Towards an explanation of the corruption of care

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Abstract

The last 20 years have seen a long series of scandals in long-stay hospitals, children's homes, elderly person's homes and other caring institutions. There have been many lengthy enquiries, but there has been no attempt at a generalised exploration of why it is that caring services and institutions 'go wrong'.

In this article, we attempt an explanation of what we call the corruption of care. We set out eight propositions about systems and patterns of organisation which we see as playing a part in this corruption. Each proposition is illustrated by evidence from research[1] on the pindown scandal. The focus of the paper is primarily on explaining the corruption of care. We use pindown simply because of the topicality and importance of that issue and because one of us (JW) had been researching in that area.

INTRODUCTION

In recent years, there has been a rapidly developing interest in the issue of quality in public services. What is missing in this literature, however, is any discussion of why public service organisations 'go wrong'. That they do is all too apparent. There is the long sequence of scandals in long-stay hospitals. There have been scandals in particular children's homes – for example Kincora in Northern Ireland – and homes for elderly people – for example Nye Bevan Lodge in Southwark. There has been a series of law cases and inquiries in social services departments which have revealed abuse and other practices which would be deemed unacceptable by professional opinion.

The important question for students of social policy and for policy-makers is how such things happen. How do institutions, organisations and staff, supposedly committed to an ethic of care and respect for others, become 'corrupted' and abuse their power and their clients?

The corruption which occurs is of various kinds. Our aim is a general

preliminary exploration of the issue, so we are not here concerned with precise distinctions. Clearly, however, it is important to distinguish between the kind of corruption which takes place in pursuit of acceptable policy goals and the kind of corruption which is quite unrelated to the aims of policy.

Pindown would be an example of the first category because, though judged 'intrinsically unethical, unprofessional and unacceptable' (Levy and Kahan, 1991 p167) in the subsequent inquiry, it was aimed at securing generally desired change in behaviour. On the other hand, violence towards long-stay hospital patients is quite unrelated to any official policy objectives and would be defended by no one. Corruption, therefore, can be of various kinds. The essential element, however, is that it constitutes an active betrayal of the basic values on which the organisation is supposedly based. It is much more than a passive neglect of the principles of good practice. It amounts to active abuse of a position of responsibility and of a client's fundamental human rights.

Any discussion of the corruption of care must start from John Martin's rich and reflective analysis of *Hospitals in Trouble* (Martin, 1984). He analyses the sequence of inquiries into the scandals in long-stay hospitals in the late 1960s and 1970s. What is needed now is an extension of Martin's analysis to a wider range of organisations and institutions to see if it is possible to construct any general theory of the corruption of care.

The early hospital inquiries all began from the 'bad apple' assumption – that the scandal they were investigating was explicable in terms of the corrupting influence of particular individuals. They soon found that this approach was inadequate and they were forced by what they found to look at the organisation in which the corruption had taken place. In this, of course, they were following Goffman, who saw the corruption of institutional care as produced by the very nature of institutions (Goffman, 1961). Once corruption is seen as, in some sense, the product of particular kinds of social systems, then the way is cleared for a social analysis of the problem.

Our aim in this paper is to construct a preliminary, provocative analysis of the problem. We do this by propounding eight elements in systems of organisation which we see as playing a part in the corruption of care. All, therefore, make a contribution to the explanation of the problem we are addressing. We provide some limited evidence for each proposition, but the aim is to provoke reflection and discussion rather than to claim any definitive answers. After each of these eight propositions we consider evidence from the pindown experience in Norwest to illustrate the application of our propositions to a specific issue of the corruption of care.[2]

Our eight propositions start from a general assumption which we owe to Kelman's paper 'Violence Without Moral Restraint' (Kelman, 1973) and which we then apply to our concern with corruption. This argument is that the focus of an enquiry into violence should be not on the motives for violence but on the conditions in which the usual moral inhibitions against violence become weakened (Kelman, 1973 p38). Suitably translated, this means that our focus is on factors which threaten or weaken a commitment to the normal canons of good practice in the human services.

PROPOSITION 1

The corruption of care depends on the neutralisation of normal moral concerns

For people to be abused in long-stay hospitals, elderly people's homes or in children's homes, they have to come to be regarded as beyond the normal bounds of moral behaviour which govern relations between person and person or carer and client. They have to come to be seen as less than fully human. 'The workhouse paupers', said Robert Roberts of his Salford childhood, 'hardly registered as human beings at all' (Roberts, 1973 p21). That is a necessary stage on the road to the corruption of care.

How does this come about? Ritualised admission procedures to institutions aim, of course, to humiliate. Stripped of identity, ritually bathed, dressed in institutional clothing, people become less than the people they were. Living in an institution also depersonalises as it institutionalises. In *The Last Refuge*, Townsend wrote of the gradual process of depersonalisation which overtook elderly people in residential care (Townsend, 1962 pp328-9).

Zygmunt Bauman has wrestled with the question of how the holocaust could have happened. How could a situation have been created in which five million Jews were put to death?[3] His answer is that the Jews had to be placed beyond the bounds of moral obligation. Responsibility, he argues, depends on proximity. Therefore, the Jews had to be excluded from normal social life, depersonalised and dehumanised, before deportation and extermination could begin. They had to be:

> 'transformed in practice into exemplars of a category, a stereotype – into the abstract concept of the metaphysical Jew – until, that is, they had ceased to be those "others" to whom moral responsibility normally extends, and lost the protection which such natural morality offers.' (Bauman, 1989 p189)

Exclusion led to depersonalisation and a moral invisibility which were

the necessary prelude to the organisation of the "final solution". That was made possible by the very nature of modern bureaucratic forms of organisation.

Bureaucracy seeks to adjust human actions to an ideal of rationality. What is involved, above all, in this, is what Bauman calls 'the silencing of moral considerations' (Bauman, 1990 p132). The task of the members of the organisation is reduced to that of obeying or refusing to obey a command. Action is removed from the sphere of moral issues. In the bureaucratic organisation, the wider consequences of the work of a single bureaucrat are not necessarily visible to the actor. Moral issues become matters of organisation or technique. People become simple 'specimens of a category' (Bauman, 1990 p136).

Such neutralisation of moral concerns may be expressed in terms of racism and cultural stereotyping. Black writers have commented on the adoption by some white social and residential care workers of a 'pathological' framework in their dealings with clients (Ahmad, B., 1990; Barn, 1990). Black clients may be related to more in terms of cultural stereotypes – 'Asian families tend to look after their own', 'West Indian families believe in firm discipline' – than in terms of their individual needs and experiences. In particular, a long history of white racism, encompassing slavery, colonialism and imperialism, serves to devalue the black child in care, or the black elder in a long-stay hospital (Ahmad, S. et al, 1986).

Our argument is that the corruption of care depends on the neutralisation of what Hannah Arendt calls 'the animal pity' (Bauman, 1988 p486) which she believes all normal people feel in the presence of the physical suffering of other people. That neutralisation takes place via the processes of depersonalisation and dehumanisation which depend on the creation of moral distance. It is of the essence of some forms of organisation to create this neutralisation by depriving their clients of their basic humanity. Our concern now is to consider the mechanics of this process of neutralisation.

Much has been written concerning disciplinary techniques within institutions, the processes of humiliation, depersonalisation, dispossession and degradation which mark the beginning of the 'moral career' of the inmate of an institution (Goffman, 1961). However, in our analysis of pindown we are concerned as much with the staff world as with the world of the inmate and we agree with Foucault that:

> 'the notions of institutions of repression, rejection, exclusion, marginalization, are not adequate to describe ... the formation of the insidious leniencies, unavowable petty cruelties, small acts of cunning, calculated methods, techniques, "sciences", that permit the fabrication of the disciplinary individual.' (Foucault, 1977 p308)

First, however, let us examine the 'inmate world', in particular the extent to which pindown can be conceived of as a regime conforming to Goffman's analysis of the key processes by which institutions curtail an inmate's sense of self: will-breaking ceremonies; leaving off and taking on; humiliation; mortification; confession; and interpersonal contamination.

'Peter' was one of the first children's home residents to be placed on pindown, in 1983. He had a history of glue sniffing, truancy and stealing, and was placed on pindown in response to his having absconded from care. Along with two other boys, he:

> 'had to take a cold shower and do some "keep fit" exercises. Later they were moved into another room and slept on mattresses on the floor with no other bedding . . . The log book recorded that they were to have "no privileges". The following morning the boys were required to do "bunny hops" round a concrete square outside the building in their underwear for about twenty minutes. Peter described what happened: "We were bunny hopping around and (a residential worker) had a stick . . . and he was saying move over and he was whipping us, he is mad, but I was laughing, so I was getting it and he was taking it worse because I was laughing".' (Levy and Kahan, 1991 pp114-15)

This passage neatly illustrates the key elements of the use of pindown as a will-breaking ceremony: ritual bath or shower, deprivation of bedding, 'no privileges', forcible humiliating activities and physical violence. Most importantly, there is the contest over authority: 'I was laughing . . . and he was taking it worse because I was laughing'. Such defiance attracts immediate punishment, the inmate's will must be broken. Staff were to absorb this lesson more thoroughly as time progressed. 'Peter' serves as an example of the earlier period, when pindown was instituted in response to some misdemeanour or other – truancy, absconding, petty crime. Later, all entrants to the children's homes in question were placed on pindown as a matter of routine, presumably to establish authority immediately rather than waiting for infractions of the rules to occur.

Thus, many of the elements of pindown as a will-breaking ceremony were evident from the earliest days of the practice: as time passed, these elements were refined and perfected, becoming routinised as an essential feature of the institution. For example, the cold shower to which Peter and his peers were subjected became established as a routine stripping, bathing and donning of night clothes on first entering pindown, accompanied by twice-daily baths while on the regime, along with the wearing of night clothes or shorts (often inadequate for the un- or under-heated conditions of the pindown room). This resonates with Goffman's observation that:

> 'The admission procedure can be characterised as a leaving off and a taking on, with the mid point marked by physical nakedness.' (Goffman, 1961 p27)

The leaving off of personal clothes serves, at a physical level, to induce discomfort, humiliation and embarrassment and, at a psychological level, to represent a loss of identity and feelings of self-respect. In terms of gender, this humiliation was likely to have been particularly acute for young women, given the social construction of the female body and, in particular, the sexualisation of women's experiences as a means of social control (Griffin, 1985; Lees, 1986). Power imbalances between staff and residents were accentuated by gender inequalities: for example, male workers were known to have supervised the undressing of young women in their 'care':

> 'A residential worker recorded that "somehow she had obtained some of her clothes . . . I went straight away to (Sophie) and asked her to take her clothes off and get back into her nightdress. She refused to do this so I started to undress her".' (Levy and Kahan, 1991 p113)

Similarly, routine deprivation of bedclothes, food and drink, free access to bathroom, access to educational or recreational materials, represents loss of personal identity: the definition of such materials or actions as 'privileges' rather than as part of the ordinary routine of life constitutes a process of humiliation.

> '(Sheraz) said "I *want* some clothes, I'm freezing" . . . No food to be given till lunchtime at 12.30. Because of (Sheraz's) stroppy attitude heavier tactics needed – ie please/thank you/may I's etc. otherwise nothing to be given . . . upstairs room and landing is cold. Fuse has been taken out of fire in (Sheraz's) bedroom.' (Extract from logbook, Levy and Kahan, 1991 p116)

Mortification is a process whereby 'the individual', Goffman argues, has 'to engage in activity whose symbolic implications are incompatible with his conception of self' (Goffman, 1961) p31). Perhaps one of the most severe mortifications for any individual is involuntary isolation, confinement away from everyday social exchanges. For the adolescent, whose personal and social development is heavily reliant on peer group interactions, this form of deprivation is particularly harsh:

> 'Jane said that "After I'd worked my way out of the Pindown room, I was so depressed and frustrated that I took an overdose. I was taken to hospital semi-conscious . . . I mean that's the only way I got out . . ."' (Levy and Kahan, 1991 p108)

Other forms of mortification used within the pindown regime included

an alternative to loss of all books and other materials – that of 'make-work'. One person interviewed reported being required to copy out names and addresses contained in the telephone directory, beginning at 'A'. It may not be stretching the point too far to compare this with Victorian penal regimes which required prisoners to spend a large part of their time engaged in the repetitive, tedious and unpleasant tasks of picking oakum (Dobash et al, 1986).

The process of individual or group concessions is an established part of institutional life, 'the most spectacular examples of such exposure comes to us from Communist confession camps and from the *culpa* sessions that form part of the routine of Catholic religious institutions' (Goffman, 1961 p32). Just as these more drastic forms of confession aimed to inculcate the correct political or religious attitudes within inmates, so are confessional routines an integral part of some therapeutic regimes. Young people on pindown were frequently required to make a written record of where they thought they had gone wrong in the past. For example,

> 'Michael under protest was made to "write down all the misdemeanours he was involved in over the past weeks". This process apparently took over three hours'. (Levy and Kahan, 1991 p111)

This was justified on the (therapeutic) grounds that this process allows for personal growth and improved self-awareness. Perhaps here we should recount Susan's verdict on the therapeutic value of pindown:

> 'It lets you think, I mean it gives you time to think about what you have done and everything, but it doesn't really help in another way because you just hate them, the people who've put you there.' (Fieldnotes, JW, 1991)

However, such young people were not allowed to overtly hate 'the people who've put you there': conversely, they were required, if not to love their goalers, at least to enter into relationships with them. A central, and very public, setting for this relationship was the 'review' meeting, which:

> 'was undoubtedly the most crucial element in the programme and they were often heated and charged with emotion by the young person and his or her family ... (the chairperson) encouraged positive and negative role play with the idea that by creating conflict, people start saying what they think.' (Levy and Kahan, 1991, p120)

Such meetings, along with the rest of the pindown regime, were conducted within a therapeutic (or pseudo-therapeutic) framework, although there is little evidence that they were of any positive benefit to

any of the participants, let alone the child in question. One social worker told the Levy-Kahan inquiry that she

> 'used to go in with butterflies in my stomach and feeling really worried and I really don't know what the child felt. Others were offended by the bad language deliberately used. A child, for example, was told "you are fucking useless".' (Levy and Kahan, 1991 p120)

Review meetings, then, may be viewed as an example of 'interpersonal contamination', whereby the inmate is degraded by being forced into unwanted personal and social relationships (Goffman, 1961). One boy, for example, was the subject of more than 50 review meetings during a five-year period: there is little or no record of any therapeutic benefits which may have resulted from this procedure.

Pindown appeared to be based on ideas drawn from the 'psy' sciences, in particular drawing inspiration from therapeutic regimes used in other institutions –

> 'it appears to include elements of the "time out" system of stimulus reduction in behaviour therapy, the "seclusion" of difficult patients in hospital, and the "anamnestic" approach to offenders used in secure therapeutic communities, where offenders are encouraged to describe in detail their offences.'

However, pindown

> 'managed to combine the dangerous aspects of almost all the groups of therapies they have drawn on without including any of the safeguards in any of them.' (Dr David Foreman, quoted in Levy and Kahan, 1991 pp124-5)

The foregoing analysis of pindown as a system provides ample evidence of 'calculated methods, techniques, "sciences" . . .'; and within that system there was considerable scope to exercise 'leniencies' (the giving or withholding of 'privileges'), 'petty cruelties' (the more or less arbitrary withholding of heat, clothing or food, or psychological and emotional cruelties, such as manipulating family conflicts as a means of control), and 'acts of cunning' (eg deliberate play-acting by staff during review meetings) (Foucault, 1977). All was intended to degrade and depersonalise those subjected to the regime and so neutralise ordinary moral concerns for the children and young people involved.

PROPOSITION 2

The corruption of care is closely connected with the balance of power and powerlessness in organisations

Most of those who have been victims of the corruption of care have suffered from powerlessness. Weakness and vulnerability are essential

characteristics of long-stay patients in mental handicap hospitals[4] or geriatric hospitals, or of children in care. They have little power or influence, little knowledge of how the organisation works, little awareness of how to assert their rights or how to call to account those on whom they often depend for the basic elements of living.

In addition to the powerlessness inherent in the position of being accommodated in such institutions, some residents are further disempowered on the grounds of gender or ethnicity. For example, black children in care may suffer particular disadvantages or incivilities as a result of racism or cultural stereotyping on the part of white workers (Ahmad, S. et al, 1986; Johnson, 1991). Such disregard for the needs and experiences of black children and young people in care has been matched by the marginalisation of their concerns within the literature on child care (with some notable exceptions, see for example Ahmad, S., 1990; Barn, 1990; Johnson, 1991). However, it is worth noting that in recent years this particular disempowered group has begun to address such issues by means, for example, of the formation in 1984 of the consumer group Black and in Care (Ahmad, B., 1989).

Those responsible for these and other very vulnerable groups have almost absolute power over them. That is a potentially corrupting situation. If power corrupts, so too does powerlessness. While staff have near absolute power over many clients, they are in many other respects powerless. They are taken for granted by the organisation, seldom regarded as its heroes, given little support, not consulted about the organisation of their work.

There is considerable evidence (eg Raynes et al, 1979, pp158-9) that, for high quality residential care, staff involvement in decision-making is crucial. Tizard found the same to be true in residential nurseries (Tizard, 1975). Involvement can increase commitment, can create a sense of personal worth in staff and of the worthwhileness of the job being done.

We must not make the simple leap from the association of staff involvement with high quality care to equating non-involvement with the corruption of care, but the association sounds a credible one. Clearly, there is no simple causal connection but there seems to be an association between staff powerlessness and the corruption of care. We saw in Proposition 1 that a necessary precondition to the corruption of care is the depriving of clients of the status of full moral beings. If the staff's status as full moral beings is damaged by powerlessness, they may well cease to behave in a fully moral fashion. The crucial issue may be that staff are simultaneously powerless and powerful and that this creates a dangerous ambivalence.

In relation to pindown, it is evident that staff had considerable

powers over the young people in their care. They had considerable degrees of control over the physical movements of their charges – confining them to a single room, giving or withholding permission to visit the bathroom, allowing or denying the 'privilege' of attending school – and there is also evidence of the considerable emotional influence they were able to exert. The Levy-Kahan inquiry found that pindown was deliberately confrontational in approach, and was explicitly designed to evoke a strong reaction in those experiencing the system. Staff themselves noted the range of emotional reactions that were evoked:

> 'anger', 'depression', 'weeping', 'sobbing', 'anxiety', 'talking in sleep', 'talking to self', 'staring into space', 'lost confidence in people', 'frustrated', 'bored', 'banging on wall', 'loneliness', 'desperation', 'despair', 'could not eat', 'frantic attempts to get out', 'temper tantrums' and 'absconding'. (Levy and Kahan, 1991 p123)

The dynamics of power and powerlessness between staff and residents was complicated by gender inequalities. The main architects and instigators of pindown were male (although at least one female senior social worker was involved in formulating the system), while the lowest-status care workers were primarily female. The possible permutations of power relationships were many, and ranged from the high degree of control exercised by senior male workers over female residents, to the more ambivalent power available to lower-status female care workers in relation to male residents. At one extreme of this power-powerlessness continuum lie those situations in which male workers deliberately employed techniques to humiliate young women, in public settings. Levy and Kahan report that:

> '... we heard that children often attended (family meetings) in their night clothes and girls who were wearing short night dresses felt very embarrassed and humiliated.' (Levy and Kahan, 1991 p121)

Such humiliation was, we would argue, particular to their positions as young women vulnerable to abuses of adult male power.

Pindown existed under many guises, and children not in residential care were sometimes placed on a 'trial pindown' for a short period of time, in an effort to encourage regular school attendance. The child's own social worker played a role distinct from the residential care staff, the purpose being to:

> 'induce the child to trust the social worker, who appears to rescue the child from pindown, then negotiates on their behalf with the care staff concerning their return to school.' (Team leader, fieldnotes, March 1989)

Such evidence of staff's manipulation and abuse of the powers available to them may, however, be set against their self-perception as victims of emotional and physical abuse by their charges.

> 'You can't see the marks now, but that's where he (a resident) hit her (another staff member) the other week. He's only 12 but as you can see he's big and strong. This kind of thing happens all the time.
>
> 'The kids here, you just give them everything, but they give nothing back. They're ungrateful little bastards, excuse my language, but that's what they are. I really mean that.' (Residential care worker, fieldnotes, 1989)

In the family centre in question, these remarks were made within the context of a changeover of team leadership, rapid staff turnover, high levels of staff dissatisfaction and alienation, and deteriorating staff-resident relationships.

Paradoxically, these very conditions which made residential care staff feel vulnerable and powerless at the same time contributed to a climate within which abuses of power could easily take place. Inadequate supervision, lack of proper inspections, little accountability, absence of advocates for children in care, all of these factors allowed care staff to arrogate power to themselves. Children in care, at least equally subject to a sense of powerlessness and vulnerability, had no such scope for the exercise of power, and no legitimate outlet for their frustrations.

PROPOSITION 3

Particular pressures and particular kinds of work are associated with the corruption of care

Certain kinds of people seem to be particularly at risk from the corruption of care in human services – mentally handicapped people in long-stay hospitals, elderly people and children in residential care. What are the links between these groups and corrupted care?

They are all groups for whom – to put it euphemistically – society has little regard. They lack value and worth in the eyes of society. They are easily stereotyped, and this affects the resources made available for their care. Policy is built up of fine words but the reality of what is provided for these groups denies their truth. The work is wrapped round with high-sounding terms such as care, reform, rehabilitation, but the resources and facilities made available convey to staff the low value which society puts upon their work and upon their clients. Official aspirations and standards are therefore deprived of legitimacy.

This predisiposition towards the corruption of care may be exacer-

bated by the over-representation of particularly disadvantaged groups within these already-devalued categories of clients. There has been much debate concerning the possible over-representation of black children in care, and in the absence of official statistics it is difficult to draw firm conclusions (Ahmad, B., 1989; Dept. of Health, 1991; Johnson, 1991). Recent evidence from the Utting Report on residential child care suggests that younger African and Afro-Caribbean children were over-represented in terms of admission into care, that Afro-Caribbean adolescents were slightly over-represented, but that Asian children of all ages were under-represented in admissions into care (Dept. of Health, 1991).

However, some sources suggest that at least some groups of black children (especially those of 'mixed parentage') are likely to spend longer periods than white children in residential care, thus accounting, at least in part, for their apparent over-representation (Johnson, 1991). Perhaps more importantly, white residential care workers may perceive that black children are in care in disproportionate numbers, thus serving to confirm their beliefs about the 'pathological' black family (Ahmad, B., 1990). This, in addition to the dehumanisation and powerlessness experienced by this group of young people (discussed in Propositions 1 and 2 above) may help to explain how (pressured) work with particular groups of people may be associated with the corruption of care.

In contrast to the over-representation of black children in care, there is some evidence that black elders are *under*-represented in receiving at least some of the social services, and that the services that they do receive may be inappropriate to their social and cultural needs. In considering this contradiction, Bandana Ahmad asks:

> 'Do agencies wish to indoctrinate our children with white values and identity? Is it because older black people have less time left for conforming to white values and norms that agencies tend to ignore their welfare needs?' (Ahmad, B., in Kahan, 1989 p159).

Where work is difficult, and resources are short, the emphasis is on survival, on getting by. That creates a dangerous situation for at least two reasons. Firstly, Ryan and Thomas point out how it leads to all the emphasis being on control, on order, on an institutional rather than on an individual approach (Ryan and Thomas, 1987 p49). This is both the product of the depersonalisation of patients which pressure causes and a cause of further depersonalisation.

The Committee of Enquiry into Farleigh Hospital pointed out that North Ward took the most difficult male cases in the whole hospital group. Forty patients were crowded into one large room. There was a

lack of equipment and a shortage of staff. The situation led to what was described by the Committee as the staff's 'probably unnecessarily robust . . . handling of the patients' (HMSO, 1971 para. 123). Violence became contagious (para. 163). The slide from stress on control, inevitable in some situations of pressure, into violence towards patients is all too easy to comprehend.

The second way in which difficult work is potentially dangerous is that few questions will be asked by management about what exactly is being done so long as the lid is successfully kept on the system. Some kinds of work – for example caring for profoundly mentally handicapped people or for very disruptive children – put staff under enormous pressure. In different ways, members of neither group are perceived as being fully persons. Staff experience them as trying patience and reason to, and beyond, the limit. These pressures are exacerbated by lack of resources and the way the moral legitimacy of the work is undermined by the gap which separates the rhetoric of policy from the sharp reality of practice.

There is also the almost universal fact of social service provision that those staff with the most difficult jobs are the least trained, least supported and lowest paid. In many caring and controlling situations, staff are therefore simply out of their depth.

Such pressures on staff, particularly the low-status, under-qualified and under-resourced residential child care service, were recognised by the Levy Report (Levy and Kahan, 1991) as helping to explain, if not condone, the circumstances within which a regime such as pindown emerged and remained in existence of six years. One particular form of pressure on staff – that of reorganisation of the service – seems to be central to our understanding of both the initial creation of the system in 1983, and of the period when it was at its height, in 1988-89.[5]

In April 1983, the residential child care service in the county was reorganised, entailing the transformation of some children's homes into family centres. One of the centres under consideration (Beechwood) became a family centre, while the other (Church Street) became designated as a 'semi-staffed independence unit'. While these changes were conceived of as a positive step forward in child care provision, the evidence is that the service remained under-resourced, and the staff largely untrained and unqualified. Both centres were settings for considerable tension and conflict during 1983, and pindown was first used at Church Street in November 1983, in response to three boys having absconded from Beechwood family centre. During November and December 1983, a total of five children were placed on a pindown regime, for periods of between 1-12 days.

What originated in response to a crisis situation soon became estab-

lished as routine practice. Over the next few years, pindown was used regularly in both homes, to the point where the team leader of Church Street stated, in 1989, that it was standard procedure to place any child entering the unit on a pindown regime (Fieldnotes, JW, 1989). Any child subsequently engaging in any 'difficult or disruptive' behaviour, for example truancy or absconding, would again be placed on pindown. Such usage of pindown took place within a context of extreme pressure on staff, and consequent frustration and alienation. Different workers reflected that

> 'A time bomb is all this place is becoming. All I seem to do is contain too many kids, in poor ratio, in a small space. Narrowly avoided a full scale rebellion last night.' (Levy and Kahan, 1991 p60)

> '... it would be difficult to give any reader an adequate idea of the atmosphere here tonight. (The family centre) is ticking away like a time bomb.' (Levy and Kahan, 1991 p76)

These statements are taken from staff log books for 1985 and 1987 respectively, a period when the number of young people placed on pindown each year averaged 20-30. In 1988, there was a significant increase in this number to 50, an increase which may be associated with, if not directly attributed to, further impending reorganisation of the service. During 1988, child care units – involving both staff and residents – experienced a period of tension and uncertainty regarding their future. The proposed closure of the area's Community Home with Education (CHE) in January 1989 meant that family centres would have to absorb placements of young offenders alongside their existing residents. In particular, Church Street was to become a 'community unit' within an integrated juvenile justice service. In the words of the team leader, they were moving towards 'dealing with the sharp end, taking more young offenders than just kids coming into the care system' (Fieldnotes, 1988). The consequent demands placed on a largely untrained workforce may well be imagined.

Although pindown pre-dated the transfer of young offenders from the CHE to family centres by several years, there is evidence to suggest that it was a flexible system, and that variations on 'basic pindown' were constantly evolving. While the CHE was gradually being run down during 1988, prior to its closure in early 1989, for example, 'new pindown' began to emerge at the Beechwood family centre as staff struggled to cope with different and 'difficult' clients.

We may conclude, therefore, that both the initial development and the continued evolution of pindown are associated with, if not directly attributable to, considerable pressures on staff, and that it is to these

pressures that we must look for an explanation of how and why a corruption of care takes place.

PROPOSITION 4

Management failure underlies the corruption of care

This proposition is, at one level, a truism. The corruption of care inevitably suggests a failure of management. What is striking about the corruption of care, however, is the totality of management failure which has been revealed by a range of enquiries. It was a comprehensive failure across most of the responsibilities which belonged to management at every level.

Managers failed to set clear aims and objectives. An organisation without the direction and framework which clear aims and objectives provide is at risk. Secondary aims take over. Care and rehabilitation are replaced by the goals of order and control. The smooth running of the institution, rather than the individual patient, becomes the key concern. In this situation, it is easy for the staff and the organisation to slide into corruption.

Clear aims and objectives provide an impetus and a framework for desirable patterns of practice. They can assert the basic humanity and rights of service users and reinforce ideas of good practice. Without such declarations of intent, too much depends on the attitudes and judgements of fallible individuals.

Clear aims and objectives are also important for they are a prerequisite of effective monitoring and evaluation. Without them, individual staff cannot engaged in that self-evaluation which is a basic element in professional work. Equally, management cannot know what is being achieved. Nor is it in a position to call to account staff when their roles and tasks are undefined.

Managers also failed in that they allowed staff to become professionally isolated – Martin describes this as their most conspicuous failure (Martin, 1984 p87). They showed no understanding of the pressures on ward-level staff and their need for respite and the stimulus of new ideas or for job satisfaction. Managers failed, too, in their response to complaints. When complaints were made, management failed to investigate them, or simply rejected them out of hand. Martin talks of 'a remarkable resistance to internal complaints) (Ibid, p86).

What is remarkable is that every level of management seems to have been guilty. Middle and senior management were equally contemptuous of complaints and dilatory in pursuing them. So were Hospital Management Committees, Regional Hospital Boards and the Depart-

ment of Health and Social Security. As Crossman's memoirs reveal, the Department knew about the unsatisfactory conditions at Ely Hospital long before the Howe Enquiry (Crossman, 1977 p411).

It is not only in relation to hospitals that management failures are striking. One of the features of the Beck case was the failure of Leicestershire Social Services Department to take any action against Beck in spite of countless complaints by children, a dozen formal complaints by staff and children at the Beeches home and four references to the police (*Guardian*, 30 November 1991).

Why did management fail so strikingly to provide leadership, supervision or control? It is possible to suggest a number of explanations. The enclosed world of the staff of many of the long-stay hospitals (which we deal with below under Proposition 5) clearly inhibited middle managers from exercising effective supervision or responding to complaints. If they fell out with their subordinates, then their social world collapsed.

A second reason was that in some instances the pressures were so great that managers simply turned a blind eye to what went on so long as order was maintained and the institution continued to function in an outwardly acceptable fashion. Thirdly, middle managers were stranded in the middle ground without clear leadership and objectives from above. That is no excuse for their failing to respond to manifest abuse, but it helps to explain the atmosphere in which abuse could be ignored.

A fourth factor was the classic one of clinical and professional autonomy and lay reluctance to assert its management responsibilities. The Normansfield Enquiry vigorously asserted the right of a Health Authority to lay down standards and warned the members not to be confused 'still less stopped in their tracks by the use of such terms as "clinical responsibility"' (HMSO, 1978 p407). But such beliefs did inhibit management – or usefully justified inaction.

Fifthly, there was uncertainty in the Department of Health and Social Security about its role in relation to all the other bodies which shared responsibility. The tradition of the old Ministry of Health, still strong in the DHSS (now, of course, split into two separate Departments), was one of *laissez faire* in relation to health and local authorities. It legitimated an approach which those unfamiliar with Departmental ways might have interpreted as an abdication of responsibility.

Finally, there was the failure of lay management. Underlying the very concept is the idea or ordinary people laying down standards in line with societal norms. Such a view fails to grasp the complexity of large organisations, the difficulty of establishing precisely what goes on inside them, and the timidity of most lay people when dealing with professionals trailing clouds of professional arrogance and expertise.

Lay management has been exposed by the corruption of care as a dangerous fiction.

Management failure is, as Martin points out (Martin, 1984 p87) both something to be explained and an explanation of how things come to go wrong in the hospitals. That is also true of the other examples of the corruption of care. Goffman points to the conflicting interests which may contribute to such a corruption –

> 'The obligation of the staff to maintain certain humane standards of treatment for inmates presents problems in itself, but a further set of characteristic problems is found in the constant conflict between humane standards on the one hand and institutional efficiency on the other.' (Goffman, 1961 p76)

while the Levy Report identified as a factor the managerial tendency to opt for the easy way out of this conflict –

> 'Evidence from both county council and staff witnesses suggested that so long as there was no trouble, a blind eye was turned to some practices.' (Levy and Kahan, 1991 p154)

The Levy Report concluded that the residential child care service in Norwest was inward-looking, deficient in support and training of staff, and lacking any positive sense of direction. Team leaders of children's homes and family centres were isolated, 'grappled alone with problems', and were discouraged from aspiring to high standards of care (Levy and Kahan, 1991 p153). In such circumstances, it was highly likely that 'institutional efficiency' would take precedence over 'humane standards'.

There is strong evidence that this insistence on the pre-eminence of institutional efficiency originated at a senior managerial level, with middle managers reporting that there existed an ethos whereby any raising of concerns over standards or other 'care' issues tended to be regarded as evidence of individual inefficiency or lack of managerial ability. The former director of social services summed up this attitude: 'up until my appointment as director there was a clear policy decision to let him (Tony Latham – creator of pindown) get on with it and not to interfere as long as he "produced the goods"' (Levy and Kahan 1991 p136).

This notion of 'producing the goods' is central to our understanding, not only of the pressures on team leaders to manage their institutions efficiently but also of the linkage between senior managerial attitudes and priorities and the creation of a context within which pindown was able to evolve and be maintained over a period of six years.

Although pindown existed, and was known to exist, as an established

programme operating within certain children's homes, and although there existed written versions of its rules and procedures, it never had the status of an official regime – it remained an informal, albeit (tacitly) officially sanctioned system.

Pindown existed more or less in a policy vacuum: it was able to develop and flourish precisely because of the absence of any viable alternative. In November 1990, 18 team managers were moved to write to the director of social services listing as one of their areas of particular concern the 'lack of structure, direction or any coherent philosophy within the department' (Levy and Kahan, 1991 p152). Operating within a context of serious underfunding of the service, lack of training, status or rewards for residential care staff, little or no encouragement of conscientious or forward-thinking management, frequent reorganisations of the service, the conditions were right for the primary aims of care to be neglected, and the subsidiary aims of order and control to take precedence – and for management relief when the situation was contained by those below them.

Pindown, we would ague, had as its primary aim the control and management of recalcitrant children. It was a measure of the extent of managerial failure, not only that this was allowed to take place, but that it was able to continue while maintaining the façade of a therapeutic regime. The presentation of a disciplinary and punitive system as caring or therapeutic is itself an example of the corruption of care.

PROPOSITION 5

The corruption of care is more likely in enclosed, inward-looking organisations

'Isolated', 'enclosed', 'inward-looking' are words which appear again and again in the reports of the inquiries into the long-stay hospitals. Mary Dendy Hospital was cited by Martin as a powerful example of the danger of professional isolation (Martin, 1984 p41). At Winterton, group loyalty was taking 'a dangerously inward-looking and protective character' (Ibid, p44). At Church Hill House Hospital, the prosecuting counsel at the Enquiry spoke of 'a closed society where no one was to break ranks' in the ward. At Brookwood, there was 'an ominous form of group loyalty' (Ibid, p50). The enquiry at Farleigh reported that 'the standards by which the hospital was judged were its own internal standards' (HMSO, 1971 para. 42). At Whittingham, promotions were mainly internal (HMSO, 1972 para. 109).

What are the links between enclosed, tightly-knit organisations, inward-looking cultures and the corruption of care? There are at least four.

First, such an organisation can easily stifle criticism and complaints. Those who initiated the complaints which led eventually to the hospital enquiries were almost always 'outsiders' – students, new or junior staff, for example. It was easy for a tight-knit body to suppress complaints – as happened at Whittingham (HMSO, 1972 paras. 21, 25-28) or at St. Augustine's (Martin, 1984 p33) or Farleigh, where students and junior staff were laughed at by ward staff when they complained of the ill-treatment of patients (HMSO, 1971 para. 121).

Secondly, there is the enormous difficulty of insider criticism. Martin talks of 'the ingrained sense of staff solidarity' (Martin, 1984 p109). Ranks, he says, could close with formidable force – and they could close on anyone who challenged group norms – and the norm was group solidarity even if it did not necessarily approve of the ill-treatment of patients. Raising awkward questions, or challenging norms or behaviour, meant isolation at work and outside because the worlds of work and leisure were essentially the same. In the enclosed organisation, group norms are powerful and the costs of challenging them are often too great.

Thirdly, in the professionally isolated organisation, there are no new ideas, there is no renewal and strengthening of expectations and possibilities. The organisation comes to judge itself by its own internal standards. There is no empowering, externally reinforced concept of good and proper practice. The best elements of professionalism wither and perish for lack of nourishment.

Finally, the enclosed organisation develops and maintains a pattern of practice which is routinised and conservative. It expects little of staff or of clients. Its aspirations are low – control, order and the absence of trouble. Such a pattern of institution-oriented care can easily tip over into corruption. The gap is dangerously small. Where aspirations and expectations are higher, the slide is more noticeable to all involved and so more difficult.

To understand a system such as pindown, we must understand the culture within which it existed. As we have seen, in common with many other institutions where corruption of care has taken place, there was a marked sense of isolation and conservatism, both within the institutions themselves and within the county's child care services as a whole:

> 'One newcomer to the department from another local authority described it as "like travelling back in time".'

And:

> 'There was said to be an "inward lookingness', as one witness described

> it, and resistance to experiences and ideas from outside.' (Levy and Kahan, 1991 p154)

Within such an atmosphere, it is possible to understand the lack of any constructive debate around the practice of pindown. Although the pindown regime was clearly known to management, there was no official validation or supervision of the practice. This ambivalent position was due, we would argue, to the lack of clearly established good practice guidelines. In the fairly small and enclosed world of the county's residential child care services, there was thus considerable scope for charismatic – some would say maverick – individuals such as Tony Latham to wield extensive power and influence, and to be allowed considerable discretion and freedom of action in carrying out their work.

Within such enclosed worlds, few were prepared to dissent, and those who did so tended to be 'outsiders', non-participants in the local (occupational) culture. For example, one juvenile justice worker, newly appointed from another county, expressed his concern both at pindown itself, and its toleration by social services managers:

> '(Pindown) is totally illegal, you know. The kids could complain if they wanted to. The procedures are very strict for juveniles in care. I think they are insane. If it got out! But presumably (a senior manager) and all the rest know about it.' (Juvenile justice worker, fieldnotes, March 1989)

Senior and middle management did indeed know about it, but failed to intervene, largely on the grounds that the regime was successful in managing and containing troublesome youngsters. Their managerial world was sufficiently inward-looking to prove resistant to any challenges from the outside, just as the children's homes themselves were sufficiently enclosed to enable the practice of pindown to continue undisturbed for a period of six years. The system finally came to public attention thanks to the efforts of a local councillor and a local solicitor, who challenged the use of pindown in the courts, in council meetings and in the public arena.

Furthermore, a sense of isolation and enclosure were features of both staff and 'inmate' experiences. Team leaders of children's homes and family centres were frequently isolated from each other, lacking in professional exchanges and support mechanisms, while their care staff worked long hours with little opportunity for professional contact or development outside of their own institution. Isolation was, of course, a central component of the pindown regime itself – for the children themselves, but also for the staff implementing the regime who were required to engage in long, isolated and tedious hours supervising a child under pindown. Separated and alienated by their distrust and

incomprehension of the other, the key protagonists – children and staff – at least had in common their sense of isolation.

PROPOSITION 6

The absence of clear lines and mechanisms of accountability plays an important part in the corruption of care

One of the characteristics of the organisations and institutions which we describe as corrupt is that they are not clearly accountable to anyone. Users of the service lack the status, or the capacity, to assert themselves. Their families and friends lack the knowledge or the position to play a part. The local community is unorganised and usually uninvolved – and, as regards many long-stay hospitals, non-existent. The enclosed nature of institutions and organisations means that there are few links to the outside world.

Management, as we have seen, often neglects its responsibility to know what goes on, to set appropriate standards and to insist on staff accountability. Front-line staff are frequently simply left to get on with things. Dr Knappe, the Deputy Medical Superintendent at Farleigh, admitted to the Enquiry that he did not know how the patients on North Ward spent their day. He had not enquired about this as he considered it a nursing issue (HMSO, 1971 para. 82). He saw himself as in no way accountable for conditions there. Unfortunately, no one else was really accountable either.

The danger of a lack of management and external accountability is plain. Everything depends on the quality, commitment and values of the front-line staff. That is fundamentally unsatisfactory. There need to be mechanisms for making staff effectively accountable. There must be checks and counters to the enormous powers they wield over very vulnerable people and the pressures they face. Society must accept, and assert, its own accountability for what happens to those in positions of such dependency.

Without mechanisms of effective accountability to management, front-line staff are, in effect, unsupervised. Without mechanisms of effective external accountability, the organisation comes to judge itself by its own internal standards – which is dangerous in practice and unsatisfactory in principle.

In cases where no formal documentation or authorisation of a system exist, it is difficult to clearly apportion responsibility or blame. Indeed, it may take a long time for any abuses to come to light. This was the case with pindown. Family centres and children's homes operating the regime were the subject of routine visits of inspection without any

incorrect procedures being identified. Firstly, the homes experienced regular statutory visits which raised:

> 'occasional questions ... about the care and treatment of children ... (but) wholly failed to bring to light the practice of Pindown ... critical comments made by a statutory visitor on the forms used would be missing from or couched in more anodyne language in the report which was later sent to the district advisory sub-committees.' (Levy and Kahan, 1991 p129)

Secondly, a Social Services Inspectorate visit in 1987 similarly failed to say anything about pindown in the final report. This was particularly important, as it was taken by the practitioners of pindown as effectively giving the 'green light' to their system.

However, the issue of accountability is not confined to 'front line' practitioners, but relates also to middle and senior managers. The Levy Report found that:

> 'Social services department management appeared to be related more to crises than careful and well-informed planning.' (Levy and Kahan, 1991 p193)

Senior and middle managers responsible for the 'pindown' institutions could be said to be culpable on one or other of the following two counts: either they were aware of the pindown system and failed to take steps to deal with it, or else they were ignorant of the system and thus guilty of a major lack of supervision of the institutions and staff under their control.

PROPOSITION 7

Particular models of work and organisation are conducive to the corruption of care

Our argument is not that certain approaches to work and organisation directly cause the corruption of care, but that they can play a part in creating the context in which such corruption takes place. We suggest five connections.

In the eyes of the world, professionalism stands for high standards of work. At its best that is clearly true, but, equally, some aspects of professionalism, as traditionally understood, can play a part in the corruption of care. In some of the hospital scandals, narrow clinical models of professional responsibility led doctors to ignore grossly unsatisfactory physical conditions which became a factor contributing to the corruption of care. Again, mistaken notions of professional auton-

omy contributed to management's failure to set standards and hold professionals to account for their achievement. Another factor was management's faith in the self-sustaining power of the professional ethic, however taxing the work involved – which led to the failure to provide staff with the support they so often needed.

Secondly, hierarchical structures make complaint from below very difficult. Organisational structures, in part, explain how difficult it was for complaints about patient ill-treatment to gain a hearing. Hierarchy also means that those whose responsibility it is to set standards and objectives are a long way distant from where the action really is. Distance deprives their views of legitimacy for front-line staff because 'they' do not really know what conditions are really like. Given the lack of legitimacy granted to the views of managers, secondary aims and goals take over.

Thirdly, size is a factor in that it contributes to the patterns of institution-oriented care which can tip over into corruption. Size leads to regimentation and batch living which contribute to depersonalisation which in turn reinforces regimentation and batch living and can slip into corruption.

A fourth problematic element in the organisation of human service work is the concentration of the most difficult cases. Most of the hospital scandals related to particular wards, often the 'back wards' where the most difficult and handicapped patients were concentrated. Raynes and her colleagues point out 'the negative consequences of exclusively grouping profoundly and severely retarded residents together' because 'such a practice appeared to guarantee institution oriented care for these clients' (Raynes, 1979 p159).

Meacher argued against the segregation of confused elderly people on the grounds that it encouraged infantilising procedures and that such patients were less likely to have visitors (quoted in HMSO, 1978 p273). Treating mentally handicapped people or those who are mentally confused as children is one way in which staff have traditionally come to terms and coped with their condition. Nevertheless, it is potentially dangerous. Children lack the rights of adults and, till recently at least, a modest degree of violence in dealing with them was regarded as reasonable and appropriate. That could easily lead on to more general violence. Visitors, too, are important as a way of combatting enclosedness and opening the institution to wider accountability.

Finally, we need to recall Bauman's arguments about bureaucratic forms of organisation and the direct links which he argues exist between bureaucracy and 'the silencing of moral considerations' and between bureaucracy and the loss of individuality and personhood on which moral behaviour depends (Bauman, 1990 p132). There is no

deterministic relationship between particular models of work and organisation and the corruption of care, but clearly there are links.

Earlier, we identified five characteristics of work and organisations which were associated (not necessarily in a directly causal manner) with the corruption of care: professionalism, hierarchy, concentration of those regarded as the most 'troublesome' clients in one place, size of an institution and bureaucracy. Here, we will examine just one aspect of professionalism, that of discretion, in relation to pindown.

A central power of welfare professionals is that of the operation of discretion, the professional ability to make decisions in the 'best interests' of the child. Stewart and Tutt (1987) have argued that such exercise of discretion may supersede any concept of children's rights or natural justice, and may in any event be illusory in that:

> 'those who are thought to operate discretion may well not and that professional decisions are frequently a range of routinised responses to categories of familiar "problems" with which the organisation must deal.' (Stewart and Tutt, 1987 p94)

As we have already seen, pindown practitioners may have incorporated an element of discretion in its application during the early days, in selecting particular categories of youth such as absconders. Later, however, the use of pindown became routinised, and was used with all those entering care for whatever reason, in particular institutions. Thus, we would argue that the ability to exercise discretion – a key component of welfare professionalism – contributed to the corruption of care as represented by pindown. Early discretionary use of the system soon became routinised, albeit while retaining the impression of professional decision-making powers and expertise.

PROPOSITION 8

The nature of certain client groups encourages the corruption of care

The groups where there is most evidence of the corruption of care, people experiencing mental handicap, people who are classified as 'frail' elderly and children, share certain common characteristics. Our argument is that these contribute to the corruption of care. Most of them are seen as less than fully sentient beings because of their age, and disabilities. Once defined as less than fully persons, the way is clear to forms of behaviour and treatment which would be unacceptable with those not so stigmatised.

As we saw earlier, defining mentally handicapped people as children opens the way to certain patterns of potentially risky treatment. One

way in which some of the perpetrators of violence in the long-stay hospitals justified or defended their behaviour was with the argument that 'they don't understand'. The same argument was used to justify not improving physical conditions in wards. Those conditions made the lives of staff more unpleasant than they need have been and conveyed to them a message about the valuation society placed on the groups for which they were caring.

Given the way in which society provides for them and the resources made available for their care, certain groups are obviously more difficult and trying for staff. They tax the patience of staff. They may create permanent anxiety about the possibility of violence. They offer staff few rewards in the sense of positive achievements. Low expectations feed a philosophy of containment and control which, in turn, can lead to boredom among clients and a spiral of violence.

A third link between the corruption of care and the nature of certain client groups is the lack of interest society shows in their care – in terms of resources, support for staff, training and so on. A lack of society's interest is evident in low material standards which legitimate low standards of care and behaviour by staff.

Finally, the relatives of certain groups will be not much involved in their care. They will visit infrequently because they have lost touch and because of the stigma of having relatives in these groups. So they can provide no effective commentary on standards of care or influence for change. Their expectations, too, are low.

It is indisputable that the care of any special needs client group can be a difficult occupation, and that working with particular groups can be especially stressful – we think here of children and teenagers, mentally handicapped people and frail elderly people. It is not insignificant that pindown developed at a time when the residential child care institutions were dealing with older teenagers rather than younger children, many of them from difficult and disruptive backgrounds, some with a history of offending, and few with a prospect of successful foster placement. When high staff turnover, low staff morale, a service frequently in 'crisis' are added to this picture, it becomes clear that staff could expect few rewards from their task of caring for these youngsters. Staff frustrations were frequently expressed in log books:

> '... tonight has been a total waste of time – it's not human beings you want working here but morons who don't have hearts and are without feelings.' (Levy and Kahan, 1991 p57)

> 'He has drove me mad ... At 1.45 I lost my temper, he doesn't know how close to death he was. I don't think he likes me any more, he won't

answer or talk to me. HAHAHAHA. I will have to do it more often.' (Ibid, p59)

At the same time as we recognise the pressures on staff which cause such feelings of frustration, we must identify the particular processes by which client groups are perceived as not just causing feelings of irritation, hostility and animosity, but also become defined as 'the Other'. Just as:

'A man in a political prison must be traitorous; a man in prison must be a lawbreaker; a man in a mental hospital must be sick.' (Goffman, 1961 p81)

so a child in residential care must be difficult, troublesome and disruptive? The point is not so much whether these young people engaged in troublesome behaviour – which they undoubtedly did at times – but that *all* of their actions were interpreted in the light of their presence in the institution, that is, as troublesome. This held true even for actions prompted by the system of pindown itself. For example, it was specified in the 'rules' that a child's initial request for anything should be ignored or denied, yet staff soon became frustrated at repeated requests for basic facilities:

'She thinks I'm room service, hasn't anyone told her it's not an hotel . . . the little knocker has not knocked so much tonight, when I go in I usually look for a tip as I feel like a waiter.' (Levy and Kahan, 1991 p109)

This interpretation, that everything a child in care does is symptomatic of their essential troublesomeness, can be extended beyond behaviours under their direct control to include physical or psychological states of health. Thus:

'She . . . *claims* to have asthma . . . need to clarify if she does suffer or if it is attention seeking. Excuses to come out of her room.' (Levy and Kahan, 1991 p59, emphasis added)

Also, those who attempted to escape from pindown were further blamed for having brought a prolonged period of confinement on themselves:

'"The pitiful part of it all is that he keeps doing silly things and blotting his copy book – but he can't seem to tie those incidents in with not being allowed any contact, freedom or privileges." Amongst the "silly things" that he had done were calling out of the window of his room and banging on the bedroom door and walls in an attempt to communicate with two girls who were also in Pindown.' (Ibid p56)

It is difficult not to equate such attempts at communication with the

'wall tappings' of incarcerated adults (Scheffler, 1986). It is evidence of the power of institutions to define and control the individual that such testimony to human resilience may be redefined as troublesomeness, and that ideas and principles of care may be corrupted into a desire for control.

CONCLUSION

The corruption of care is a fact and a problem. While we were completing this article, the issue became prominent again with press reports of the inquiry into Ashworth Special Hospital (eg *The Guardian*, 10 March 1992) and the publication of the NSPCC's report *Institutional Abuse of Children* (Westcott, 1991). Obviously, it is important to try to understand how it is that care becomes corrupted.

Our approach has been to set out eight general propositions about the corruption of care developed from an examination of relevant literature and to test them out as explanations against the Levy-Kahan report and empirical research on pindown. In our view, the eight propositions are useful. They are not all relevant in all situations but they are certainly helpful in pinpointing circumstances in which care systems are at risk.

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2 All personal, institutional and place names used in relation to pindown are pseudonyms, except those cited by the Levy and Kahan Report (1991).
3 Bauman's focus is on the Jewish victims of the holocaust. In addition to five million Jews, there were a further two million victims including gypsies, homosexuals and mentally handicapped people. They were also categorised as less than fully human.
4 We use the term mentally handicapped rather than the more contemporary designation 'people with learning difficulties' because that was the term in current use at the time of the various hospital inquiries on which we draw.
5 During those six years (November 1983-October 1989), it is conservatively estimated that 132 young people were subjected to the pindown regime, 81 males and 51 females (Levy and Kahan, 1991).

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