# LIBERATING INSTITUTIONS

## Finding Community in Care

**A Discussion Paper from the Centre for Welfare Reform**

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# SUMMARY

John Burton describes the way in which care homes and the people who live and work in them are subjugated and constricted by a social care system run and regulated for the benefit, protection and preservation of an elite of - mostly well-meaning - politicians, bureaucrats, care organisations and, of course, in a large part for the profit of owners and shareholders.

However, there is an alternative - more hopeful - way to look at the same picture. In every care home there is another sort of institution trying to get out, a community formed of people in mutual caring relationships in search of self-determination, empowerment and liberation.

# 1. INTRODUCTION

**I've now been 'in' social care for fifty years. Starting by working as an assistant in a secondary school while living as a resident in a nearby probation hostel, I shared an attic room with three other young men in a grubby and deprived little institution. My fellow residents were all products of institutional life - children's homes, approved schools, borstals, and prisons - and I was not . . . or at least not to the same extent. (Institutions feature in all our lives.) With no sense of an intentional community from the management of the hostel, the 'lads' (as the residents were known) resorted to re-creating the institutional subcultures with which they were most familiar.**

After four months I left the hostel and sofa-surfed until I found a flat to share, but the experience left a strong impression on me. I was free to leave and find my own place living with another group of people. A couple of years later I was a resident member of staff in an inner-city, local authority children's reception centre. My room was between the boys' dormitories. It had a half-glazed door (with a curtain over it) which served as a fire exit, so there was a key in a box outside available to unlock the door in an emergency. A trap door in the corner of my room led down to the kitchen via a ladder. Apart from days off, we were 'on duty' all day and night. But this was an institution that was run on therapeutic lines, so, while delinquent subcultures were still present, the purpose of this community was to understand, heal and grow. We ate together. We built, created, played, went on expeditions, kept rabbits, chickens, and geese, told stories and put on shows, painted pictures, made pottery and model aeroplanes . . . together. The everyday life of the place was creative and full of new experiences for the children and grown-ups.

I went on to lead a therapeutic children's home with shared responsibility and community meetings in the 70s, and then a very large care home for adults with day care and strong neighbourhood involvement in the 80s. Like other residential workers of that era, I am still in touch with some of the people who lived in the children's home and they are in touch with each other. The community lives on. I'm a very close friend of a few, with their children and grandchildren - a large extended family.

Throughout my working life (I'm still working) I've been involved with social care 'institutions'. In addition to living in, working in, and leading residential institutions, I've been a tutor, inspector, researcher, campaigner, advocate, writer and independent consultant. Many institutions - not only residential ones - need liberating, and many are liberating. However, care

homes are not often thought of in this way; we are more likely to think of educational institutions - schools, colleges, and universities - like this. But education is experienced by many as a constraint on freedom, as a long period of compulsory, competitive compliance, as frustration and failure at a time of one's life which should be free and creative. On the other hand, education is sought after by millions world-wide as the route to personal and political liberation. Residential homes can be places of incarceration, yet many are places where people can be freed from a daily struggle imposed by mental and physical frailty, by loneliness and isolation.

# 2. BARRIERS TO LIBERATION

## Regulation and compliance

**A care home that is run simply to be 'compliant' is unlikely to be a good place in which to live or work. Compliance is alien to the ethos, principles and good practice of the social care profession and residential social work.**

Compliance, the main tool of measurement used by regulators of any sort, has very limited validity in the life and work of a care home. It is a negative and submissive concept, the very opposite to liberation. Nothing ever grew and developed, no initiative, no advance was ever made by compliance. Compliance is static and growth is dynamic. Of course, the notion of compliance is useful to check important but secondary technical services to the home, and such checks should be made by suitably qualified and experienced technicians. For example, the lift must be properly maintained, medication managed well and accounted for, and food stored and prepared safely, but such compliance is not the primary purpose of a care home.

Those of us who were trained and qualified as residential workers or residential social workers - trained to practise, manage and lead - received a thorough grounding in such areas as human growth and development, loss and change, social psychology, group processes, community and institutionalisation, leadership, ethics, ageing and society, social work methods, social policy, counselling, dependency and power relationships, family and individual therapy, and more. We were encouraged to enquire, to challenge, explore, and debate ideas. We thought, read, and argued. Much of our learning was experiential and reflective. We were not taught 'compliance'. Some of these courses were better than others, but I very much doubt if any residential social work course ever mentioned 'compliance'

No, I'm wrong. In the early 70s, when I did my qualifying training, the word compliance described a worrying aspect of, for example, a child whose infancy and early years had compelled them to keep their heads down and to find a way of surviving the hostile and persecutory world around them. These days, we might take compliance in an eighty-year-old resident of a care home to suggest that they may be being abused, bullied or medicated, and they had attempted to avoid further pain and humiliation by withdrawing into themselves and being 'quiet', compliant and unnoticed - 'no trouble.'

Care homes are caught up in what the regulatory machine has created - compliance. Led by an entirely inappropriate and outdated application of

'quality assurance', the regulators draw up the standards, make the rules, and then 'enforce' them. Care home managers will break free of the constraints of compliance only by thinking and acting like professionals and leaders in our care communities. We must stop acting like quiet, frightened, compliant children, learning by rote, anxious to please by fitting in with the rules and restrictions imposed on us. This is work for grown-ups. We can join forces in taking responsibility for our own profession, and lead the development of care homes as highly valued local centres of care and support, fully integrated with their neighbourhoods and communities.

## Upside-down social care

**Over twelve years, the national regulators have turned social care upside-down. Instead of the needs of users determining the form and operation of care services, and those services, led by the managers, being designed and managed at a local level to meet those needs, the regulators have imposed their measurement formula - a new one every couple of years - for arriving at 'judgements' on the 'quality' of care.**

This top-down approach has in turn spawned a new layer of quality-assurance, management and consultancy which is now seen as essential to prove to the regulators that providers are compliant. And this self-perpetuating arrangement flourishes alongside the cosy pretence of personalisation. Compliance-driven care is the very opposite of truly person-centred care.

So widely accepted is this dysfunctional form of regulation that, as with the banks before (and after) the crash and now with the brazenly cheating car manufacturers, the social care regulators have completely misunderstood their role and function. Instead of being the servants of the public, they have assumed the role of 'industry' leaders using such phrases as 'key lines of enquiry' and 'intelligent monitoring', and endlessly redefining 'what good care looks like' (to them, not to the residents). Yet, at the same time, they refuse to investigate individual complaints about care. Their reports are written in a lofty, repetitive, impersonal, and bureaucratic language, using 'we' even when there is only one inspector and giving no name or direct contact details so that the public, for whom they are meant to be working, can communicate only through a call centre, very like many other failing services, BT and the energy companies amongst them.

What do we think Tom Kitwood (*Dementia Reconsidered*, 1997) would have made of this compliance culture? Would it not fit perfectly with his description of a 'malignant social psychology'? Is it not understood at any

high level in government, the Department of Health or the Care Quality Commission (in England) that the malignant effect of compliance does not merely 'filter' softly down to the way residents in care homes are treated, it is - albeit unwittingly - aimed directly at them and blights their lives.

When some senior members of the CQC are confronted with this analysis, and when they can't bluster their way out of it, they resort to the excuse that they have no choice and are merely complying with the orders given them by government, and they are short of resources: "Give us time - we're a young organisation." Such excuses are a betrayal of professional ethics.

As social care professionals and leaders, registered managers must take their cue from their core task (care) and their own professional standards. We must refuse to put compliance before real care and relationships. We must support each other, learn from each other, and always put our clients first.

# 3. DANGEROUS COMPLIANCE

## Winterbourne View

**Compliance, bullying and abuse, and the projection of guilt (scapegoating and blame) are linked psychological processes. We saw them working at Winterbourne View and they are still wrecking people's lives in institutions up and down the country.**

These processes are intrinsic to the current system of regulation and governance of social care. The public are asked to believe that we can eliminate abuse by demanding tighter compliance from all care providers and punishing the persistently non-compliant. While the exposure and punishment of non-compliant providers assuage guilt, at the same time they perpetuate abuse. (Winterbourne View was technically a private hospital not a residential care home.)

At Winterbourne View the regime of governance - from the regulator (CQC) to the managing owners (Castlebeck) - was one of compliance. Previous inspections found the place to be compliant with CQC's standards. The inspectors and their reports were compliant with CQC's internal standards of operation. (The reports themselves were subjected to a rigorous test of compliance or 'quality assurance' before being published.) The management of Winterbourne View, the staffing, the training, and the practice were compliant with the demands of the owners. The staff were compliant with the internal management and most of the residents had learned to be compliant with the staff. And while that was the case - top to bottom compliance - Winterbourne View would have continued, as many other broadly similar compliant establishments continue, without the disruption of non-compliance.

However, there were some persistently non-compliant residents. Often this sort of non-compliance is referred to as 'having challenging behaviour' or, more euphemistically, 'exhibiting behaviour that challenges services', as if this was some sort of diagnosable condition with no connection with the social situation to which people are reacting and responding. To call people, especially 'vulnerable' people, 'non-compliant' is uncomfortable, but, let's face it, that's exactly what they were. Of course, their non-compliance or, as the 'professionals' would phrase it, their challenging behaviour was the very reason for their being at Winterbourne View, and was the justification for commissioners spending £3,500 a week keeping them there, ostensibly

for short-term assessment and treatment but in reality for long-term compliance management. Castlebeck had recruited staff to work with these non-compliant people. They had selected them and trained them in techniques of 'restraint' so that when the residents' behaviour was too challenging - or when they had been provoked into resistance - compliance could be enforced. Such regimes survive because most of the staff and most of the residents comply.

At Winterbourne View there were some residents and some staff who continued to resist. We saw on the Panorama film residents struggling to maintain their personhood, fighting back, protesting their sense of self: "I am a human being... I will not be compelled to comply... I will not be treated like an object." They were fighting for their liberation. Although there were staff who had previously protested and had resisted compliance, the only staff we saw on the film were those who were compliant with the prevailing abusive regime, either by their passive acceptance or by their enthusiastic participation, or, indeed, by leading it. Eleven of these regime-compliant staff were subsequently convicted and punished. Those who had resisted had been ignored and were identified as troublemakers. Terry Bryan, working there as an agency charge nurse, had already been through the whole gamut of reporting the abusive regime to the management and being ignored before he contacted CQC, the compliance regulator, and was again ignored. He was non-compliant. If he had not then contacted Panorama, Winterbourne View and Castlebeck would still be in compliant operation.

Government, CQC and the whole care sector have been very active ever since in self-flagellation, in hunting down non-compliance using updated compliance benchmarks, and attempting to dissociate themselves from Winterbourne View. A succession of task forces and reviews have promised change and failed to 'deliver' it. What has not been learned is that compliance itself, the central measure and ethos of CQC, leads to abuse.

At the time of writing, it has just been announced that the NHS will reduce the number of people with learning disabilities in hospital by between 30% and 50% by April 2019 and it will spend £45m on expanding support in local communities. This sounds exactly like what was being proposed in the last century and should have eliminated 'hospitals' such as Winterbourne View in this century. Government fails repeatedly to deal with causes (why Winterbourne View existed in the first place), sets targets for eradicating the symptoms, and punishes non-compliance with those targets, without understanding that if they don't attend to the causes yet forbid one set of symptoms to exist, another set will inevitably appear. Winterbourne View and current hospitals are symptoms of a failing, diseased care system. Much of the £45m will be consumed in the management, administration and

monitoring of this doomed project, and comparatively little of it will provide the direct care and resources that people need.

## Bullying and abuse

**The propensity to bully is built in to command and control organisations. Schools, the police and armed forces, prisons, care homes are all thought of as likely breeding grounds for bullying and abuse, but such tyrannies are rife in many workplaces such as the media, Number 10, Whitehall and city and county halls, and in the compliance regime of the care regulator. Targets are set; delivery is demanded, and failure is punished.**

And, somehow, intent only on its own survival, the whole operation of this large bureaucracy (CQC) has lost its way. The purpose of checking on behalf of the public (including of course on behalf of the residents of care homes and their relatives) that care is good enough comes a very distant runner-up to foot-stamping threats of compliance or else. And it is passed down the line . . . to the inspectors, to the providers, to the managers, to the staff, and, yes, to the residents of care homes, the very people the whole shebang has been set up to protect.

## Unlearned lessons

**The residents of care homes are likely to be non-compliant people. Therefore, imposing any regime of compliance is punitive and institutionalising, and will manifest itself in bullying and the suppression of residents' sense of self.**

- Compliance with externally imposed benchmarks can co-exist with abuse and neglect.
- Care, not compliance, is the one and only task of a care home. Real care is a relationship between people. Therefore, only by checking care itself - what is happening between people - can effectiveness and quality be judged.
- Care is a complex, reciprocal relationship. It has to be seen, heard and felt to be believed and understood.

- Care takes place in a multi-layered system of human relationships in which hidden and underlying psychological and social drivers are the most powerful influence on the quality of care.
- Evidence of care is not found in records or action plans or, indeed, of 'statements of purpose' (all of which may be used to disguise its absence); it is found in lived experience.
- The whole system, including the regulation of care, must be coherent with the primacy of care relationships and must be designed to enable, support, and enhance caring relationships.
- A caring organisation must recognise, understand, and work with the deepest, hidden, mixed feelings of both care givers and clients, and with its own institutional defences against anxiety.

# 3. SAFETY AND RISK

## Why buses don't have seat belts

**The current approach to safety and risk (led by the regulators) has decreased safety and increased risk, and has taken care workers' and managers' time and attention away from the people with whom they have a caring relationship.**

As a frequent bus traveller, I have ample opportunity to observe and think about the approach to safety on buses. The latest statistics for London buses show that out of every million journeys on London's buses, there is a 2.6 chance of getting injured. Buses are a very safe form of transport but they don't have seat belts; passengers stand, go up and down stairs, and move around while the bus itself is moving. Buses frequently appear to be overloaded. Descending the hard metal stairs while the bus is accelerating and braking takes some doing. So, why are buses so safe?

While constant research and thought goes into making buses even safer, the bus operator must never forget that safety is not the core task of the bus. No, buses exist to get passengers from A to B. If safety were to be imposed as the primary objective of a bus company, there would be no buses. Imagine a bus that had to have seat belts and that passengers had to use them. Imagine no standing was allowed, or a bus could not move from the stop before the driver had checked that all passengers were wearing their seat belts. Imagine the arguments and fights over the last available seat. Imagine the traffic chaos that would result from banning the use of the upper deck on double-deckers because the stairs were so dangerous. London and many other cities would come to a standstill.

In everyday operation, buses are largely self-policing. Passengers sort themselves out and take the risks that they choose. Nevertheless, the driver certainly has a part to play. Care, consideration and helpfulness go a long way to making even the most crowded journey tolerable . . . sometimes sociable, amusing and pleasant. Passengers and driver are united by the common core task - getting to their destination, quickly and safely.

In care homes we have allowed risk aversion and safety to get in the way of the core task, to be separated from it and to take precedence over it. Instead of the residents, care team and manager working out together how they can reduce risks while enabling people to live full lives and be supported how

they wish, they are constrained by externally imposed restrictions that result in care providers trotting out such defensive platitudes as "ensuring the residents' safety at all times is our top priority."

# 4. DEMANDING CONSISTENCY

**With the dominance of national 'quality' standards, ratings and requirements comes the demand from providers for consistency, and the growing army of 'quality assurance' and 'improvement' managers and consultants. For the larger providers, inconsistencies in 'judgements' between care home inspection reports can be identified and used to contest the ratings (ranging from inadequate to outstanding) and to undermine the already doubtful validity of the regulator's judgements.**

The ratings and the inevitable emergence of inconsistencies result in an unending game being played out between the two sides. On one side, the providers employ their experts and legal teams to spot the inconsistencies and play one report off against another, and on the other side the regulator plays the counter game which involves attempting to substantiate, quantify and define ever more precisely in the vain hope that they can draw clear boundaries between their ratings.

Running alongside this adversarial game is the search for solutions: the magic formulae that will produce a 'good' or 'outstanding' rating. This is all a world away from the real lived experience of residents and staff, yet, to survive, all care homes have to play the game and, in doing so, are diverted from their core task.

## The bias against 'community'

**There are deep seated political and cultural barriers to communal living in institutions.**

In Britain, as much if not more than other European countries, we have an individualistic and competitive culture which produces a bias against living in groups other than family groups. Sharing accommodation is strictly for students and the children of the wealthy who spend up to ten years of their lives in boarding schools, and grow up to avoid and despise communal living.

## Liberating discussion

**Linked with this prejudice against communal living is a fear of ideas and democratic discussion. For many politicians, policy makers, and senior managers, the notion of shared responsibility and decision making is akin to anarchy; indeed, it is often referred to publicly as 'anarchy' or 'chaos'.**

The current experience in the Labour Party (2015) of opening up debate and including people who have been excluded, has taken the Establishment (in all its forms) by surprise. The widespread reaction from those who are challenged by this development has been to ridicule, patronise and reject, but not very far below the surface is fear. My own experience in care homes that have grown into strong, democratic, therapeutic communities, is that in every case the owning/managing organisation and the external 'establishment' of social care has turned on the non-conforming, non-compliant care home in what seems like a vengeful attack attempting to expunge this reminder of what a care community is all about and how strengthening and liberating the experience of communal living can be.

# 5. BUILDING INSTITUTIONS OUTWARDS

**I have drawn a picture of the way in which care homes and the people who live and work in them are subjugated and constricted by a social care system run and regulated for the benefit and preservation of an elite of - mostly well-meaning - bureaucrats, and, of course, in a large part for the profit of owners and shareholders. Elsewhere, I have likened this to colonialism (Burton, 2013). However, there is another - more hopeful - way to look at the same picture. In every care home there is another sort of institution trying to get out - to achieve liberation.**

Just as there were non-compliant people living at Winterbourne View fighting (sometimes literally) for change and liberation, and there were workers - yes, more than one - who joined in the fight, this is the case for every care home. And some institutions are both liberated and liberating.

How? Central to the development of liberating institutions is clarity about and commitment to the core task - care through relationships - and we build from there. Human relationships are not an exact science, they are a reciprocal, emotional and experiential art. Relationships of care are matters of the heart. Building a liberating institution requires special leadership - not of just one person because such an institution is by necessity a community. This kind of leadership is to be found in institutions that are seeking liberation.

**According to Paul Hoggett at the University of the West of England, social work/social care professionals need the capacity (Hoggett, 2009):**

- to tolerate and contain uncertainty, ambiguity and complexity without resorting to simplistic splitting into good/bad, black/white, us/them, etc
- for self-authorisation, that is, the capacity to find the courage to act in situations where there is no obvious right thing to do
- for reflexivity, that is, to take oneself as an object of inquiry and curiosity and hence to be able to suspend belief about oneself; all this as a way of sustaining a critical approach to oneself, one's values and beliefs, one's strengths and weaknesses, the nature of one's power and authority, and so on
- to contain emotions such as anger, resentment, hope and cynicism without suppressing them and hence to be both passionate and thoughtful

**In the last chapter of *Leading Good Care* (Burton, 2015) I propose that leaders of good care (liberated institutions) achieve it by:**

- stepping up from a low position - taking up your role assertively
- daring to tell the truth and to take the initiative
- having the courage not to follow the crowd, to hold on and to allow a course of action to emerge
- having the capacity to look ahead and envision where you are going, to tell stories and listen to those of others
- sticking to your principles, being reliable and resilient, and being true to yourself - integrity and authenticity
- being organised and attending to detail
- leading and following, sharing responsibility and decision making
- joining with others and creating a movement for liberation.

Institutions are liberated and liberating when the people living and working in them, those leading them and associated with them in their neighbouring communities liberate them. Presently government has made yet another resolution that people who need care (this time - and not for the first time - people with learning disabilities) will be cared for 'in the community'.

Without liberation being at the centre of this initiative and in the hands of those who live and work in the institutions, it will be another failure. In fifty years of taking part in the struggle to liberate institutions, I have never come across an owning or managing organisation that, while proclaiming their intention to free people from the oppression of institutional care, are not at the same time consciously and unconsciously resisting liberation. Liberation always has to be fought for.

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# ABOUT THE AUTHOR

**John Burton's** lifetime association with and commitment to social care began in 1965 when he was given lodgings in a probation hostel while working as a teaching assistant in a secondary school. Since then, he has worked in children's and adults' homes and communities; he has studied, researched, taught, supervised, mentored, inspected, consulted, campaigned, advocated and published - books, chapters, articles - in a quest to join with others to promote the liberating potential of therapeutic social care and communities.

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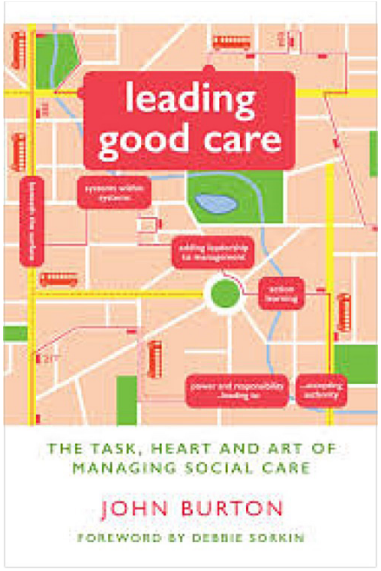


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The guide is available to purchase at: www.jkp.com/uk/leading-good-care.html

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