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Choices for people with an intellectual impairment: official discourse and everyday practice

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Choices for people with an intellectual impairment: official discourse and everyday practice
Abstract

Official policy talk of "choice" for people with intellectual impairments tends towards fundamental life-choices (e.g. who to marry, what job to work at) at the expense of the minor but more frequent concerns of daily living (when to wash, what to eat, where to go in the evening). Statutes and Mission Statements are unspecific about how any such choices, big or small, are, or should be, offered. It is also silent on the relation of choices to institutional imperatives. To redress the balance, we report on five everyday varieties of choices in a (British) residential home. The data come from an ethnographic study of residential services for people with intellectual impairment, located within a National Health Service Trust in the South of England. Over the course of nine months, a researcher (one of the authors, C.W.) engaged with residents and staff in two residences in the geographical boundaries of this Trust. He took ethnographic field notes of everyday interactions, and made video and audio recordings. Conversation Analysis was used to explicate the interactions. It showed how staff, although undoubtedly well-meaning, can use the discourse of choice to promote institutional managerial objectives, and we discuss the gap between such practice and overarching policy theory and recommendation.
Choices for people with an intellectual impairment: official discourse and everyday practice

Introduction
In the United Kingdom there is a strong governmental steer towards providing people who have intellectual impairments (also termed "learning disabilities", and, in the United States, "mentally retardation") with more choice in, and control over, their lives. Some seven years ago the UK Department of Health (2001) issued Valuing People, a now much-cited manifesto which called explicitly for people with such impairments to be given more say in what they did. That call has now been enshrined in statute, in the UK's Mental Capacity Act of 2005, and the talk of choice and control has echoed down through regional health authorities to local service-providers, and indeed to individual units such as care homes. "Choice" and "personal control" are now pervasive aspirations of mission statements at all official levels. Two questions present themselves: what sorts of choices are envisaged in the official documents, and what does everyday choice look like in actual practice?

"Choice" in official documents
"Choice", as a word, is amply represented in such influential documents as the UK Department of Health's Independence, Well-being and Choice (53 times in 85 pages of text) and the Foundation for People with Learning Disabilities' Communicating Choice with People who have Learning Disabilities and High Support Needs (22 times in 4 pages). Yet, to our knowledge, "choice", as a concept, is nowhere defined in these or in the broad wash of similar policy documents. Perhaps this should not surprise us. Choice here is, after all, a members' notion (in the ethnomethodological sense of a notion familiar to members of a culture, for whom its use in context is more pressing than its philosophical subtleties). Public agencies' concern is not with theoretical reflection, but rather an appeal to the hopes (and fears) of users, their families and their carers.

What is wanted in such documents as the ones cited above is the appeal to a familiar idea, and that is what they deliver. The ordinary sense of "choice" is so robust that no reader will be in any doubt that the agencies involved see that people with ID lack, or are being denied, an important component of human dignity, and should be given
more of it. Official agencies, no less that the ordinary reader, would endorse the view that people with ID ought to be given a say in leading a fuller and freer life.

Were we to push up closer to see the subtler meanings implied in the use of the term "choice" in this discourse, we would quickly see that the broad outlines reveal no fine detail. Two things prompt reflection. One is that the kinds of events or experiences being discussed are what sociologists call "cover-sheet" facts: address, marital status, job description, and so on. Thus: "People with learning disabilities are amongst the most vulnerable and socially excluded in our society. Very few have jobs, live in their own homes or have choice over who cares for them" (Valuing People, p 2), or "Like other people, people with learning disabilities want a real say in where they live, what work they should do and who looks after them." (ibid, p 31). These are manifestly not the kind of lower-denomination events that are the common currency of everyday life (when to go to the toilet, who to sit next to, where to go in the evening).

The other absence we may note is of any attention, in these documents, to what "being given a choice" might mean in actual practice. Without any such consideration, the reader probably unconsciously has the image of a question-and-answer exchange, judiciously administered, in which responsible carers sensitively tease out what the person with ID wants to do, in their own terms and without constraint. But this is likely to be an unrealistic image. Without guidance about how such choice (or any other) is to be exercised, the complexity that lies just behind each large phrase ("choose a job", "choose a partner", "choose where to live") will preclude any easy plan for change. Here is where the unconscious default image implied in public discourse is unhelpful: no one can be granted meaningful choice, in a one-off question and answer exchange, over their living arrangements; nor, a fortiori, what job to work at or who to marry.

In parallel with the absence of policy on how such choices might be offered in theory, there is, so far as we know, no research into how it is done in practice. Our intention in is paper is to redress the balance by a close look at just how everyday choices are offered to people with ID in the daily round of living in their homes.
The data come from an ethnographic study of residential services for people with intellectual impairment, located within a National Health Service Trust in the South of England. Such Trusts are the main providers of state-supported services in Great Britain; they are semi-autonomous regional organisations that dispense health services through a constellation of directly-funded and out-sourced facilities. Trusts are centrally funded from the Department of Health, and are accountable for maintaining deficit-free budgets.

Over the course of nine months, a researcher (one of the authors, C.W.) engaged with residents and staff in two residences in the geographical boundaries of this Trust. He made ethnographic field notes of everyday interactions, and made video and audio recordings. The video recordings provided the data analysed in this article. They comprised a total of some 20 hours of everyday episodes, shot in the public areas of the residences (that is, the dining room; the living room; the kitchen; the linking corridors; and the garden) and, when on excursion, the mini-bus and the picnic area of a public park. Permission to record and publish data was granted by all participants who appear in these extracts. All names of speakers, and of individuals, agencies and places mentioned, have been changed.

Participants
Five men with intellectual disabilities, aged between 43 and 65 years, who we have called "Dominic" (shortened to "Dom" in transcripts, when a shorter version of his name is used in talk), "Alec", "Henry", "Victor" and "Oliver", live in the home in question. Through the day, two members of staff per shift support them. Each of these men has been in receipt of residential care services for at least 30 years. In all cases the residents’ files say only that each is diagnosed as having ‘Learning Disabilities’ (this label has the same meaning in the UK as ‘intellectual disabilities’ and ‘mental retardation’ in other countries); in Dominic’s case the file says that he is diagnosed as having ‘Learning Disabilities and Down’s Syndrome’. All the residents require some level of support from members of staff to engage in activities ranging from intimate care, to cooking, to accessing services and resources in the community. They also require support to communicate with people outside the home (e.g. when shopping). No other, more detailed, clinical information, for example measures of the verbal or cognitive abilities of the residents, was recorded on the files available to the
researchers, nor was there evidence that staff were aware of, or made reference to, any other such official information, if it existed.

Although all the men can communicate verbally, they have a range of difficulties which place obstacles in the way of easy verbal interaction: Alec’s speech is idiosyncratic, with many utterances being formulated as questions; Victor is capable of using full sentences, but his speech is very quiet, often being inaudible to others, and as a result he makes extensive use of non-verbal behaviours such as facial expressions and gestures; Henry tends to wait for others to initiate vocal interactions, affording him the possibility of responding in limited terms, often just echoing the appropriate word or short phrase necessary to communicate (dis)agreement, or pointing to objects; Dominic’s speech is indistinct and as a result he makes regular use of signs, many of which are idiosyncratic and require a familiar audience; Oliver is capable of using full sentences but he tends to use short phrases or single words. The men were supported by a shifting series of non-resident staff, among whom we shall see, in the extracts presented here, "Dave", "Kath" and "Brenda".

The other residence we studied was home to 10 adults, aged between 34 and 53 years. It had a staffing level of 4 members of staff per shift. The residents of this home all experienced more significant communication difficulties than those in the home referred to above, and relied on staff for still closer support for intimate care on a day-to-day basis. We select one episode to analyse (in Extract 3), in which we pseudonymise the resident as "Steven" and the Staff members as "Sandy" and "Jill". Note that support staff receive general care and health and safety training, and may seek extra training that leads to social work qualifications. So far as we understand, however, explicit tutoring in offering choices to residents does not feature as part of staff training.

Framework for the qualitative analysis
In what follows we shall present speech extracts in some detail, cleaving to the principle, established in certain forms of discourse analysis, that the details and exact organisation of talk are crucial for its understanding. Conversation Analysis (for a review of which, see Hutchby and Wooffitt, 1998, ten Have, 1999) provides the general principle of analysing the details of the exchanges between residents and staff
as they play out in real time. Conversation Analysis' strength is in seeing how one utterance projects a certain kind of next utterance; how its internal design achieves a certain social action; how an utterance can be marked as expected or unexpected, sufficient or insufficient, tentative or final, and so on. To this can be added CA's sensitivity to the sequence of talk as the interaction unfolds, which gives it an advantage (as many have argued) over systems of content-analysis which seek to identify given taxonomies of speech-types (open v. closed question, and so on).

Analysis
The video recordings of everyday life in the two residences yielded no examples of high-level discourse of choice in life-style, emotional attachment, or paid employment. There is nothing remarkable in that: such choices, if they do happen, are presumably reserved for set-piece occasions. But we did see useful evidence of what choices were offered to residents - and how those choices related to institutional imperatives. We shall report on five varieties of choice-offering that we saw:

(A) choice about matters important to the institution;
(B) choice as a format for a running commentary
(C) choice as reactive to misfires;
(D) choice as a format for refusing an expressed preference; and
(E) choice about abstract, unfamiliar or underspecified alternatives.

This article is not meant to be a survey of all that happens in residences, nor a statistical comparison among staff, residences or residents. That is beyond the remit of this article. What we offer is a close explication of how choices are offered, in the close design of talk, and how the staff members' different ways of offering choices have different implications.

In reporting the exchange between interactants, standard Conversation Analysis notation has been simplified for the sake of greater legibility. Nevertheless, two important conventions need explaining. The first, and probably the most disruptive to easy reading, is the use of square brackets to indicate, in adjacent lines, that two speakers are overlapping each other. This is a significant departure from the norms of speech that we felt imprudent to leave unmarked. A second feature which the reader will encounter is the use of brackets timings (e.g. "(2.0)" or ".8)", or merely "(.)"
when it is just-noticeable) to indicate the length of pauses or silences; again, this is a significant feature of actual talk that would be misleading to leave out. A glossary of the notation is appended at the end of this article.

A. Choice about matters important to the running of the institution

It is striking that what is offered for a choice may be something that mattered to the staff, but might not have occurred to the individual as wanting consideration at the time (or indeed, at all). Consider this episode, right at the start of a house meeting ("Dave" is a staff member; the others are adult residents. Here, as in all the extracts, all names are pseudonyms, and any identifying details have been changed).

The choice being offered to Victor, Henry, Dom, Alec and Oliver, in turn, is whether they want to go to the toilet now, during what Dave, the staff member, calls a "pit stop" in line 1. The matter is not formatted as a request or an order, but as a choice; Dave repeatedly uses the formulation "do you want to...." which is one of the commonest formats for choices in this residential home. The alternatives to going to the toilet right now are not mentioned, but implicitly they are either not going at all during the meeting, or risking inconvenience and disruption by asking to leave once the meeting has begun.

A case could be made for seeing this as an empowering choice - one could say that by reminding residents about what might become a pressing need (and perhaps one they are known to monitor unreliably, although there is no evidence of this in the ethnographic notes) and getting it out of the way, it clears them to attend to more important matters in the house meeting.

On the other hand, it would be all but inconceivable to offer this choice to 'normal' adults, or to children above a certain age. At the very least, Dave’s offering of this ‘choice’ implies that the residents are unlikely to consider their immediate or imminent need for the toilet and to pre-emptively visit the toilet so as to avoid disrupting the running of the meeting. We don't blame the staff member; he is mandated to run the meeting, and it will go more effectively if it proceeds without the
disruption of individuals leaving to go to the toilet, as and when their needs occur to them, and with everyone visibly in place to hear the discussion and contribute their comments. But we note that the very act of casting a trip to the toilet as a choice is effectively to construe the chooser (correctly or not) as impaired in at least those self-monitoring capacities. It privileges the interests of the institution (in ensuring the smooth running of the upcoming meeting) over those of the residents.

We must emphasise that our (authors') knowledge of the history of institutions for people with intellectual disabilities requires that we contrast this with previous, and much more overtly directive, formats in which staff got residents to do things. Previously it would have been unremarkable to see them simply issue the instruction that the resident should go to the toilet right now, or take a bath at such-and-such a time. Here, the staff member does at least cast the matter as one of choice (if only as to timing).

B. Choice as a format for a running commentary

In Extracts 1 and 2, above, we saw the staff offer choices which one would not put to a non-institutionalised adult. But those choices were are at least phrased as such, and meant to offer a real, prospective decision. However, we did see more retrospective uses of choices, as we show in this section. The kind of choices we have in mind here are those which were offered to the resident in a context, and in a sequential format, that stripped them of their meaning as a matter of personal preference. Such "choices" were to be understood rather as the staff member's running commentary on, and tendentious naming of, an activity already underway.

In the example below, taken from a residence where residents are multiply impaired, we shall see a staff member "Sandy" (here too all names are fictitious) lead a resident ("Steven") by the hand toward a room in which weighing scales have been set up for the monthly weigh-in. The question is what Sandy's nominating this as a 'choice' means in the context of her actions.

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Table 2 about here
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Residents' weights are monitored, according to the staff, to check for sudden weight loss or gain which might signal illness. Each resident's weight is to be entered on a record sheet and available for official audit. Of course, it is understandable that none of this rationale be explained on any one of a series of routine occasions (leaving aside the difficult question of how any of it might be phrased to a man with severe intellectual impairment). If the lack of explanation on a routine occasion isn't remarkable, this particular use of 'choice' is. Sandy has already taken Steven by the hand, and is leading him along the corridor, before she asks him "d'you wanna be weighed, darling (. ) mh?". The activity was set in train first, and then the 'choice' emerged second, post-hoc.

The subsequent unrolling of the sequence indicates what function this post-hoc offer of choice may serve. At line 4, the other staff member on duty observes that "that's as far as I gottim", in reference an earlier try at getting Steven to the weighing room (not seen by the camera, which had been occupied with another resident). Sandy's approach to Steven, then, will have been informed by this earlier failure. She has decided to push things along by getting him in motion first, and only then asking him if he wants to go. This way is more likely to guarantee compliance. As it happens, Steven continues his resistance (by physically holding back, as the transcript shows) to the point where, in line 23, Sandy can note his choice explicitly, and ask "why don't you wanna get weighed".

C. Choice as a format to cover a misfire

Example 2 (above) illustrated the staff's use of the choice format to describe an activity already underway - and, indeed, where the resident had already implicitly expressed a choice not to take part. Not all such post-hoc choices were meant to gloss over residents' non-compliance: it is a resource usable for any event that may have misfired. Recasting what is going on as a (new) choice may put an optimistic gloss on what would otherwise be a possibly dispiriting failure. In this next episode, Brenda has come back to the dining table to tell the residents that the planned dessert is not ready.
Brenda picks out one resident (Alec) among all the diners; possibly it had been Alec who had nominated jelly in the previous week's meal planning meeting. In any case, she announces the unavailability of the jelly and offers him a replacement. As in the episode with Dominic (and as often happens in our data) Alec does not respond (lines 8-9, even after some cajoling from Dave (line 10). Brenda pursues the question (line 14): "what d'you wanna do."). In the face of no actionable response from Alec, the conversation then mutates into one between the two staff members (lines 21 onwards) and Brenda finishes the conversation by unilaterally asserting that cake instead of jelly has been agreed, and leaves the room. The institutional resource of 'offering choice' (if only: "d'you want cake instead?") has prevailed to turn a kitchen mishap into an opportunity for a new preference to be solicited; whether the resident's part in the arrival at an agreement can be counted as full and unambiguous is arguable, but the meal can now proceed as a consensual, chosen, achievement.

D. Choice as a format for refusing an expressed preference
If a resident wants to do something that the staff consider inappropriate, the staff have the resource of denying the proposal by offering the resident an alternative. One may see this as a well-intentioned move, meant to turn the residents' attention away from an ill-chosen course of action; in any case, it is a use of the choice format which is in explicit contradiction to the alternative principle of respecting the resident's own spontaneous preference. Here is an example, involving a resident who is blind and rarely uses expressive language. When he does, it tends to be single words. He needs to be assisted by the staff in his movements around the house.

The staff (Rachel) is leading Steven into the lounge with her arm through his. When they reach the sofa he pulls back.

In this first section of the episode, Steven pulls away from the sofa and walks towards the middle of the room. The staff accepts his preference ('ok go this way then'), and
when he stops in the middle of the lounge, she offers him a choice: “Where d’you want to go.” Steven makes some sounds we cannot pick up from the tape, then makes a shrieking noise. The staff member seems to recognize this as having something to do with him wanting to go to the toilet but rejects his preference: ‘you can’t go back in the toilet .. you’ve just been in the toilet’ (line 13). Steven shrieks again, and the staff offers him another choice, but one that does not involve the toilet (line 15).

After this they walk through doorway into corridor, Rachel holding Steven’s hand and leading. As they walk down the corridor Steven stops and pulls his hand free. Rachel again asks ‘Where would you like to go? .. where we going? … Going to have a cuppa tea’. At this, Steven shrieks and turns to face the wall. Rachel then walks past him to the lounge to get his cup of tea. When she comes back, she takes his hand, suggesting he goes back to the lounge to drink it. However, after one step, Steven stops again, and here we see Rachel offering him another choice:

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Table 5 about here
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To gloss the proceedings, we see the resident make a clear show of wanting to do something which the staff member explicitly denies and corrects as being inappropriate on the basis that he's just done it (go to the toilet). Our ethnographic notes tell us that Steven often spends time in the toilet as a matter of preference – simply sitting there rather than using it, and that the staff often encourage him to leave the toilet. Just after the transcribed section above, Rachel comments to Chris, the researcher: “actually he didn’t want to get off it. I got him off it because he’s been there a little while …. He’s not usually cantankerous.”

What we see in this episode is a dilemma faced by the staff – between on the one hand allowing Steven to exercise choice over where he sits, and, on the other, their institutional imperative to encourage ‘appropriate’ behaviour, which in this case would involve encouraging Steven to spend his time, and drink his tea, in some other place than the toilet. Paradoxically, they make efforts to deny him his choice while at the same time ostensibly offering him choices: either open choices (“where do you want to go?”) or suggestions framed as choices (“back in the room ‘n listen to music’/
‘in the dining room’), which here come immediately after his preference is rejected (line 15) or in a pre-emptive fashion (line 40). The choices offered as open questions are not unconstrained, of course, in that one of the possible options, and the one that Steven is often known to choose, is several times refused by the staff (lines 12, 44-45) or deferred (lines 49-50. Indeed it takes some persistence by Steven before his choice is finally accepted (line 54).

E. Choice as preference among routinised, underspecified or in-principle alternatives

This, our last, section is about a kind of choice that is pervasive in the residences. We often noticed that, in the more formal exchanges between staff member and resident (the sort of exchange that would happen in round-table house meetings) the choices offered did not seem to afford full consideration of options, but rather to an invitation to the resident to express a recordable preference for one or other merely routine, underspecified or unexplained alternatives.

The crucial issue to note here is that it was the round-the-table framework in which the choice was being offered that was doing much of the semantic work. The options could be under-specified because the overall activity carried by far the greater burden of meaning. Thus, in a round-table exchange, in which each resident would take a turn to express a choice for a food item or a leisure activity or a holiday destination, any given item's qualities as a food choice, leisure activity and so on would be taken as a given, and attention paid only to its preference over others. Its particular features were simply assumed, unless there was reason not to.

Rather than give examples of such null choices, consider this useful deviant case, in which some attempt is made to explain the features of the chosen item. In a meal-planning meeting, Kath is trying to determine what Alec wants to have for breakfast in the coming days. It is only when Alec gives Kath cause to doubt that he really does know what this food item means that she attempts to explain it.

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Table 6 about here
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Alec's pointing to a picture at line 3 seems to be, to Kath, ambiguous. Indeed, the practice of getting residents to choose non-verbally, by pointing to images of menu-items, though clearly a well-meant policy decision, seemed to generate a deal of trouble. We leave that aside to note that Alec's choice does at least prompt Kath to engage in a pursuit of just what sort of bacon dish Alec wants. But what does Alec make Kath's multiple rewordings (marked as a to g in the transcript above) of the food item (bacon; bacon in toast; bacon buttie in a roll; bacon on its own; the bread with it; bacon butties; bacon in a toasted sandwich)? At some points Alec says nothing; at others he agrees; and when he does articulate a named preference ("jus' bacon", line 12) it is in overlap with, and perhaps unheard by, Kath. Nevertheless, in spite of soliciting only a set of hesitant "yehs" to her own final suggestion, Kath can conclude that "he's sorted" (line 23-4) and move to next business.

There is no doubt that staff are meaning to implement the institutional objective of giving the residents greater say in what they do and what happens to them. Indeed, these round-table house meetings are explicitly designed to solicit and record resident's choices. But equally, it is clear that this objective - perhaps like any institutional objective - has become, at least in these interactions, rather fossilised. The staff are certainly offering choices, but these reduce to preferences among overly-familiar options; and the recurrence of the options (to the staff) militates against much - or any - explanation of what they mean. The dilemma facing staff is that when they do try to explain what an option means (and this sometimes happens when the resident's choice seems to be ambiguous), then they embark on what, to the resident, may be a confusing list of further alternatives to try and specify exactly which is wanted.

Discussion

This paper has been an investigation of what sort of things people are given choices about, in two residential homes for people with intellectual impairments in England. Inspection of some thirty hours of mundane life (mealtimes, kitchen work, leisure outings, menu-planning meetings, discussions about holidays, weekly weighing sessions and so on, as well as unnameable, non-episodic "time" in which "not much happened") confirmed our uncontroversial prediction that nothing like official policy choices about marriage, employment and place of residence would be raised. There is
no surprise there. Grand decisions about marriage or job are unlikely to be taken at the kitchen sink, and we concede that we would never have expected to see such high-denomination talk.

What we did see was the small change of everyday choice, and that is more representative of what daily life is like. And here, we reported on five kinds of choice-offering that ran to a theme: the staff's control (for better or worse) of the agenda. Choices could be offered for things about which the resident seemed to have no immediate interest (going to the toilet, committing to a bath time); they could be used a retrospective gloss on some event (a frozen jelly, an uncooperative trip to the weighing room) that had gone off badly; and they could be used as an item-ticking routine to generate recordable responses to formal lists (in meal or holiday planning).

Whether these uses of choice-offers are desirable is for others to decide. But our results show up some stark differences between, on the one hand, a literal reading of policy recommendations at the level of official Mission Statements and, on the other, the lived reality of staff who must juggle between the demands of their work-schedule (get the residents up, washed, fed, on the bus, and so on) and the 'softer' imperative of asking them to choose; indeed, the staff have to first solve the still more fundamental prior puzzle of re-imagining the residents' life as, indeed, one in which "choice" and "personal control" are realistic aspirations at all. The language of considered choice is not always consistent with the contingencies of residential life, as we have seen in other aspects of these and other intellectually disabled residents' lives (Antaki, Walton and Finlay, 2007; Antaki, Finlay, Jingree and Walton, 2007; Antaki, Finlay, and Walton, 2007; Finlay, Antaki and Walton, 2008a,b; Finlay, Antaki, Walton and Stribling, 2008). For those residents affected by profound limitations in their language, senses and mobility, such a re-imagining is a challenge.

This paper has constantly reiterated a simple, and perhaps obvious message: that policy discourse about choice - though obviously humane and well-meaning - sets its sights so high that it bears little relation to the kind of experiences about which choices are actually available to people with ID, and no relation at all to the interactional reality of the professional interactions in which even limited choices are actually offered. If we want to contribute to the understanding of what choices are
routinely available to people with ID, and to how professionals actually deliver those choices, we might have to start not from the top down but from the ground up. Analysis of real-time interactions reveals the complexities of offering choice, and the pervasive, not always helpful, influence of basic institutional imperatives on the delivery and understanding of choice in mundane reality.

Nevertheless, as we have seen, the staff do rise to it, and have developed a set of routine practices which at least have the visible form of offering choices and giving control to the resident. In feedback sessions with staff, where we have looked over selections from the tapes, they themselves (or some of them, at least) have been quick to see and recognise their practices, and to reflect on how those practices promote empowerment or not. In the empirical bulk of the paper, we reported on five formats (sometimes accompanied by physical reorientations at the level of picking people up and moving them about) for offering choice and, implicitly, ceding control; but, as we also saw, each format is vulnerable to the danger of imposing order and preference on the resident in just the spirit of institutional convenience that Governmental and regional authority discourses are meant to displace. When opportunity is offered to allow them to use the video record to reflect on what they do, staff themselves can see this. Not all staff, perhaps; some declined to take part in the project from the beginning, and were not captured on video; others made no arrangements to attend our feedback sessions. Policies of change, then, will have a mixed audience at the level of those staff who actually deliver choice to residents with an intellectual impairment. But if willing staff can be supported in avoiding the less empowering formats in offering choice, the more likely it is that actual practice will come into line with official discourse.
References:


Transcription Symbols

Note - the full CA system has been much simplified in these extracts to aid legibility. Crucial elements, however, have been maintained. Perhaps the most unfamiliar notation is the use of square brackets to indicate overlapping talk in adjacent lines.

( . ) Just noticeable pause

( .3 ), ( 2.6 ) Examples of timed pauses

word [ word ] [ word ] The start of overlapping talk.

.hh, hh In-breath (note the preceding full stop) and out-breath respectively.

wo(h)rd ( h ) shows that the word has "laughter" bubbling within it

wor- A dash shows a sharp cut-off

(words) A guess at what might have been said if unclear

( ) Unclear talk.

word=

=word No discernible pause between two sounds or turns at talk

word, WORD Underlined sounds are louder, capitals louder still

Analyst's signal of a significant line

((sneeze)) Note of something hard, or impossible, to write phonetically