to comment on this because of ignorance on my part.

Distance of senior managers with different priorities

The study identifies an issue with senior managers not being interested in addressing issues related to detainees' behaviour; reference is made to "the company" that ran the detention facility, which suggests that it was/is a for-profit organisation rather than a state-run organisation. An issue that has been identified in a number of SARs and other reviews is a separation between operational and strategic priorities and even awareness of the reality of service delivery. The best known of these is perhaps Winterbourne View, where it would appear that senior managers within Castlebeck Care were unaware of and did not seek assurance of the quality and nature of care provided in the service and that even operational managers on site were either not aware of or chose to ignore signs of abuse and neglect. One can only assume that the lack of remedial action was due, either directly or indirectly to different priorities at a senior management level to those of operational good practice.

The study contained five recommendations that can be summarised as follows:

1. psychological and mental health support to be available on-site to staff;
2. a formal peer support programme to be developed;
3. social activities to be organised to encourage staff bonding and help develop interpersonal support systems;
4. provision of specialised training for staff; and
5. provision of gym membership to encourage staff to exercise to help manage workplace stress.

I have some reservations about the third recommendation; it appears to me to risk exacerbating the tendency for some services to move towards becoming "total institutions" by focussing staff into the service. I also have some concerns about the fourth recommendation; what staff need is the training to do their job effectively not training to undertake specialist therapeutic inputs. Likewise, the fifth recommendation seems

somewhat cynical – encouraging staff to look after themselves, both their physical and mental health, is one thing but not just to enable them to manage workplace stress. It is better to combat the causes of the stress!.

The establishment of a peer support programme as in the second recommendation makes a lot of sense; the problem with a formal one is that it often has to be accountable to management and therefore less acceptable to the staff. I would also argue that efficient practice supervision is better than a formal psychological support system, as accessing it can be seen as "a sign of weakness". This does not mean that access to external counselling services should not be made available when necessary and wanted. In my view, the essential components of both the first and second recommendations can be met by services through encouraging and enabling reflective practice by their staff. Provided both operational and managerial staff implement reflective practice, it will impact on service delivery to the benefit of both staff and service users.

In fairness to the author of the study, my reflections on it and its findings and recommendations come from a social work background; the study refers to some of the interviewees being ex-police officers, and it may be that other interviewees came from other backgrounds such as the armed forces. Their expectations and experience of "supervision" and support may well, therefore, be quite different from my own. The sample was only 9, and it was not therefore known if the sample was representative qualitatively or quantitively. What is known is that most of the interviewees had continued to work in the detention centre despite the stress they had experienced.

All of the stressors identified in the study can be seen as being of relevance to the provision of health and social care and also being instrumental in practice becoming abusive or neglectful. Some means of minimising their impact have been drawn out already; these can be summarised as follows.

Recruitment practice

The provision of social care has long been since as a poor relation to health care; this is true in terms of pay, status and qualifications. As a result, recruitment has tended, in my experience, not to consider the stresses and strains both physical and emotional, of the role. The study identified some interviewees who were not prepared for the impact of their work on their well-being, and the same is true, I suspect, of many staff in social care roles. It would certainly help explain why some staff find it easy to treat their service users as objects rather than individual human beings. This is not to suggest that those staff are somehow unable to behave differently, but if the advertising for these roles give the appearance that the job does not have these stresses such as dealing with incontinence, progressive and deteriorating conditions, dementia, death and service users who may be ungrateful for, resentful of and challenging of service provision, then they are being sold an unrealistic expectation of what will be asked and required of them. As a result, there has to be an increased likelihood of abuse and neglect occurring, whether intentional or not.

Staff development and retention

This is linked to the aforementioned; however well-prepared the new staff for the realities of providing social care or indeed health care outside of the acute sector may be, they will require development opportunities once in post and appropriate support to enable them to translate into their practice what those opportunities provide. That support should include supervision that is more than just a management mechanism to quality assure the service being provided – often a rationalisation for ensuring budgets is met. The combination of developing and supporting staff should facilitate staff retention and ensure the quality of service provision – a mutually reinforcing process that should also reduce and speed-up the recognition of any poor practice that can develop into abuse and neglect.

Reflective practice

Key to any supportive supervision is the concept of reflective practice; staff need to be enabled and encouraged to reflect on their own practice and that of colleagues in a constructive manner. Reflective practice does require some commitment of time and resources from managers, but these can be allocated within existing supervisory arrangements such as one-to-one sessions or team meetings. Staff can be encouraged to reflect informally with colleagues about their own practice – the simple question "Why do we do it this way?" What is also essential is that this reflection extends beyond operational staff to include managers, including strategic managers, but is always linked back to operations and the impact on service delivery and the experience of service users; reflection has to be both horizontal and vertical.

Senior managers retaining an operational focus all the way to strategic level

This is obviously linked to the point above but goes beyond it to include senior managers seeking assurance from service users and their families/significant others that services are meeting their needs and aspirations effectively. The old maxim "Don't bring me problems, bring me solutions" is fine provided you know what the problems actually are; organisations and staff can all too easily fall into the error of either not telling management about the problems or framing the problem in terms that they have a solution to it. Senior managers have a responsibility to seek assurance about the quality of service provision from the perspective of staff, service commissioners and, where appropriate, service regulators but particularly service users and their families/significant others.

Cross sector and professional staff development opportunities

The provision of health and social care services is not the responsibility of just one sector or profession; invariably more than one agency and profession are involved. It is therefore vital that staff development opportunities are, where practical, multi-agency and multi-professional. Some training will have to be in-house because of the numbers of staff who need to complete it, its specificity to the agency concerned, etc., but if health and particularly social care is a multi-agency and multi-profession activity, then staff need to be developed across professions and sectors if they are to work together to safeguard their service users.

Cross sector quality assurance systems

As I have said earlier, my knowledge of the Australian Immigration system is non-existent, but I am aware of the degree of independence of prison governors in this country and would assume the Australian system will be similar; the relevance of cross sector quality assurance systems to the study is likely to be small. However, given the points above about cross sector service provision, the need for cross sector monitoring systems is obvious. I am aware that some such systems do exist with regard to care home services; the approach could be developed further for domiciliary services but the number of providers could make this problematic.

The role of commissioning and regulatory services

It is too easy to expect service providers to ensure the quality of their provision on their own; there obviously is a responsibility on service providers to quality assure their services but that does not absolve commissioners and regulators from their responsibilities to ensure that the services they commission or regulate are of high quality. By doing so, they also provide an additional perspective and independence to that assurance.

I am aware that the aforementioned can appear a fairly daunting set of expectations of service providers, commissioners and regulators. However, most of the activity or information necessary to implement the aforementioned is or should either already be in place or could easily be developed with limited impact on workloads but with potential large benefits both for service users and staff – a win-win situation.

This article was started, though not completed, before the COVID-19 lockdown was initiated. The commitment and dedication demonstrated across both health and social care services have been well-documented and acknowledged, and I am not suggesting that any of the aforementioned suggestions would have further enhanced the quality of the care staff provided. However, the lockdown has raised the profile of social care staff in particular and the relative lack of status that they and their service users have enjoyed from central government as demonstrated by the lack of testing, provision of PPE, etc. It may be that, once the lockdown is over and reviews are held into how we came to have the number of deaths we have had in care homes and the community, that additional resources will be made available that will help facilitate some of the ideas contained in this article. We will see!

Reference

Goffman, E. (1961), *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates*, Penguin/Random House, London & New York, NY.

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