COMMUNITY LIVING ASSOCIATION

THE RED FLAGS LIST, or

AVOIDING ABUSE -- WHAT TO WATCH OUT FOR

May 20, 2003, revised: 3-26-09, 10-25-12, 3-21-13

Many years of experience have been distilled to produce this list of red flags. They are early warning signs of the conditions and employee behaviors that may precede, enable or cover up abuse. Supervisors are expected to report these behaviors to their supervisors. Staff who exhibit these behaviors must receive coaching from their supervisors. Repeat instances should be viewed as serious evidence that the staff is misplaced in this field.

1. **Failure to support the mission**.
* The mission is "why we're here." Some people just don't catch on. Some people don't have the empathy or talent to work in our field.
* Staff uses derogatory words about people served, e.g. “retard” **No one who cares about CLA’s mission would use that word.**
* Staff wonders why we spend so much money on “these people”.
* Staff suggests that people with disabilities or a subgroup thereof should live with ‘their own kind”, not in the community.
* Staff states lame reasons for working at CLA: “good hours”, “pays better than Walmart”, “need the money”, “need health insurance”.
* When a supervisor is not around, staff doesn’t interact with people served.
* Staff offers fake choices to people served or provide clues as to what staff wants before offering the choice.
* Staff making people wait while conducting personal business. Staff puts personal comfort, preference or interests above CLA's mission.
* Staff choosing to wait in van with a consumer rather than taking him/her in with others
* Staff focus on changes that increase staff autonomy or flexibility at the expense of consumer autonomy or flexibility
1. **A wide gulf between what direct support staff (DSS) know and what management knows**
* The gulf may exist between leadership and DSS or between frontline supervisors and DSS.
* Something has gone very wrong to disrupt essential communication between the people who provide direct support and the people who are expected to minimize risk for the organization.
* Examples:\*
* DSS know that a program is never followed as written, but supervisor doesn’t know.
* DSS know that a fellow worker has a sexual interest in a person served, but supervisor doesn’t know.
1. **Failure to bond with people served** **or with a specific person**
* Reluctance to eat with people served
* Reluctance to be seen in public with people served
* Over-sensitivity to body smells, body fluids, noises, habits
* Staff says other staff “baby” a person served, or consumer is “getting away with” bad behavior
* Reluctance to go on outings
* Unkind nick-names
* Anger at consumer behavior that causes staff “extra work”
* Consumer behavior that may mean a reluctance to have a particular staff support him/her
1. **Staff form a closed culture**
* "Closed" means certain people are excluded. In a closed culture the bond between members becomes more important than the interests of the organization they are paid by. They protect each other by not reporting incidents that might mean trouble for a member or attention to the group.
* A sign may be insistence that "we’re different” (different from other programs in the organization).
* The people in closed cultures tend to be highly resistant to change.
* Relationships between staff are more important than following laws, regulations or policies, especially in regard to reporting of incidents.
* Unfortunate but true: long-term staff are more likely to form a closed culture.
* New staff are either drawn in or rejected. A test is how the group treats a staff known to be incorruptible.
* A sign of a closed culture: new employees receive counter-training on “how things really work." This may lead to the promise, “I’ll cover your back if you cover mine.” **Hearing those words is almost certain evidence of a closed culture.** **Report it immediately.**

The investigation process can be the window management needs to resolve local or immediate causes. The systemic resolution requires transparency in leadership, governance, policy, communication as well as focus on the hiring, coaching and support of frontline supervisors.

1. **Overly prescriptive, controlling and/or possessive staff.**
* Highly authoritative voice tone (it says: “don’t argue with me”)
* Signs of a power struggle: staff says client always gets his way, consumer behaves differently when staff is close, staff acts differently when supporting a certain consumer, staff complains about consumer behaviors that other staff don't see, staff emphasizes consumer deficits
* Choices, if offered, are not real choices
* Other staff and/or people served refuse to answer questions about this staff (possibly due to fear of reprisal)
* Staff is always in the center of controversy, or the opposite, there are “never any problems” on this person’s shift
* Failure to shift from how he/she deals with his/her children to working with people served
* Staff speaks of “my house, my clients”, and “my shift”
* Staff unnecessarily hurrying people served
* New staff repeatedly chooses not to follow advice of fellow staff
* Staff doesn’t allow others opinions to be considered in planning meetings
* Staff set up unnecessarily strict rules to govern consumer behavior when consumer is out of the home or program
* Staff becomes angry when others give the consumer infrequent special treats
* Identifying inappropriate behaviors as “attention getting”\*\*
1. **Chaos**
* Chaos is a failure of management.
* Among the primary causes of chaos in a human services organization are
* Supervisors not available, mentally or physically
* Supervisors not held accountable for failing to supervise
* High turnover among supervisors or DSS or both
* Too few supervisors and/or DSS.
* No support or attention from leadership
* A sure sign of chaos: no one can answer basic questions.
1. **Low staff morale**
* High worker’s comp rates and high turnover are indicators of low staff morale.
* Low staff morale and chaos often appear together.
* One person can cause low staff morale; so low staff morale is far easier to reach than high staff morale.
* Low staff morale is a self-perpetuating condition.
* Low staff morale is high priority for leadership, both recognizing it and acting on it. Giving it less than top priority costs more.
* Staff surveys and investigations are essential tools in identifying areas that need attention.

If you see any one sign it is of course not necessarily cause for alarm, but it is always cause for heightened alertness. For example, many people use the phrase “my shift” to mean the shift the person always works on. It would be a red flag if “my shift” meant, “I own this shift and if you want anything you’ll have to deal with me.” Seeing one of these red flags in the absence of an obvious explanation is a call for increased alertness and attention.

If you see evidence of a closed culture, you must talk with a supervisor about it. If you recognize a closed culture and you don’t report it, you become part of it. In that case you become part of the problem. Two staff can form their own closed culture. If two people see a reportable event but neither reports it because it would “cause trouble”, they have formed a closed culture. Closed cultures become visible in investigations because the difference in behavior between people involved in a closed culture and those who aren’t is so readily apparent. Closed cultures may be commonplace in the nation’s workplaces, but they are intolerable in human services.

\*These two examples are based on actual court cases as reported by an attorney with a national reputation as a defender of not-for-profit organizations. The organizations were hit with newsworthy lawsuits over abuse allegations. The attorney’s basic message was that if people are well trained, have good morale and are following their training when the very bad event happened to the person served, then he can defend the organization with hope of success. If any of those factors are compromised or missing the organization’s prospects for defense dim accordingly. A common tactic of the plaintiff’s attorney is to feed information to the press that presents the organization as poorly managed and the staff as uncaring and poorly trained.

\*\* We may indeed recognize that a behavior is “attention-getting”, but we are obligated to take the next step in analysis, which is to ask, “why?” Why does this person need attention? Why aren’t we giving sufficient attention? If we don’t ask these questions, we are blaming the person served.

 Developed by CLA’s Home Team