

The Events at Winterbourne View

Peter McGill and Glynis Murphy

Co-Directors, Tizard Centre

The BBC Panorama programme on the events at Winterbourne View provides a further reminder of how easy it is for things to go wrong in supporting people with learning disabilities. Of course, first thought should go to the individuals involved and their families. In previous such incidents, well-intended but knee jerk responses have led to the wholesale removal of individuals to other settings. Not only has this usually happened without adequate consultation with individuals and their families, it has often resulted in a continuing failure to find a stable and supportive environment. What happens to the individuals at Winterbourne should be determined in **their** best interests, not be part of some kind of PR demonstration of how quickly the authorities can move when roused. This **may** mean some or all of the people staying where they are for the moment but with differently arranged support. Remember, the individuals living at Winterbourne are the primary victims here and everything that can be done should be done to ensure that the damage done to them over who knows how many months or years is put right as far as it can be.

Such considerations also apply to the individuals' families. Put yourself in their position for a moment. Your son or daughter has significant disabilities and both professionals and family members have doubtless struggled to respond adequately to the behaviours they present or the distress they experience. At some point, perhaps after several other placements, your son or daughter is sent, at considerable cost to the public purse, to an "assessment and treatment" unit run by a large, national provider with apparently considerable specialist expert resources. Maybe now your son/daughter will get the help that they need. But over the months you begin to wonder...not much seems to be happening...what treatment are they getting?...is this really doing any good? Maybe too you pick up that there may be problems – your son or daughter doesn't seem to like some of the staff or complains about this or that or has an unexplained bruise or stops liking showers. But this is a specialised unit arranged by your local NHS, surely everything is ok? Then you discover that everything is not ok. The first person you blame is yourself, for allowing your son/daughter to go through this, for not working out what was going on...for failing in your duty to protect your child. **YOU ARE NOT TO BLAME! YOUR SON OR DAUGHTER IS NOT TO BLAME!** The families of the individuals living at Winterbourne now need considerable support themselves. The first step in this is to make sure that nothing is hidden, that there are no surprises years down the line during the inevitable investigations. They need to know the worst now and be given the help needed to deal with it. They need support from each other and from other families who understand what they're going through.

Inevitably, the programme will lead to discussion of why such things happen and how they can be prevented. There are no easy answers here but we would like to draw attention to three things that could make a difference.

First, we mustn't treat the events shown in the programme as simply being the result of bad people doing bad things. There have been too many such events over the years to allow this interpretation. We all know that similar things happen elsewhere. If we allow the programme to be portrayed as exceptional we risk missing one of the main lessons. That is that the kind of treatment seen on the programme reflects the broader social status of people with learning disabilities. This is not a status

to which anyone would aspire. It is one in which, in our society it seems to still be “acceptable” to discriminate against people with learning disabilities in employment, education, leisure and a range of other areas. Worse, it is one likely to be associated with bullying and hate crime. The society in which people walking down the street can be derided loudly as “raspberry ripples” by others is the same society in which people are abused, punished and treated as less than human. Events such as those shown in the programme happen in the community too, with sometimes appalling results such as the murder of people with learning disabilities and the suicide of carers and their sons/daughters (see, for example, <http://www.guardian.co.uk/society/2011/jun/01/disability-hate-crime-keith-philpott>) . They will only cease when we become better able as a society to accept and include people who are “different”. This is a hard ask but is no more than the kind of change in British society over the last 40 years in respect of people from black and ethnic minorities. We need to learn from that and other similar broad social changes how to make things different.

Second, and another reason for not taking the easy route and simply demonising the staff involved in the incidents. It is very clear on the programme that staff simply do not know what to do. If you don’t know what to do, and no one is telling you what to do, you make it up as you go along. You are influenced by those around you, especially those with the loudest voices. Very soon, a culture develops in which the very things that will later be regarded as abusive and even criminal are simply elements of your culture, the way in which you, unthinkingly, practice your trade. Staff in these situations have been let down nearly as much as the individuals with learning disabilities and their families. No one has told them what to do, no one has shown them what to do, no one has pointed out the error of what they are doing. The job they are doing is difficult and skilled. If you don’t know what to do, it is unlikely that you will invent the best ways of doing it by yourself. Instead, we need to give much more attention to developing the skills of the staff who work in these kinds of settings. This is not just about NVQs or the like, it’s about serious training and supervision so that all staff understand why the people they are working with behave as they do and both know and believe in the best ways of working with them. It is absolutely astonishing that we are still in this situation, where we spend a fortune on services for individuals that are no more than glorified babysitting.

Third, Winterbourne is in some respects no different to all the other places in which such abusive practices have been “uncovered” – it is, in a very real sense, “covered” i.e. hidden from plain sight so that as a culture in which unacceptable practices become acceptable there is no one to question what is happening, no one to say “hang on a minute, that can’t be right”. This is the traditional closed institution where anything can be got away with. The antidote has to be openness, transparency. There is, of course, a potential conflict here between the privacy of individuals and such transparency. But we must build on approaches like advocacy to ensure that it is very hard to get away with the kinds of practices found at Winterbourne without detection. The advocate role is one of the least developed in provision for people with learning disabilities yet one with great potential.

There will, no doubt, be extensive enquiry into the events at Winterbourne. This is as it should be. In the rush to blame, however, the staff, the provider, the regulator, the commissioners and so on we must not forget the reasons why such events happen in the first place. Only by attending to the root causes of the problem can we hope to prevent similar events now and in the future.