

POINTS OF VIEW

The impact of ideology on provision of services for people with a learning disability

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This paper argues that policies based on ideology have influenced and constrained planning and tied the hands of those working in the field of learning disability. The origins of this ideology arose from a genuine desire to abandon outdated attitudes and approaches to service delivery, including the institutionalization of vulnerable people, and to restore to them the right to live in the community and benefit from the same range and quality of services that the general population expect. However, until researchers, service planners, and health and social care professionals in the field of learning disability can free themselves from ideological bias, services for people with a learning disability will continue to struggle. It is argued that managers should be given the freedom to introduce and/or commission tailored services that meet the individually assessed needs of each client.

KEYWORDS Ideology, Learning disability, Mainstreaming, Normalization, Social inclusion

Introduction

This paper seeks to show that the main stumbling block to the creation of effective services for people with a learning disability is the excessive and uncritical application of the principle of ‘normalization’. There is no question that the normalization principle has provided the right ‘direction of travel’. Closure of the old style disability institutions and the dropping of outdated approaches that amounted to domination, and in extreme cases, abuse, of people with a learning disability, were essential. The problems arose when the rules determining service provision became overly dogmatic and rigid, and prevented learning

disability service staff from delivering tailor-made services flexibly and cost-effectively and on the basis of common sense, logical and clear evidence of beneficial outcomes.

The crucial point that advocates of normalization miss but which earlier writers took pains to stress is that normalization is a philosophy and not a technology (Tizard, 1964; Nirje, 1969). It is a system of values and beliefs which should help guide, not dictate, thought and action. This necessitates a sensitive and pragmatic approach, not an inflexible and dogmatic one. Zigler *et al.* (1986) have made the point that empirical examination should replace polemics; not to do so is to risk engaging in a massive programme of social engineering.

Further, propagation of the normalization principle within a crusade is both dangerous and counterproductive, for it can foster professional intolerance, division and disaffection (Hansen, 1976), lead to the application of powerful and insidious pressures on professional staff to conform (Boucherat, 1987), devalue the worth of those who, for valid professional reasons, find ground for criticism (Mesibov, 1990), promote the growth of a propaganda industry which places a low value on objectivity and truth (Jackson, 1989), prompt the use of strategies and techniques which indoctrinate rather than teach (Renshaw, 1986), encourage poorly trained professional staff to believe that the application of a simple formula will resolve the complex problem of delivering effective and humane services (Tadd, 1992), and result in the creation of an inflexible service that is unresponsive and insensitive to the needs of people with learning disabilities (Rhoades and Browning, 1977).

Rapley and Baldwin (1995) have drawn attention to the fact that Wolfensberger increasingly cloaked the ideology of normalization in the language of science and, in so doing, allowed the adoption of an ideology under the guise of empirical science.

Normalisation is scientifically lacking and cannot therefore be considered empirically 'right', or even a best guess, but one among a number of competing service models. This is a necessary reason for questioning normalisation as an ongoing paradigm for the delivery of human services. (Rapley and Baldwin, 1995: 153–154)

Zigler and Hall (1986) cogently summed up the situation that existed in the USA over 25 years ago, which suggests that the kind of problems currently experienced in service provision in the UK have been known for some time.

Care must be taken that we do not adopt an all-or-nothing attitude towards normalisation. There will always be a need for the institution, and there are a number of eminent workers who have shown us that there can be habitable and humanised institutions. Unfortunately, many of the forces at work, such as that represented by the judicial system, depict the issues surrounding normalisation as win-lose, either-or choices, driving out the moderate middle ground position. Those who polarise the situation by promoting either normalisation or institutionalisation to the complete exclusion of the others do the situation and its complexity a grave disservice. (Zigler and Hall, 1986: 1)

There is an extensive literature which addresses the impact of ideology on learning disability service policy, provision, and practice. Much of it refers to the wholesale closure of institutions in the absence of suitable community provision. The most poignant is written by aging parents of adults with a severe or profound learning disability, many of whom have formed pressure groups aimed at supporting families who wish for communal residential facilities for their children and who fear for their future after they are gone (Jackson, 1996). Many of these parents believe that their child is safer and happier in a communal setting and have come to resent the lack of consideration to their views as stakeholders who believe they know their children best.

This reliance on ideology rather than on an evidence base has also been formally articulated by health staff in the published literature, although perhaps less frequently. A senior clinical medical officer for learning disabilities in Salford has observed.

Over the last 20 years, patients formerly resident in the old disability mental handicap hospitals have been gradually decanted into the community and the national policy is now one of care in the community. The changes in patterns of care have been based on ideology rather than on pilot studies with proven outcomes. (Jolly and Jamieson, 1999: 29)

Gates and Atherton (2001) have argued that in examining the field of learning disability, it is necessary to look at the ideologies and beliefs to which people subscribe. They argue that evidence continues to be published that demonstrates that the health needs of people with a learning disability are not being met as a result of the excessive influence of these ideologies and beliefs.

The negative impact of political correctness in shaping policy in the field of learning disability was a key stimulus for the development by Heinz Klatt of a graduate course on the subject at the University of Western Ontario (Klatt, 2000). Klatt defined political correctness as: 'a canon of orthodoxies and prohibitions and as a set of claims that society today does not readily allow to be questioned'. He observed that psychology was replete with such dogmas that were based on ideology rather than empirical research. Put another way, political correctness occurs where any policy (e.g. mainstreaming) comes to be seen by those directly affected by it, as an imposed, unchallenged and unchallengeable orthodoxy. Psychiatrists in the learning disability field have also expressed concerns about the impact of political correctness on their way of working. This was made clear at a conference of the Royal College of Psychiatry's Faculty of Learning Disability, where the house proposed that 'Political correctness is laying waste to learning disability services' (Royal College of Psychiatrists, 2007).

Service Redesign: The Single Tenancy

Service redesign in the field of learning disability appears to have been particularly influenced by ideology rather than logical or an evidence base. The application of the principle of normalization is at the heart of many of the current problems and has given rise to a number of policy edicts, many of which have proved unhelpful to the process of planning effective health and social services to people with a

learning disability. For example, the summary to the Scottish policy document *The Same as You?* (Scottish Executive, 2000) makes clear that single tenancies in the community should be the preferred option, on the grounds that people with learning disability ‘want to have their own homes in the community’. Nowhere in the policy document itself is this preference clearly articulated and nowhere is there any suggestion that there should be an examination of the full range of provision ranging from single tenancy through to different forms of congregate care (Scottish Executive, 2000). A recent report on supported living by the National Developmental Team for Inclusion has stated that an analysis of the 5-year Supporting People strategies suggests that administering authorities intend in future to focus on the development of services which offer individual tenancies to people with learning disabilities (NDTi, 2010: 11). Yet in 2009, 84% of Scots lived with someone else, either as a dependent, a partner, a relative, friend or a spouse (General Register Office for Scotland, 2011). The clear support for single tenancies has coincided with the downplaying of the value of intentional communities, despite the fact that these were clearly validated by the research conducted by the Hester Adrian Research Centre on behalf of the Department of Health (Emerson *et al.*, 1999). In fact, the national policy makes no mention of either villages for people with learning disabilities or the evidence of beneficial outcomes associated with such villages, as if they do not exist and there is nothing to be learned from them.

Despite having a single tenancy in the community, an undetermined number of people with a learning disability are more socially isolated than they had been when they lived with their family or lived in a long-stay institution, because they do not have regular contact with anyone other than their paid carer (Shaw *et al.*, 2011). The willingness and ability of the local neighbourhood to accept people with a learning disability who are living in their own tenancies is often patchy and disappointing. The end result is that such individuals are often cut off from other people with a learning disability, seeing very few people with no learning disabilities other than those who are employed to look after them or who are commissioned to interact with them (e.g. buddy system). The opportunity for choosing friends and developing preferred social relationships is thus very limited.

Chappell (1992) makes the point that normalization literature can at times reinforce the notion that people with a learning disability are deviant. Attention is drawn to the argument advanced by Atkinson (1983) that friendships between people with and without a learning disability are preferable to friendships between people with a learning disability. Chappell comments that this position is reminiscent of race relations sociology of the 1950s and 1960s with its emphasis on assimilation, integration and ‘sameness’. Chappell points out that relationships between people with a disability may actually be a source of great pleasure and an opportunity to share experiences. The suggestion that friendships between people with a learning disability are less desirable compared to those between disabled and non-disabled people assumes a stigma attaches to the individual with a disability which can only be masked if they associate with non-disabled people.

What is often overlooked in single tenancy living arrangements for people with learning disabilities is the stress experienced by the carer who may have to do

12- or 24-hour stints working in a one-on-one relationship with the client, often without supervision. This arrangement is difficult to regulate, because of the large number of physical sites where care is offered. Single tenancies can offer high risks for both the client and their carer, because of the nature of the working environment. And it is expensive for the commissioning agencies (social work departments) to provide, because of the loss of economies of scale and scope. This was demonstrated when social work budgets for packages of care for people with learning disabilities dried up in a number of Scottish councils which had been focused on providing single tenancies.

The case for providing single tenancies for people with a learning disability also cannot be judged without reference to the social and geographical context within which the tenancies are set. Whether or not an individual with a learning disability can cope with the demands of living independently in a single tenancy will depend in large measure on local community acceptance and freedom from victimization (Jackson, 2011). In a recent survey by Turning Point, a leading health and social care provider, it was found that more than half of those surveyed believed that people with a learning disability were the most discriminated against group in society (Williams, 2010a). Growing public concern at the vulnerability of disabled people, in particular their greater risk of experiencing violence or hostility than the wider population, led the Equality and Human Rights Commission recently to examine the issue (Sale and Mickel, 2009; Walker, 2009; Williams, 2010b). The findings were subsequently published in the report *Promoting the Safety and Security of Disabled People* (EHRC, 2009). The Commission recommended, among other things, investment in and evaluation of innovative approaches to independent advocacy to ensure that the most marginalized disabled people have a voice and the confidence to challenge negative behaviours and to seek protection and redress. This recommendation ignores the fact that almost all advocacy programmes in the UK are funded by health and social services and, therefore by definition, are not independent (Gray and Jackson, 2002; Jackson, 2005a).

The Commission also recommended that policies relating to care and support should be reformed and that the role of social housing associations in creating and minimizing the risks of people with a disability be examined. However, what the Commission could not do was challenge the normalization agenda upon which programmes of community inclusion, including single tenancy provision, are based. As Zigler and Hall (1986) have observed, judicial bodies — and presumably that includes quasi-judicial bodies like the Equalities and Human Rights Commission — are not going to weaken in any way their commitment to the principle of normalization which includes the right of people with a learning disability to be integrated into mainstream society. Accepting that some people with a learning disability may prefer a placement within a congregate care living arrangement rather than a single tenancy is likely to be seen as diluting that principle. Zigler and Hall (1986) have made clear that judicial bodies rarely hold a middle ground position on the matter of rights as any dilution of a principle is interpreted either as a denial or a betrayal of some particular right.

Models of Care

One can also discern an ideological preference for what might be termed the ‘social model’ as opposed to the ‘biomedical model’. That bias appears to filter through to the teaching of nurses and social workers in academic settings. The WHO made clear the need to use both the social and medical model as long ago as 2001 when it published its International Classification of Functioning, Disabilities and Health (ICF) (WHO, 2001) and related guidelines on the need for a common language (WHO, 2002). The WHO ICF Common Language advocates a ‘better model of disability, one that synthesizes what is true in the medical and social models, without making the mistake each makes in reducing the whole, complex notion of disability to one of its aspects’. This more useful model of disability is termed the biopsychosocial model — an integration of medical and social.

In an article seeking to decode *Valuing People* (Department of Health, 2001), it is observed that social inclusion is used to ‘apply a romanticism about learning disabled people so that significant impairments ... are not so much denied as glossed over, making the real difficulties in providing supports to enable inclusion, autonomy, good health, meaningful activity, and acceptance appear insignificant, and thereby not requiring substantial additional investment’ (Aylott, 2001). The same article points out that: ‘if inclusion is to happen, there needs to be a realistic assessment both of the level and types of supports that are required ... failure to do this risks cynicism and a return to negative expectations’. In short, one risks compromising the social goals if one subordinates the health goals.

Respect for rights/choices of people with a learning disability may also take precedence over providing duty of care. When there is an excessive promotion of the normalization agenda, which is in part defined by the aim to respect the client’s choice in all things, there is a risk that duty of care is neglected when healthcare professionals are expected to witness unhealthy choices and behaviour and ‘let it go’. Evidence was presented at a recent national conference and described in a published report commissioned by the Scottish Government and Capability Scotland (Hogg, 2009). In the report it was suggested that there might be a tendency for social workers to have a higher threshold prior to intervention in possible or suspected cases of abuse of people with a learning disability, than healthcare workers, where cases of abuse are audited as part of the follow-up studies resulting from the introduction of the Adult Support and Protection Act (Scotland) 2007 (Scottish Government, 2007).

A further concern is the popularizing of ambiguous and conflict-generating slogans such as that people with a learning disability are ‘the same as you’, when manifestly they are not. While it is true that people with a learning disability have many of the same needs and desires as the general population and should be offered rights alongside their non-disabled peers, they can be more vulnerable and may need a degree of protection. Frequently, they need an advocate who genuinely has their interests at heart (Gray and Jackson, 2002) and moves by the Scottish Government to ensure that health boards and local authorities have strategies in place to ensure adequate advocacy is available to people with learning disability is testimony to the fact that government is aware of that need, one shared by other vulnerable groups such as the mentally ill or the frail or the elderly with dementia.

People with a learning disability often require more time for appointments, and often need services from a range of professionals who have specialized knowledge of learning disabilities: therefore they are not the same as the wider population. At the most dependent end of the spectrum; some need almost continuous care and support. Perhaps emphasizing the ‘sameness’ of people with learning disabilities has been used to mainstream their health, education and social services, when there is a clear need for specialist services for people with learning disabilities as argued below.

Mainstreaming

It is relevant to examine the application of the normalization principle to the field of education, where Lindsay (2007) has concluded that the available evidence does not provide a clear endorsement for the positive effects of inclusion. The assumption that mainstreaming is best for all children (those with a learning disability and those without) has also been accompanied in Lindsay’s view by the loss of the ability to study the cause and nature of negative attitudes to disability with a view to combating discrimination at source. Instead, there has been an assumption that inclusion of young people with a learning disability in mainstream schools will cure society of prejudiced and discriminatory attitudes.

A study recently conducted by the Foundation for People with Learning Disabilities, which sought the opinions of students with special needs included in mainstream settings, highlighted a number of serious concerns — the most important of which was a plea by students to be allocated designated safe places in their schools and colleges where they could escape the social rejection, intimidation, and bullying experienced when not attending classes (FPLD, 2008). MacIntyre (2008) has also drawn attention to the predicament of young people with a learning disability who were being marginalized socially and excluded in mainstream schools and colleges. These two studies demonstrate that it is important to avoid conveying a unidimensional representation of the inclusion process and move beyond ideological and bureaucratic inspired definitions of social inclusion to one that is meaningful and relevant to students with special needs.

It is particularly instructive to look at the experience of Italy which is frequently held up as one country where one can find a successful model of inclusion in practice. The policy of inclusion was introduced by the Italian government in 1971, so one has 40 years to assess its efficacy. What do the findings of recent research reveal? Bertoli *et al.* (2011) examined the experience of a cohort of individuals with Down syndrome, aged between 30 and 35 years. The cohort was drawn from possibly one of the first groups to have been raised in a fully integrated school system. After secondary school, the researchers found that this cohort faced a sudden abandonment as there were few support services for adult people with Down syndrome and their families in Rome. Their free time involved little activity — a fact that the researchers acknowledged could adversely affect mental functioning, as well as their overall sense of well-being. Participation in employment, including sheltered work, was limited. Even when allowance was made for the number of people employed in educational activities (e.g. day centres), two-thirds of adults with Down syndrome had ‘full days of empty time’.

Bertoli *et al.* (2011) commented that the lack of employment opportunities was likely to contribute to a loss of acquired skills. In their opinion what was needed was a policy of work inclusion for all, on a daily basis. While it was acknowledged that some people with Down syndrome could enter the open market, most adults urgently required opportunities for daily employment in day centres or sheltered workshops. It was believed that such inclusion would contribute to improved social interaction, increased autonomy, better health checks and relief for families whose quality of life would be considerably enhanced.

Bertoli *et al.* (2011) commented that the media tends to focus on people with Down syndrome who are coping well. While this could be seen as encouraging, it also contributes to the marginalization of the majority of people living with Down syndrome who face enormous challenges. What is required is a change in public opinion and popular culture to make all citizens visible, including those with Down syndrome. Support services have to be adapted to the changing needs of people with Down syndrome which require staff to be properly trained (Jokinen and Brown in Kober, 2011). The concluding observation of Bertoli *et al.* (2011) is worth highlighting. They make the point that an inclusive school system alone does not in itself guarantee a satisfactory quality of life for people with Down syndrome in adulthood. What is needed is a comprehensive policy of inclusion and support which should extend over the entire lifetime of people with Down syndrome.

Research undertaken by Reversi *et al.* (2007) has indicated that students with special needs in Italy continue to show a higher sense of social isolation compared to their peers without special needs. Given that a sense of isolation arises from feeling that one has few or no friends, it raises questions as to the actual degree of acceptance and inclusion experienced by children with special needs in mainstream settings. Sidoli (2008) has highlighted the critical importance of professional development to enable special education and class teachers to implement the policy of inclusion in Italian schools. She notes that class teachers often find it hard to work with the special education teacher as the assumption is made that it is the function of the special education teacher to work on her own with the child with a disability whether in or outside the classroom. Ianes (2006), too, has acknowledged that too much is asked of the special education teacher whose work, if performed in isolation, is often ineffective as many of them lack a specific training and are managed inadequately by both school and local authorities. Further Italian research indicates that only a small group of pupils with a disability experience full inclusion according to their parents (51% in vocational training, 46% in kindergarten, 30% in primary school, 25% in secondary junior, and 44% in secondary high school) (D'Alonzo and Ianes, 2007).

As D'Alessio (2011) points out, despite economic and cultural barriers, the process of integrating disabled pupils into ordinary classes has tended to be considered a 'natural phenomenon' in the Italian education system. However, it has been argued, such 'naturalness' represents a double-edged sword. While it has promoted the placement of pupils with disabilities in ordinary schools by opposing segregationist forces, it also has prevented the conduct of any large-scale 'scientific' study of this policy. Some commentators (Abbring and Meijer, 1994;

Mittler, 2000) claim that Italy has implemented *inserimento selvaggio* ('wild' integration — placing disabled pupils in common settings without changing the conditions in which their education took place) and has not provided any satisfactory empirical evidence that has shown how disabled students' achievements improve, once they are educated in integrated settings.

What research evidence exists strongly suggests that we should be cautious before accepting the view that the Italian school system presents a model of inclusive practice. The question arises as to why the Italian government introduced the policy of inclusion. Was there an expectation that it would contribute to the creation of a more inclusive society or was it simply because it offered a cheaper option? There is no compelling evidence that in the 40 years since the introduction of this policy in 1971 that the message of inclusion has gone beyond the schoolroom.

Ten years after the Italian government introduced mainstreaming into its school system, the Westminster Parliament passed the 1981 Education Act which shifted the emphasis on special educational provision away from special schools to ordinary schools. This change is usually attributed to recommendations made by the Committee of Enquiry which was set up to look at the education of handicapped children and young people (Her Majesty's Stationery Office, 1978). The Committee was chaired by Mary Warnock. What is rarely appreciated is the fact that the Warnock Committee was forced to accept the case for integration well before the Report was published. It was a last minute unexpected and unwelcome incorporation of a clause in the 1976 Education Bill (Clause 10) that changed the emphasis of education for handicapped children and young people from special to ordinary schools. The introduction of this clause caused a tidal wave of protest not only from most professional bodies, but also from Mary Warnock herself (Jackson, 2005). She was particularly dismayed that a decision had been prematurely taken, while the Committee was still in the process of taking 'evidence'.

There is a certain irony in the fact that when giving the 2005 annual lecture to the General Teaching Council for Scotland, Mary Warnock stated: 'no serious suggestions for reform can be made without proper research and a proper reliance on evidence'. It is ironic because the Committee of Enquiry that she chaired sponsored no major research! In that respect, it differed significantly from previous committees commissioned to examine some important aspect of the British educational system: Plowden Report on primary education (Central Advisory Council for Education, 1967), Newsom Report on secondary education (Central Advisory Council for Education, 1963), and the Robbins Report on higher education (Committee on Higher Education, 1963).

What is now clear is that Clause 10 had been introduced as a result of pressure applied by a powerful and readily identifiable lobby which represented the interests of a minority within the 'handicapped' population (those who were intellectually able but who possessed a physical disability). The tactics employed by this lobby succeeded in outmanoeuvring the Government, the Department of Education and most professional organizations. It was a pre-emptive strike taken, because it was feared by this group that the Committee of Enquiry might, at the end of its deliberations, not support a policy of integration (Jackson, 2005b).

It is worth noting that the Department for Education (England) has recently published a Green Paper on special educational needs which states the Government's aim to reduce the number of children labelled as having special educational needs and to abandon the presumption of a mainstream placement for children with special educational needs (Department for Education, 2011). This change in position was almost certainly influenced by the recommendations of the Second Report of the Commission on Special Education Needs. The Commission was set up by David Cameron and its Report published in 2007. The Report is quite unambiguous in its position.

The Commission is clear in its view that Inclusion has come to be, in the last decade, an ideology which has spectacularly failed a generation of special needs children and put spurious conceptions of equality before the needs of individuals. (Balchin, 2007)

However, since settling into office the position of the Conservative Party, as a Coalition partner, has softened on the policy on inclusion. The Minister for Education, Michael Gove, has promised to 'end the legal bias' towards sending children with special educational needs to mainstream schools and to end the closure of special schools.

Workforce Polarization

A further concern is the evidence of an ideological polarization among the learning disability workforce. A small interview-based study of 21 learning disability social work services staff in Glasgow published in 2002 described the tension and conflict between members of staff consequent upon the issuing of a series of directives from social work headquarters (Deeley, 2002). Following the closure of Lennox Castle (Learning Disability) Hospital in 2002, a clear division arose between those who had been formerly employed at Lennox Castle, the so-called 'paternalists', and the more recently employed staff who had officially adopted the new prevailing orthodoxy of normalization, the so-called 'normalizers'. Although the overall reporting of their perceptions in this study makes it tempting to side with the 'normalizers', the fact is that the 'paternalists' made a number of very valid points. Further, even the 'normalizers' ended up contradicting the normalization orthodoxy both in their expressed statements and in their behaviour toward the clients in their care, regularly reverting to paternalism on the grounds that it was 'in the clients' interest', or because it was more convenient or less costly to do so. The 'normalizers' also conceded that the aims and methods used to promote normalization had not been completely worked out and that the resources required to support a functioning normalization agenda were absent, including: (1) the provision of a sufficiently wide range of necessary support services; (2) adequate training and education facilities for clients; and (3) tailored support to assist clients living in single tenancies. The author concluded that effective communication of the aims and objectives within caring practice was essential for all professionals and that the key to harmonious working practice would be the creation of a shared ideology which acknowledged professional differences but which permitted the pursuit of consistent and achievable goals.

Commissioning Out-of-House

The imposition of the normalization orthodoxy has been accompanied by a further apparently unrelated ideological imperative that arose, in part, out of the application of market principles. This additional ideological imperative is the notion that by contracting services out of house, as opposed to directly providing such services, the state can drive up the quality and increase the choice, while driving down the price it would have to pay to procure services as a result of increased competition. This has necessitated purchasing the services from either the voluntary or private sector. This has proved very expensive overall despite the modest wages paid to support workers by both these sectors. It follows that commissioning agencies may be limited by what is available to purchase from these sectors in the way of local services. Furthermore, it means that groups of staff who would normally be expected to have trained in social work departments as direct providers and managers of services are expected to be very adept at a quite different set of skills, namely purchasing services when they become ‘commissioning officers’. There is evidence from the UK public sector’s experience of Private Finance Initiatives (PFI) to suggest that the cost and complexity of setting up and managing PFI projects has been underestimated by councils and health boards who lack the staff who are sufficiently skilled in this regard (HM Treasury 2003; Pollock, 2004; Craig and Brooks 2006; Robinson and Scott, 2009). Contracts of one-sided financial benefit characterized by high unitary fees have resulted and PFI and its successors have fallen out of favour.

In order to achieve some economy of scale for their provider organizations, from which they hope to share the financial benefits in contractual terms, and to simplify the regulation of the services they are purchasing, some commissioning agencies have reduced the number of provider organizations from which they are prepared to commission services to five or fewer providers (e.g. Reserved Supplier Lists). This can be expected to limit the range of services that are available to people with a learning disability, when in fact what is needed is the ability to flexibly provide any combination of service on the basis of person-centred planning. What evidence is there that the commission and competition paradigm has driven up quality and choice?

Whether one should provide in-house or outsourced services and whether outsourcing should be from the private or voluntary sector should be determined by the quality of that service and not by ideological considerations. There are examples of high quality and cost-effective services on offer in both the private and voluntary sector which vindicates the move to promote outsourcing of contracts. However, there are some services that are needed for a minority of people with a learning disability that are not readily available locally or of sufficient quality or at a suitable price. The logical conclusion is that there are some services that are better provided directly by the state including those where there is little profit margin (therefore not attractive to the private sector) and where there is a need for expensive and specialized health staff (e.g. for people with a learning disability presenting extreme challenging behaviour) (BMA, 2009). Ideological opposition to the direct provision of long-stay beds for a minority of people with a learning disability who will never be suitable for placement in the community is not helpful.

Financial Considerations

Finally, a further concern relates to financial incentives that appear to promote or pursue non-evidence based policies that are deemed 'right', thereby further consolidating ideologically driven decision-making. One example is the widely presumed greater ease of access to financial streams such as housing benefit and independent living allowance when a single tenancy is pursued for the client, funding streams that may not be available to clients seeking group settings or intentional communities for people with a learning disability. Local and health authorities will naturally be under pressure to favour policies that enable them to draw upon additional resources, outwith their own budgets.

Conclusion

Kavale and Forness (1998) have described what happens when political, ideological and philosophical considerations count for more than the logical, objective, and rational study required to scientifically underpin a sound understanding of any condition. This should be a prerequisite to the development of any service designed to respond to the needs of people with a learning disability. The fear is that for some people with a learning disability, we may have replaced one oppressive living arrangement, that of the institution where highly structured, repressive and closed regimes ensured that opportunities for people to be accorded dignity and to function independently were minimal or non-existent, with another arrangement which locates people with a learning disability in the middle of densely populated urban areas, where unskilled, under-resourced and stressed paid staff are the only people the client ever interacts with and where it is not safe for the client to venture out unaccompanied.

Responses to every condition, including a learning disability, require a balance between scientific insights and an appreciation of real-world contingencies. In the UK, there is considerable evidence to suggest that learning disability service provision has been made unnecessarily more difficult, complicated and expensive to deliver because of the intrusion of ideological factors. Service planners and managers need to remain aware of the inherent danger in becoming wedded in an inflexible way to any particular ideology, and applying it across the board, when the needs of people with a learning disability are so varied. They would also be wise to accept what staff at the 'coal-face' have long concluded, namely, that uncritical adherence to the ideology of normalization, in particular the priority given to providing single tenancies, can tax the service financially and potentially put the most vulnerable clients at risk. Policy shapers and makers would do well to review all of the consequences of implementing normalization policies to which reference has been made in this paper and address them accordingly, only by so doing can learning disability services realign and rally their workforces, survive the current financial crisis and have a real chance of meeting the needs of people with a learning disability.

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