

**Duty of Care, Safety, Normalisation and The Mental Capacity Act: A Discourse  
Analysis of Staff Arguments about Facilitating Choices for People with Learning  
Disabilities in UK Services**

**Keywords: Learning Disabilities, Discourse Analysis, Choice, Empowerment,  
Mental Capacity Act.**

## **Abstract**

The benefits of having choice and control for people with learning disabilities<sup>1</sup> are well documented and front-line carers often make efforts ensuring that these are facilitated. However despite this, Government policy reports that disempowerment within learning disability services in the United Kingdom is a persistent problem. Using critical discursive psychology, 15 interviews with support-workers about empowering people with learning disabilities were analysed. Interpretative repertoires about 'duty of care,' 'safety' and 'normalisation' and discursive strategies involving 'comparative evaluations' were found, which opened speaker positions of granting or withholding choice, assuming responsibility for those in care and constructing service-users as lacking capacity. These resources also allowed speakers to regulate the choices of service-users and to normalise limited choice in ways which undermined taking up more empowering practices. The findings may explain the persistence of disempowerment within services by indicating how such discourses are deeply entrenched in service talk and are invoked to justify disempowering practices. This is discussed in view of the implications for empowerment and also current legislative frameworks such as the Mental Capacity Act.

## **Introduction**

For people with learning disabilities, having control over one's life significantly enhances domestic and community participation and decreases challenging behaviours and depression (Stancliffe et al, 2010). Yet, forty years following the white paper, 'Better Services for the Mentally Handicapped,' (Department of Health (DoH, 1971), which called for improvements based on principles of normalisation (Wolfensberger, 1972), this group continue to be marginalised, segregated and disempowered (Stainton, 2000, Goodley, 2000). More recently, there have been moves to facilitate inclusion. Underpinned by values of empowerment, individualisation and personalisation and enshrined in White Papers such as 'Valuing People' (DoH, 2001; 2009), these have called for ways to enable people to take control of their lives by making real choices and having their preferences recognised.

As part of policy objectives to facilitate choices and control, the Mental Capacity Act (MCA) Code of Practice (2005) provides a legal framework for decision-making in services where users may lack capacity. It proposes five principles where carers are advised to 1. assume a person has capacity unless established otherwise; 2. take all practicable steps to assist individuals in making their own decisions; 3. invoke the unwise decision principle where 'a person is not to be treated as unable to make a decision merely because he makes an unwise decision' (p. 19); 4. ensure that decisions made for individuals lacking capacity are in their best interests and; 5. ensure that decisions made for persons lacking capacity are least restrictive of their rights and freedoms. Such a framework protects individuals from discrimination by 'creating a legal presumption in favour of capacity' (Wilner, Jenkins, Rees, Griffiths and John, 2011; p. 159). Nonetheless, studies suggest gaps in knowledge about its implementation, both in highly trained professionals of learning

disability services (Wilner et al, 2011), and in support-workers from residential settings (Dunn, Clare and Holland, 2010).

The proposals made in ‘Valuing People’ (DoH, 2001) suggests that empowerment may be facilitated by targeting e.g. housing, employment, relationships, health and introducing initiatives such as independent living, person-centred planning and direct payments. However, without clear interpretation there is much disagreement amongst professionals, carers and family-members (Jingree and Finlay, 2012) over how this may be achieved. Indeed, Forbat (2006) examined the hopes of policy-makers and experts on ‘Valuing People’ (DoH, 2001) and identified gaps between policy and its implementation. Jingree and Finlay (2008) examined support-worker arguments about facilitating empowerment in their day-to-day work. They found speakers dilemmatically undermined service agendas to facilitate choices by privileging practical obstacles.

Emancipatory values also underpin models of person-centred care such as ‘Active Support,’ which has been found to increase choices of service-users in many domains (Beadle-Brown, Hutchinson and Whelton, 2012) by shifting care-taking away from pragmatic tasks and placing control in the hands of service-users (Mansell et al, 2002). However, there has been little uptake of this as it conflicts with staff values and other more prioritised work (Mansell et al, 2002). Beadle-Brown et al (2012) suggest more examination of the motivational contexts and leadership practices is needed to promote such models. Thus, though the facilitation of choices and control are treated in learning disability policy as straightforward goals, in practice, they are difficult to implement, conflicting with other agendas and values within the service as well as with how support-workers strive to accomplish a high standard of work (Finlay, Antaki and Walton, 2008a).

These Government documents, therefore, minimise other concerns that carers may have. Indeed, such conflicts of negotiating practical dilemmas when implementing empowerment policies into the care of people with learning disabilities are also supported by studies examining naturalistic micro-interactions between service-users who pay for their support via direct payments (Williams, 2011). They are also observable in interactions between service-users and supporters within residential care homes (e.g. Antaki et al 2006; Finlay Antaki and Walton, 2008b; Jingree, Finlay and Antaki, 2006) and within advocacy meetings (Redley and Weinberg, 2007). Redley and Weinberg (2007), for instance, report that though structural mandates ensure that individuals are given voice in venues such as advocacy meetings, these fail when supporters are faced with the interactional impairments of those they support. Supporters often resort to more restrictive 'old' pedagogical practices to compensate, which has the effect of undermining service-users' right to speak, advise and to hold onto the discursive floor (see also Bartlett and Bunning, 1997). Similar problems have been identified within residential services, however, here, these restrictive practices have been attributed to an imbalance of power between support-workers and people with learning disabilities, produced by support-workers ascribing 'incompetent' identities onto the individuals they support and treating their contributions as unrealistic and unreliable (Antaki et al, 2006; Jingree et al, 2006).

These studies are useful in revealing that despite mandates to empower people with learning disabilities, there continues to be obstacles in practice. This analysis builds on previous research by focussing on how support-workers argue about empowering service-users with learning disabilities and manage dilemmas of facilitating independence, choices and control against other institutional agendas.

## **Method**

### *Staff*

Twelve female support-workers and three male support-workers participated in the study. All were white British, between the ages of 22 and 59 (mean age 43.13) and employed by the service (a trust providing residential and day support for people with learning disabilities and epilepsy) for between 4 months and 19 years (mean employment period 8.85 years). The participants were asked to specifically speak about service-users with learning disabilities.

### *The Interview*

This study observed ethical recommendations of the British Psychological Society. The data consisted of audio recordings of 15 semi-structured interviews. These focussed on seven topics (finance, health, diet, employment, housing, alcohol, social and sexual relationships), chosen by reviewing literature and government policy about empowering people with learning disabilities, which captured ‘Valuing People’s’ (DoH, 2001) central themes. To ensure a relaxed environment, interviews were conducted at the service where all interviewees worked. An interventionist/confrontative style of interviewing was adopted where many interpretative contexts were generated by revisiting the issue of empowerment under each topic described above, allowing accounting practices and their functions in talk to emerge (Potter and Wetherell, 1987).

The interview started with a general warm up section (e.g. “How would you describe the people you work with who have learning disabilities?”), before introducing the seven topics at relevant points in the interview. Beginning with open-ended questions (e.g. diet- “How much control do you think someone with learning disabilities should have over what they eat?”), topics became more focused

by using prompts when required e.g. (“How about if they were diabetic or seriously overweight?” “Why?”). Semi-structured interviewing allowed for unexpected topics to be pursued further.

### *Transcription and Analysis*

All interviews lasted 60-90 minutes and were transcribed verbatim, including features e.g. overlaps in speech (indicated as []) and large pauses (indicated as (-)). All identifying names and locations were changed. The data was analysed using critical discursive psychology (Edley, 2001; Potter and Wetherell, 1987, Wetherell, 1998; & Wetherell, Taylor and Yates, 2001) whereby transcripts were repeatedly read in a manner mindful of the interpretative repertoires being drawn on to explain and justify how choice and control were promoted or restricted. Attention was also paid to the identities emerging from various discourses engaged in and the functions performed by these. The analysis, therefore involved an examination of micro-rhetorical devices and a global consideration of the interpretative repertoires being invoked (Potter and Wetherell, 1987).

## **Analysis**

Interpretative repertoires about ‘duty of care’ were found in all interviews about facilitating choices and control of service-users and produced staff positions of granting and withholding choice, and being responsible. They also justified positioning service-users as lacking capacity. Within these, some speakers also invoked repertoires about ‘safety’ and ‘normalisation’ with powerful implications for facilitating choices.

### *1. Duty of Care*

Below, 'duty of care' repertoires position service-users as unaware of risk and lacking capacity, allowing Martha to justify her argument about overruling rights and choices.

Extract 1 Martha (Lines from the original transcript 491-542)

- M And that you know I think in some cases that has got to override rights and choices. (Few lines omitted for clarity). Is you know is this very fine delign (-) line between giving the residents rights and choices and our duty of care.
- R Umm
- M And you know you you are walking a a tight-rope a lot of the time.
- R Umm
- M We're obviously trying to give residents as much rights and choices as possible. (-) But by the same token you do not want them taking any unacceptable risks.
- R Umm
- M Because not because taking unacceptable risks is wrong, but that because they are not aware of those risks.
- R Yeah. Would you feel the same if erm it it were a person without learning disabilities taking risks, who wasn't in your care?
- M Erm, in what way? I mean they would then be aware of the risk so that wouldn't be the issue it's the awareness of the risk, not the risk itself if you see what I mean?
- R Yeah
- M If erm somebody without learning disabilities who wasn't in my care but was aware of the risk wanted to go bungee-jumping without a bungee the(h)n okay [you just get on with it.
- R [huh
- R Umm
- M But if it was one of my residents who really didn't realise that bungee-jumping without a bungee was going to end in death
- R Umm
- M Then I'm sorry you know I would feel that my duty of ca(h)re would be such that I'd have to, (-) in that circumstances do something really stro(h)ngly



Martha begins by asserting ‘I think in some cases that has got to override rights and choices.’ She also creates a binary between rights and choices and her duty of care, positioning them in opposition by dividing them with a ‘fine-line’ or ‘tight-rope.’ Using a disclaimer, (‘we’re obviously trying to give residents as much choice as possible. (-) But,’), which positions her as facilitating choices, she nonetheless constructs a criterion based on what she describes as ‘unacceptable risk,’ where she argues that choices are not possible if individuals are unaware of risk. In doing so she produces a blanket construction of all service-users lacking capacity (‘They are not aware of these risks’). Indeed, notice how this develops. A contrast structure is introduced by the interviewer, asking Martha to consider what she has just said in light of someone not in her care. Here, Martha furnishes this contrast, stating that someone not in her care would have capacity or awareness of risks. Next she generates an extreme, ridiculous case (see Jingree and Finlay, 2008) to strongly justify her argument, and construct people in her care as lacking capacity by inferring that if left to manage their own rights and choices, service-users would be ‘bungee-jumping without a bungee.’ This again invokes her duty of care, positioning her as ‘forced’ to take responsibility, ‘I would feel that my duty of care would be such that I’d have to.’ ‘Duty of care’ is an important priority. However, it powerfully positions carers as compelled to intervene. Indeed, in this context, carers rarely orientated to alternative frameworks or to recommendations in the MCA (2005) Code of Practice, which calls for individuals being supported to have assumed capacity unless ascertained otherwise.

In the following two extracts ‘duty of care’ repertoires are invoked together with repertoires resembling principles of normalisation to justify manipulating service-user choices. Normalisation was first defined as, ‘letting the mentally retarded (sic)

obtain an existence as close to normal as possible,' (Bank Mikkelson, 1969; cited in Wolfensberger, 1972, p. 27). It may now be considered an outdated and largely contested ideology by emancipatory models of disability. However, approximately 30% of the speakers drew on these repertoires to justify managing and guiding service-user choices.

## 2. *Duty of Care and Normalising Choice*

Below, Claire produces an account about a service-user making an unusual choice. Normalisation repertoires are advanced to justify regulating his choices by 'letting him know the consequences' of his actions.

### Extract 2 Claire (Lines from original transcript 826-840)

- C I've got somebody who just loves to dress up and come November he wants to go to college dressed as Father Christmas. (-) Now he's at college with normal teenagers, who can be quite (grimaces) can't they?
- R Umm
- C Erm so you say to him, 'well ok, (-) you look a Pratt. But, if you want to wear that that's fine, these are the consequences, people are gonna laugh at you, people are gonna do this.' I don't say 'get that off and put something sensi,' I can't say that, their rights and choices, but I let him know the consequences of what ee's going ta, what could happen! He'll still say 'no no no no,' and then come back.

Claire describes this service-user as making an inappropriate decision. Her opening utterance, 'I've got someone,' instead of 'I *know* someone,' evidences her duty of care to him, and objectifies him as a recipient of care, whilst permitting her interference. However, importantly this intervention seems motivated by outdated principles of normalisation.

Claire begins by describing this service-user in a way that corresponds with Wolfensberger's (1972), depiction of 'the deviant as an object of ridicule' (p. 23)<sup>ii</sup>. She reinforces this by drawing a contrast-structure with 'normal teenagers who can be quite...' (perhaps less tolerant). Additionally, she expresses explicit disapproval for this service-user's choice (an action permitted by her 'duty of care'), 'you look a Pratt', which positions him as lacking capacity and in need of intervention. Nonetheless, using a three-part show concession (Antaki and Wetherell, 1999), she is also careful to mention that she does not wish to remove his rights and choices 'I don't say "get that off and put something sensi", I can't say that, their rights and choices, whilst simultaneously stating 'these are the consequences...but I let him know the consequences'. Such strategies resemble Wolfensberger's (1972) recommendations for pedagogy and persuasion by presenting discouraging outcomes. They are also constructed as vivid formulations (people are gonna laugh at you), providing listeners with definite outcomes, and, vague formulations (people are gonna do this), which are difficult to challenge (Wetherell and Potter, 1992). Both strategies are tailored to dissuade.

Below, Harvey has similarly been invoking repertoires about 'duty of care' to build significant disapproval about how a service-user (Danny) personalises his walking-frame. Again, practices underpinned by models of normalisation are observed. Like Claire above, efforts to persuade Danny are not presented as forceful, controlling or even successful (Harvey-' I can see what he's trying to do and we do try and tailor that to make him more socially acceptable'), thus allowing Harvey to simultaneously honour institutional obligations of respecting choices. Nonetheless, the very act of 'offering' and 'respecting' choice, means that power belongs to those with a 'duty of care' (see Dowson, 1997). The conversation continues below.

Extract 3 Harvey (Lines 932-957 from original transcript)

H Erm so yeah he's quite a lot of work needed to get here. I mean he's actually taken all the rubbish off his trolley now erm not that we said it was rubbish but because we explained that he came back one day and was very upset that people, kids in the street had stopped him and laughed ok.

R Oh

H and he was really [cut up

R [Umm

H and crying about it. And so we was explaining "yes is why though Danny because, (-) they have not seen anyone else ever (-) pushing a trolley that looks like that"

R Umm

H Ok it makes you unique. I mean everyone does that themselves I mean personally my thing is doing up my car. So I've put all shiny bits on my car and things like that. Erm (-) I don't go too far, was trying to define for him what would be you know socially acceptable as it were. Erm and did come through through to him in the end. On his own that perhaps action man was er a bit you know past his age limit (RYeah) and so he took the rest of his stuff off his trolley. Erm (-) so yeah slight progress we will get there in the end.

This extract follows a very negative description of Danny's judgment about personalising his walking frame (not shown), which again parallels Wolfensberger's (1972) construction of 'the deviant as an object of ridicule,' (p. 23). The consequence of this is relayed via an incident where Danny is upset by children making fun of him. Using reported speech and the pronoun, 'we,' Harvey reports collective staff reaction, 'we was explaining... they have not seen anyone else ever (-) pushing a trolley that looks like that.' The pause here places emphasis on the word 'ever,' which constructs Danny as extremely 'deviant', thus privileging normalisation over tolerance towards difference and individuality. It should be noted that normalisation, which encourages conventionality, conflicts with freedom of choice and emancipatory models such as the social model of disability (Oliver, 1996). However, here it justifies Harvey's actions to intervene and help Danny avoid social victimisation by

explaining that personalisation is acceptable as long as it falls within certain social boundaries, 'I don't go too far.'

Nonetheless, there remains a conflict between guiding Danny and facilitating free choice. Indeed, Harvey could have raised the necessity of helping Danny make his own decisions (see MCA, 2005). Instead he explains how Danny has complied with advice but that 'a lot of work was needed to get here.' Therefore 'work' here reinforces Harvey's business or duty of care and responsibility for service-users, giving him a right to influence Danny's choices. There is also a sense of time involved in persuading, 'did come through through to him in the end,' and 'we will get there in the end,' which constructs Harvey as making significant investment and effort in doing a good job as a responsible carer. However, his admission of 'slight progress,' constructs his efforts as not having had the desired effect. Nevertheless, Harvey's identity as a facilitator of choices is at stake, and given that normalisation and the processes through which it may be achieved has been criticised for being controlling (Roos, 1972) (although Harvey himself does not orient to this knowledge), constructing outcomes as only partially successful allows Harvey to position himself as continuing to respect service-user choices. Moreover, moderated disapproval, evidenced by several disclaimers 'not that we said it was rubbish but,' 'Ok it makes you unique! I mean everyone does that,' positions Harvey as reasonable, allowing him to manage his incompatible positions as someone with a responsibility for Danny and that of facilitating his choices. We also see how he resolves this incompatibility by offering 'bounded empowerment,' where Danny is allowed to express his individuality, as long as it falls within the constraints of normality.

Having a 'duty of care' is a powerful rhetoric in talk, which opens up opportunities for intervening in other peoples' lives. Here, Harvey and Claire demonstrate an interactional

awareness that they have a responsibility to both their duty of care and that of facilitating choice, which they manage by simultaneously invoking repertoires resembling normalisation to justify guiding service-users. Indeed, practices constructed as only partially successful or allowing a ‘bounded empowerment’ and informing service-users of the consequences of their actions enables them to resist possible accusations of being controlling or forceful whilst nonetheless tailoring service-user behaviour to be more “socially acceptable”. At no point do these speakers refer to more empowering models in care. In the following example, repertoires about ‘safety’ are invoked simultaneously with ‘duty of care’ to justify imposing limitations on choice.

### *3. Safety, Comparative Evaluations and Normalising Restricted Choice*

The majority of interviewees invoked repertoires about ‘safety’ to argue about choice. Many justified these arguments by performing ‘comparative evaluations’ to argue that restricted choice is part of being normal. Across the data, ‘comparative evaluations’ were often used e.g. to argue about how choices could be constrained by one’s daily routines. These discursive strategies resembled social psychological theorisation about social comparison processes (e.g. Festinger, 1954), and comparative evaluations (e.g. Mussweiler, 2003) and involved speaker claims that the restricted choices of people with learning disabilities were comparable to non-disabled individuals. However, as a discursive strategy here, this allowed them to normalise and justify constraints on service-user choice. In the following extract, the speaker (Irene) is asked what happens if a service-user who is on medication asks for alcohol. Here, she invokes repertoires of ‘safety’ and makes a ‘comparative evaluation’ to defend her practice of giving non-alcoholic wine.

Extract 4 Irene (Lines 344-377 from original transcript)

I erm probably get them some wine non-alcoholic wine, but it's still wine type thing.

R Ummhmm.

I You know but as long as they were enjoying it, that's all that matters.

R Yeah. Have you ever had a situation where you've had to intervene with client drinking?

I No

R No?

I No, (-) no.

R Erm in in your in your opinion how does giving the client an alternative like a non-alcoholic wine er have an effect on the choices they make?

I Why because you might be giving them a non-alcoholic wine and they think

R [and

I it's an alcoholic wine?

R Either that or just (-) the fact that they have to take an alternative.

I Erm yeah but then again you see it's a choice.

R Umm

I We offer the choice. You know erm professionally we would be (-) not very responsible if we were if somebody were to knock back erm four glasses of wine in you know you know and that wouldn't be good for them because of their medical condition and their epilepsy. Erm you would obviously er just like a pub isn't it? If someone had too much to drink you would find you know you're not gonna serve them are you?

R Umm

I So it's the same thing isn't it? (-) (Big) deal about it and just sensible with that. And that happens on site and outside, to you and me and to everybody so.

Irene explains that she substitutes wine with non-alcoholic wine for service-users on medication. Arguably, this immediately removes 'alcohol' from the array being offered, an action which powerfully defines the choices available. By drawing on repertoires about 'safety,' Irene's actions become justified. Nonetheless, notice the additional work put in, emphasising that what is offered still honours service-user choice. After repairing 'some

wine' to a more specific, 'non-alcoholic wine,' Irene stresses, 'but it's still wine type thing.' The vagueness of 'type thing' glosses her offering as the same as wine. Additionally, by stating, 'but as long as they were enjoying it, that's all that matters,' she defines what acceptably meets service-user wishes and closes off any room for challenge. Nonetheless, following a few turns, the interviewer orients to this substitution, asking 'how does giving the client an alternative like a non-alcoholic wine er have an effect on the choices they make?' Here, Irene addresses both issues of misleading service-users and making substitutions but verifies that it is this substitution that gives service-users choice, 'Erm yeah but then again you see it's a choice,' 'we offer the choice.' Because this is received with minimal agreement, she then invokes 'safety and care' repertoires, stating 'professionally we would be (-) not very responsible' to strongly justify intervening as someone responsible for the health of service-users

Irene also provides an extreme analogy of 'knock(ing) back four glasses of wine,' which if contrasted implicitly against sensible drinking, heightens the irresponsibility of professionals who permit this and constructs service-users as lacking capacity to exercise restraint with *real* alcohol. Also note Irene's reference to 'their epilepsy' here. Given epilepsy's associated safety implications, Irene's argument becomes increasingly persuasive. However, it is important to highlight that the participants in this study were asked to speak specifically about service-users with learning disabilities, not epilepsy and though some also have epilepsy, this was only a small minority. Nonetheless, Irene draws on and generalises this medical condition as an effective resource for making her argument unchallengeable.

Next, stating 'just like a pub isn't it?', Irene advances a 'comparative evaluation.' Drawing on this culturally familiar environment where drinking is legitimised, she argues that constraints on drinking can also happen here to non-institutionalised individuals. In this scenario, though the individual in question does not have learning disabilities, Irene makes



her comparison relevant by positioning the landlord or employee of the pub as having a ‘duty of care’ and thus the power to intervene. Using the pronoun ‘you’ to appeal to her audience’s own sense of responsibility, ‘you would find you know you’re not gonna serve them are you?’ she then restates the comparison using devices such as a rhetorical question (‘So it’s the same thing isn’t it?’), a contrast structure (‘that happens on site and outside’), and a three part list (Jefferson, 1990), (‘to you and me and to everybody so’).

‘Comparative evaluations’, therefore allows Irene to convincingly construct restrictions on service-user choice as unremarkable by arguing that we can all experience constrained choice. However, these arguments are built as unchallengeable by powerfully positioning those that offer choice as ‘responsible’ in some way, and, by implication (Benwell and Stokoe, 2010), those in receipt of care as irresponsible. It is also important to note that frameworks such as the MCA’s (2005) principle to assume an individual’s capacity never enters the register of arguments made here. When safety is on the agenda, presumptions favouring capacity as recommended by the MCA (2005) Code of Practice are discarded.

## **Discussion**

This analysis examined how support-workers positioned themselves within ‘duty of care’ repertoires, simultaneously invoked repertoires about ‘safety’ and ‘normalisation’ and used ‘comparative evaluations’ as discursive strategies when constructing arguments about facilitating the choices and control of service-users with learning disabilities. Repertoires about ‘duty of care’ and ‘safety’ provided speakers with powerful positions of granting or withholding choice, intervening as responsible carers and constructing service-users as lacking capacity. Repertoires resembling ‘normalisation’ justified practices of influencing and persuading service-users to make decisions that staff approved of. Speakers also invoked rhetorical devices e.g. disclaimers, show concessions and contrast structures, to position

themselves as facilitators of choice, respecting agendas to empower service-users whilst simultaneously intervening in choices. Additionally, strategies involving ‘comparative evaluations,’ allowed speakers to construct limited choice as unremarkable.

For people relying on specialist services to support their everyday needs, having choices even over mundane things presents a daily challenge. Importantly, in research evaluating care programmes such as ‘Active Support’ (which prioritises facilitating control over choices and activities), significant positive improvements have been found e.g. increased adaptive behaviours, decreased challenging behaviours and depression (Beadle-Brown et al, 2012; Stancliffe et al, 2010). However, implementation of such programmes has been slow (Mansell et al, 2002). Thus, service-users continue to be disempowered by having to comply and fit into existing services, routines and curricula, and even by health-care professionals seeking to act in their best interests (Thompson, 2003).

The MCA (2005) Code of Practice protects the interests of individuals who may lack capacity to make their own decisions by stating, in particular, that an individual’s capacity should be presumed unless established otherwise, and, that decisions made on behalf of those lacking capacity should be done in their ‘best interests.’ However, in this context, speakers rarely oriented to this obligation. Instead, they produced many examples where service-user wishes conflicted with what they considered to be safe or normatively acceptable. This supports findings that carers have incompatible responsibilities (see Finlay et al, 2008a), which are managed by regulating choice and justified by unmitigated constructions of service-users lacking capacity. Importantly, this also highlights that staff may be unaware of the recommendations in the MCA (2005) Code of Practice. Similar findings are reported in studies involving support-workers (Dunn et al, 2010) and even in highly trained professionals (Willner et al, 2011), raising a crucial need for there to be more training in issues of capacity and decision-making for individuals involved in supporting people with learning disabilities.

When not giving or withholding choice, support-workers were also observed using strategies to influence decisions. These were justified by invoking repertoires resembling normalisation (Wolfensberger, 1972), which constructed service-users as socially inappropriate with negative consequences for integrating into the community. Ostensibly, these are important concerns for staff, tasked with empowering service-users in care. However, there is a paradox here: by normalising choice and making service-users behave appropriately, we are forcing them to change for an unchanging society; a direct contradiction of the values espoused by the social model of disability (Oliver, 1996), which locates disability in society rather than the individual. Service-users were also often constructed within extreme cases in ways resembling ‘the deviant as an object of ridicule,’ (See Wolfensberger, 1972; p. 23). Staff rarely produced inconsequential examples of facilitating control and by describing people with learning disabilities as extremely ‘deviant’, they were constructed as gaining greatly from staff interventions to normalise choice. However, in situations where such individuals struggle to ‘fit in,’ these extreme analogies could be damaging for facilitating integration. Such concerns are not unfamiliar. For example, Ryan (2005) explained how mothers of children with learning disabilities often feel ‘pulled in two different directions, of wanting their children to ‘fit in’ but, at the same time, realising that mainstream life will not, or cannot, accommodate them’ (p.72). Worryingly, the speakers here favoured repertoires resembling normalisation (instead of more emancipatory models), a model now largely argued to leave little room for promoting tolerance, in their arguments about empowering people with learning disabilities.

In addition to these less empowering models, speakers were also observed advocating practices which involved some compromise and manipulation whilst continuing to position themselves as facilitators of choice. For instance, staff described moderating service-user choice but constructed this as only a partial accomplishment (see extract 3), thus appearing

less controlling. Another strategy, involved offering ‘bounded empowerment,’ whereby service-users were allowed to express individuality as long as it fell within the constraints of normality (see Jingree and Finlay’s, 2008 discussion of ‘bounded empowerment’ in support-worker talk about health and safety). Support-workers also described presenting service-users with ‘the consequences’ (see extract 2), where choices were never explicitly refused, yet practices encouraged decisions towards what *support-workers* perceived to be the ‘right’ choice. Thus speakers preserved their positions as facilitators of choice and worked hard to argue that first preferences were always considered. However, free and impartial choice was rarely granted. As Dowson (1997) argued, this level of empowerment would not satisfy the expectations of ordinary citizens. Relatedly, Simpson (1999) notes, ‘people with learning difficulties must demonstrate their competence prior to being granted autonomy. This is a direct inversion of the principle of social intervention which holds for the rest of us’ (p. 154) and a breach of the MCA for individuals with capacity.

Support-workers were also observed making ‘comparative evaluations’ to normalise restrictions on service-user choices and construct them as shared by all members of a common community. However, though the choices of ordinary citizens may be constrained by factors such as the influence of their friends and family, this is much more widely experienced by individuals with learning disabilities (Dowson, 1997). The risk of storying constrained choice as unremarkable must be realised here and that danger is that not only could we fail to see and act on the everyday disempowerment experienced by people with learning disabilities, we may deny its very existence.

Constructing ‘duty of care’ and ‘rights and choices’ as a binary is useful for staff attempting to push through other institutional agendas e.g. protecting service-users from harm, maximising safety, minimising social victimisation and easing integration by facilitating “socially acceptable” choices. Indeed, this provides speakers with the means by

which to present themselves as even-handed when proposing unpopular restrictions on choice. Simultaneously, it also allows speakers to present themselves as good, responsible representatives of services, an appealing attribute with consequences for a service's standing within assessment reports such as those provided by the Care Quality Commission. Indeed, within such guidelines, benchmarks for good quality care and safety are uncompromising (see Care Quality Commission, 2010) and fully backed by Government documents promoting empowerment, such as the Green Paper 'Independence, well-being and choice' (Department of Health, 2005), which stresses that 'social care retains a responsibility for the protection of individuals and we do not want to weaken the framework of protection that currently exists' (p. 28). Is it surprising then, that support-workers struggle to feely facilitate choice, when even Government papers present this as incongruous with achieving high standards of care and safety.

This paper hoped to assist support-workers to resolve practical dilemmas and establish ways in which to empower people with learning disabilities. From observations made here, it may be useful to alert support-workers of the tendency to minimise genuine restrictions on choice, adopt default constructions of service-users as lacking capacity, and also of producing extremely ridiculous, deviant examples about service-user decisions, which justify arguments about regulating their choices. Constructions about deviance, incapacity and incompetence are familiar (see e.g. Rapley, 2004; Ryan, 2005) and a pattern to be broken if we are to see progress with empowerment and integration. Moreover, it is worth recognising that 'duty of care' repertoires are powerful, not only in ensuring a good standard of care and defining a 'good' carer, but, paradoxically also in permitting interference with those in receipt of care. If support-workers adopting a 'duty of care' always position themselves as granting or withholding choice, they will always be in positions of power.

## Notes

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<sup>i</sup> 'People with learning disabilities' and 'people with learning difficulties' are the terms currently used in the UK. A similar population is referred to as 'people with intellectual disabilities' in Australia/New Zealand, and the USA. The term previously used in the UK was 'people with a mental handicap'.

<sup>ii</sup> In the 1970's, when introducing ideas about normalisation in the United States, Wolfensberger (1972) wrote extensively about what he called deviant role perception to describe the different ways in which people with disabilities were perceived. Deviance here referred to any departures from what was considered the norm. The 'deviant as an object of ridicule' was one of these roles, as was e.g. 'the deviant as holy innocent', 'diseased organism', and 'eternal child'.

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