

Working with Sexual Vulnerability: The Experiences of NHS Clinicians Supporting People with Learning Disabilities

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Declaration and signature of candidate
<p>I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.</p> <p>I confirm that the decision to submit this thesis is my own.</p> <p>I confirm that except where explicitly stated, the work has not been submitted for another academic award.</p> <p>I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.</p> <p>Signed:  Date: 03/05/2025</p>

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Thesis abstract

This thesis comprises of three papers, focused on staff experiences of supporting individuals with learning disabilities, particularly in relation to managing clinical risk and addressing issues of sexual vulnerability. The aim of the thesis is to contribute to this under-researched area of literature and clinical practice.

The first paper presents a systematic review of the current literature, appraising ten studies that explore how professionals manage clinical risk within community learning disability care settings. Three overarching themes were identified: (1) Balancing risk, (2) The importance of experience and appropriate professional input, and (3) The role of policy, support systems, and education. Articles reviewed were found to be of overall good quality, however limitations are discussed. Ideas for future research are also proposed.

The second paper presents an empirical study exploring NHS clinicians' experiences of supporting people with learning disabilities around issues of sexual vulnerability. This qualitative research involved eleven participants from community learning disability teams who took part in semi-structured interviews. Data was analysed using Reflexive Thematic Analysis, resulting in five themes: (1) Ignorance is not bliss: Lack of education, (2) The internet: Fresh challenges in sexual vulnerability, (3) Protection or people's rights: What is the bottom line?, (4) Risk-focused mindsets: Negative attitudes toward sexuality and relationships, and (5) Polarity of multiagency working. The findings highlight the need for systemic change to promote inclusive, rights-based approaches to sexual health for people with learning disabilities.

The final paper is an executive summary, offering a concise presentation of the research from the empirical study. It is designed for use by the study's participants, who expressed an interest in a shorter summary highlighting key insights and recommendations.

Paper 1: A Systematic Literature Review

How do professionals manage risk in Community Learning Disability care settings?

Word count: 7598

Abstract

Background

The "Transforming Care" agenda is a policy framework aimed at improving the quality of life for people with learning disabilities by enabling them to live in community settings rather than institutional environments, but with this transition comes potential risk. 'Clinical risks' can be defined as risks whose causes or effects are primarily related to the health and wellbeing of service users or the provision of care to them, which professionals need to be aware of and responsible for. This review aims to systematically appraise and synthesise published literature on how professionals manage clinical risk with people with learning disabilities in community care settings, while identifying key themes and gaps to inform future research.

Method

Electronic searches were conducted in May 2024 and papers were screened using pre-defined inclusion/exclusion criteria, which resulted in 10 papers appraised for quality and synthesis. Quality appraisal was conducted using the CASP tool and a thematic synthesis was used to elicit themes.

Results

Three themes were identified: (1) Balancing risk, (2) Importance of experience and appropriate professional input and (3) Policy, Support systems and Education.

Conclusion

These findings highlight the need for a balanced approach to risk management, where safety and empowerment are equally considered. Decision-making is aided by clear policies and professional support systems. The research reviewed was of an overall good quality. Future research should seek to explore the experiences of people with learning disabilities, relating to their perception of risk management.

Keywords: Learning/Intellectual Disability, Risk, Community care setting

Background

A learning disability can be defined by three core criteria: lower intellectual ability (usually an assessed IQ of less than 70), significant impairment of social or adaptive functioning (such as problem solving, planning and abstract thinking), and onset in childhood (National Institute for Health and Care Excellence, 2015). Different terminology is used internationally, with “intellectual disability” being used predominantly across parts of Europe, North America and Australia, however since this review has been conducted in the UK, the term learning disability will be used, as it aligns with UK usage, as well as a range of services, including the NHS.

Historically, individuals with learning disabilities were often placed in large institutions, where they were isolated from society and received minimal individualised care (Royal College of Nursing, 2020). This approach shifted significantly with the introduction of the "Transforming Care" agenda, a policy framework aimed at improving the quality of life for people with learning disabilities by enabling them to live in community settings, such as supported living homes, rather than institutional environments (Department of Health, 2012). The agenda emphasises the importance of person-centred care, promoting independence and integration into the community. People with learning disabilities can face risks such as social isolation, discrimination and abuse therefore successful transitions from institutional to community living require robust risk management and clinical support to ensure the safety and well-being of service users (NHS England, 2017). This means that effective risk management strategies are essential to address potential challenges and prevent adverse outcomes in community care settings, while proper clinical support ensures that individuals receive the necessary healthcare and therapeutic interventions tailored to their specific needs.

‘Risk’ is a broad term and therefore it is important to define specifically what this review is referring to. The Oxford English dictionary definition is “a situation involving exposure to danger, or to expose (someone or something valued) to danger, harm or loss” (Oxford Languages, 2024) however, this review is referring to a specific type of risk encountered by people with learning disabilities, due to their vulnerability and care needs. These will be described as ‘clinical risks’ which can be

defined as risks whose causes or effects are primarily related to the health and wellbeing of service users or the provision of care to them (East London NHS Foundation Trust, 2024). Clinical risk represents issues that professionals, including NHS clinicians and community support staff, must be aware of and responsible for. These issues may include, but are not limited to, mental health difficulties, vulnerability to abuse or exploitation and reduced intellectual ability resulting in difficulties completing some tasks independently, which could lead to implications for the individual's safety (Mencap, 2019).

Effective risk management in community care for people with learning disabilities must strike a balance between safeguarding and risk enablement, ensuring that risk management practices do not become overly restrictive or limit opportunities for independence. While robust risk management is essential, it should be embedded within person-centred planning, which prioritises the individual's unique needs, aspirations, and rights (Sanderson et al., 2006). This often requires recruiting and training specialist staff teams to assess and manage risks while promoting autonomy. Collaboration between agencies is essential, with providers working closely with clinical and health professionals, as well as professionals working in community teams such as occupational and speech and language therapists, working together to ensure consistent, well-informed risk management strategies throughout both care planning and delivery. A key challenge for professionals is navigating the tension between reducing risks and enabling individuals to take positive risks that enhance their quality of life. "Challenging behaviour" such as self-harm or aggression, should be recognised as communication rather than simply a risk. A Positive Behaviour Support (PBS) approach can help address these behaviours while minimising unnecessary restrictions. Additionally, family involvement in care planning strengthens risk management and ensures localised support systems, promoting both safety and autonomy (Care Quality Commission, 2021).

Rationale

Around 1.5 million people in England have a learning disability (Mencap, 2024). In July 2022 the Department for Health and Social Care published an updated document 'Building the right support for people with a learning disability and autistic

people: action plan' focusing on six areas to develop community services and reduce reliance on inpatient mental health beds (House of Commons Library, 2023). One element of this community support is how professionals manage clinical risk and currently there is not a review of existing evidence and literature in this area, therefore the rationale for the current review is to bring together and appraise this literature in order to elicit any common findings or useful recommendations for clinical practice.

Research question

How are professionals working with people with learning disabilities managing risks in community care settings?

Aims

This review aims to collate and systematically review, whilst appraising the quality of published literature that discusses how professionals manage clinical risk when working with people with learning disabilities in community care settings. The aim of this process is to extract themes and develop further understanding of the evidence base, in order to produce a synthesis. This review would also hope to identify possible areas for future research.

Method

Search strategy and terms

An initial scoping search was conducted in December 2023 to determine if there was sufficient literature to conduct a further systematic review. Once this had been concluded, an electronic search of the below databases was conducted using pre-defined search terms during May 2024 concluding on 28/05/2024.

The databases searched included MEDLINE, CINAHL Plus with Full Text, SPORTDiscus with Full Text, APA PsycInfo, APA PsycArticles, APA PsycBooks, eBook Collection (EBSCOhost).

The search terms used were (“Learning disab*” OR “Intellectual disab*”) AND (Community team OR Community setting OR Community OR CLDT OR Community Learning Disability team) AND (Risk OR Safety) AND (United Kingdom OR UK).

The terms Learning and Intellectual (disability) were used as synonyms, as explained in the introduction of this review due to the difference in international usage and therefore the possibility of published literature occurring under either term. The review was limited to the geographical area of the United Kingdom hence the inclusion of these search terms. In order to decide on terms for the ‘community’ and ‘risk’ elements of the search, the researcher conducted discussions with peers and their research supervisor, who has expertise in this clinical area, and subsequently arrived at key terms listed above aiming to capture the concepts identified.

Screening procedure

After filters were applied to the first search including narrowing the search to journal articles (excluding books and chapters), articles must be written in English and peer reviewed, this search returned 659 results. The search was then restricted to a ten-year period of 2014-2024 which resulted in 373 results. This period was decided upon as the national plan ‘Building the right support’ came into effect at this time to develop community services for people with a learning disability and close outdated inpatient facilities (NHS England, 2015). After 97 duplicates were removed this resulted in 276 articles which were then manually screened by title and abstract

using the below inclusion and exclusion criteria to produce 37 articles. These articles were read in full, as more detail was needed to decide whether to include them in the review, this process resulted in the final 10 articles that will be discussed. A grey literature search resulted in 50 articles that were screened for eligibility but yielded no additional articles. Figure 1. displays a flow diagram detailing the screening process.

Table 1

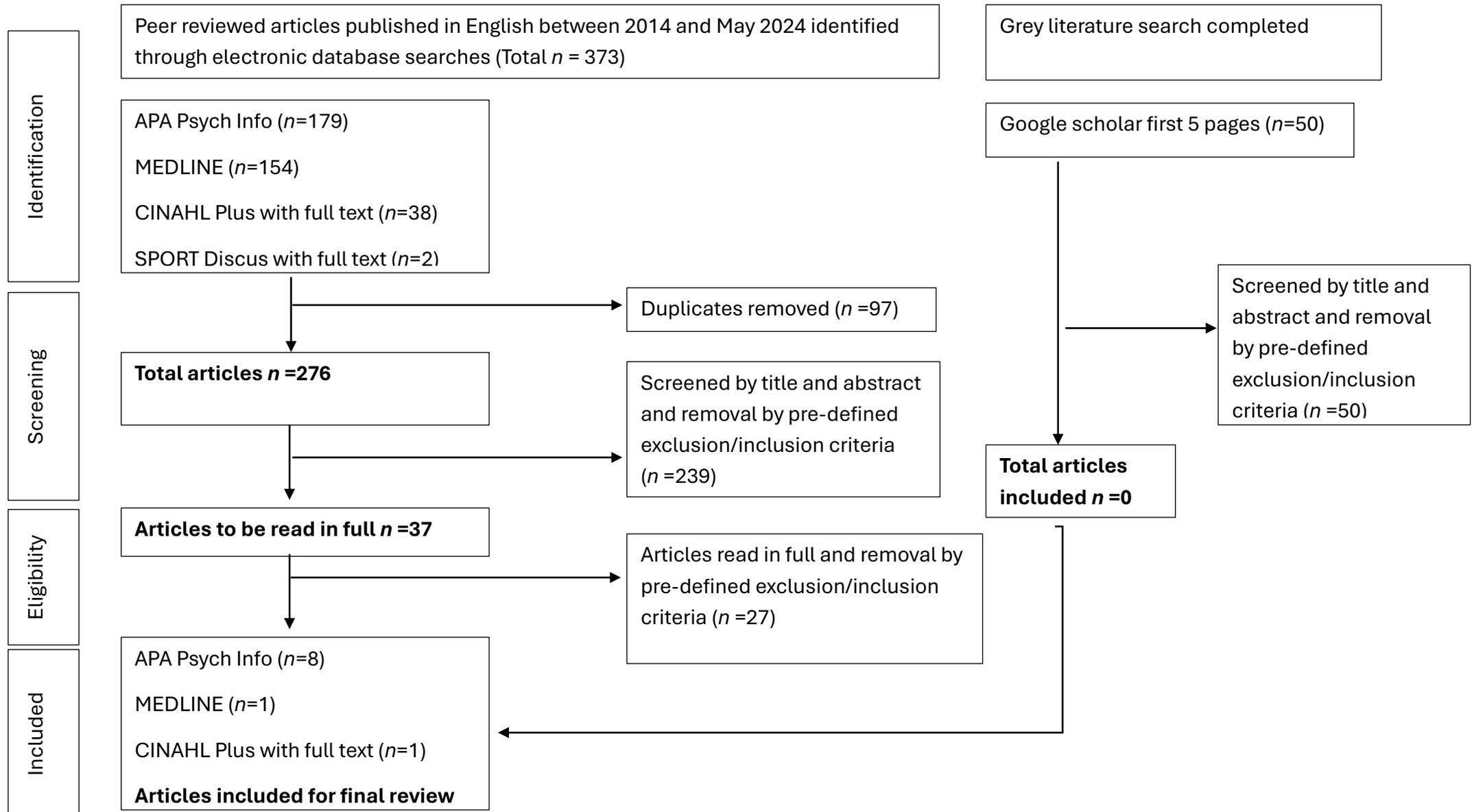
A table to show the inclusion and exclusion criteria for articles used when searching the literature

Inclusion criteria	Exclusion Criteria
Community care settings	Inpatient settings
Based in the UK	Based outside of the UK
Adults	Children
Learning disability	Autism only (not learning disability)
Risk management or assessment	Risks around pharmaceutical interactions of medications and prescribing
Qualitative methodology	Risk of developing comorbid physical health conditions or sustaining injury e.g. Epilepsy/falls/diabetes/cervical screening
	Main focus on Dementia (e.g. Down's syndrome and dementia)
	Focus on risk around COVID-19
	Safeguarding general adults (not specific to learning disability)
	Not an empirical paper (opinion papers/ study protocols/ single case studies)
	Other systematic reviews

Table 1. displays the inclusion and exclusion criteria used to decide which articles were reviewed. As risk encapsulates such a large range of topics, it was important to clearly define in the exclusion criteria which types of risk this review was not studying. Medical and pharmaceutical research was excluded due to the nature of the research as well as papers where the focus was on a specific issue separate to learning disability, such as dementia or COVID-19 as this was felt to be a different research area to the type of clinical risk aiming to be reviewed. The type of risk included is that which involved professional decision-making, linked to potential vulnerability due to the person's learning disability. Articles that focused on managing risk with children or individuals who have ASD were excluded from the search as the focus of this review was to look at managing risk specifically with adults who have a learning disability and the particular issues around this. Research conducted in inpatient settings was excluded as professionals would not be managing risks in the community, which again was a specific focus of this review.

Figure 1

A flow diagram to show the literature search screening process.



Quality Appraisal

In order to assess the quality of the literature being reviewed, the Critical Appraisal Skills Programme (CASP) was used (CASP, 2018). The CASP qualitative tool is a structured checklist designed to systematically evaluate the quality of qualitative research (Appendix A). It enables researchers and practitioners to assess the rigor, credibility, and relevance of studies by guiding them through key components such as the clarity of research aims, the appropriateness of methodology and the robustness of data analysis. The CASP has shown to be a useful tool for the quality appraisal of qualitative research, especially for less experienced researchers (Long et al., 2020) and was chosen as an appropriate tool for this review. The CASP is divided into three sections, (A) Are the results of the study valid? (B) What are the results? And (C) Will the results help locally? Each section contains individual questions in which the available answers are 'Yes', 'No' or 'Cannot tell'. These answers have been assigned scores for the purposes of generating an overall quality score in this review (see Appendix B) 'Yes' = 2, 'Cannot tell' = 1 and 'No' = 0. As part of the overall appraisal of the articles, a 'Study characteristics' table was generated, with a summary of findings, strengths and limitations and the quality score included (Table 2).

Table 2*Study characteristics*

Authors & Date of publication	Design & Methodology	Participants/sample/ data source	Findings	Strengths & Limitations	Quality score
Banks et al. (2021)	Semi structured interviews, template analysis.	10 staff working in large specialist residential LD setting/service.	-Staff perceived as weak raised anxiety amongst other staff members with regard to risk -Staff with more experience were strongly valued -Reflections around not getting too close and remaining vigilant	-Researcher did not critically examine own role. -Methodology not very clearly explained +Views of newer staff consistent with longstanding members mitigating possible bias	15
Chester et al. (2017)	Semi structured interviews, thematic analysis.	5 staff from CLDTs. (2 consultant psychiatrists, 2 managerial nurses, 1 psychologist).	-The use of risk assessments - Importance of robust plan, legal frameworks, supervision requirements, restrictive practice, - Holistic care and personalised approach -The need to have the right professionals and agencies involved in multidisciplinary and multiagency working	+Clearly justified and explained design and why some people did not take part +Justified use of thematic analysis +Thematic analysis presented clearly in quotes and table of themes +Respondent validation used -Researcher did not critically examine own role.	16
Clifford et al. (2018)	Semi structured interviews, thematic analysis.	13 managers and support staff working in specialist community placements	-Conflict between rigid risk averse practices and therapeutic risk taking -External professionals not always seen as allies – this feeds risk averse practices	+ Researcher critically examined their own role in relation to participants + Discussed triangulation between researchers during coding and theme development +Ethics considered and discussed	18
Coleman & Sharrock (2022)	Thematic analysis of meeting minutes.	16 sets of meeting minutes from Personal relationship advisory group (MDT), which discussed 11 people with a learning disability in total.	-Perceived high vulnerability/ concerns around person's ability to be safe in community -Lack of understanding/knowledge around topics leading to increased risk -Need to maintain consistent and appropriate boundaries	-Researcher did not critically examine own role. -Limited discussion around ethics +Justified use of thematic analysis + Discussed triangulation during coding and theme development to reduce researcher bias	14

			<ul style="list-style-type: none"> -Insufficient education – need to provide increased and accessible education around possible risk topics e.g. sex, internet safety -Harsh restrictions, shielding the individual -Good therapeutic relationship, 1:1 approach 		
Hodges & Northway (2019)	Semi structured interviews, grounded theory analysis.	25 registered social workers and intellectual disability nurses working in CLDTs in Wales	<ul style="list-style-type: none"> -Frustration around the lack of specific legislation to support decision making -Nurses having to do risk assessments but feeling it should be done by the clinician that knows the person best -Value in MDT view -Confidence and competence with regards to making decisions (reference to intuition) 	<ul style="list-style-type: none"> +Discussion around grounded theory process including reflexivity, audit trail +large sample -Researcher did not critically examine own role. 	16
Hollomotz (2021)	Interviews, thematic analysis, realist analysis	22 professionals involved in the care and resettlement of men with LD who had been admitted to secure hospital.	<ul style="list-style-type: none"> -The use of a risk diary to encourage self-monitoring Risk Management -Emphasis on mitigating risks through treatment strategies and support systems. -Varied readiness for discharge based on individual risk management capabilities. -Importance of ongoing support and refresher sessions post-discharge. -Differentiated management approaches based on the type and severity of risks posed. 	<ul style="list-style-type: none"> +Wide variety of professionals interviewed -Aims not clear -Researcher did not critically examine own role. 	14
Jingree (2015)	Semi structured interviews, analysed using critical discursive psychology – producing interpretive repertoires	15 support workers, employed by a service providing residential and day support for people with LD.	<ul style="list-style-type: none"> -‘Duty of care’ repertoires position service-users as unaware of risk and lacking capacity, allowing staff to justify argument about overruling rights and choices. 	<ul style="list-style-type: none"> -Analysis method, ethical considerations and research design unclear -Aims not clear -Researcher did not critically examine own role. + Good sample size 	12

Mottershead & Woodrow (2019)	Free text answer on questionnaire, content analysis	19 clinicians from adult learning disability services.	<ul style="list-style-type: none"> -Overall the practicality, utility and face-validity of the DSD RAG rating support tool, based on the responses given by participants at the time of questionnaire completion, were positively rated. -Positive comments left by clinicians suggested that the tool was clear and easy to read, potentially supporting clinical judgement in a standardised way. 	<ul style="list-style-type: none"> -No discussion around ethics -Researcher did not critically examine own role. +Participants included members of MDT and different CLDTs 	14
Niven et al. (2020)	Structured interview, thematic analysis	<p>'Informants' on behalf of 15 people with a LD.</p> <p>3/15 informants were parents, 12 were team leaders/service managers, 3 of whom included support workers/care staff. 6 people were open to the CLDT and had a care coordinator, 5 of whom were also able to be interviewed.</p>	<ul style="list-style-type: none"> -None of the individuals could go out on their own and were under enhanced supervision. -Majority were being prescribed psychotropic medications to manage behaviours or mental health. -All individuals were supported using restrictive practices. -Four individuals were not under Deprivation of Liberty Safeguards (DoLs), but agencies were in the process of obtaining them. Seven individuals had authorised DoLs in place. 	<ul style="list-style-type: none"> - Possible response bias. The majority of people who took part in the current review were generally settled and doing well -Researcher did not critically examine own role. +Justified use of thematic analysis +Discussed consent process including adapted consent forms. + Makes recommendations for practice 	15
Oloidi et al. (2020)	Semi-structured interviews using Critical Incident Technique (CIT). Thematic analysis.	18 Social care workers who provide direct support for adults with intellectual disabilities and work within community services	<ul style="list-style-type: none"> -Expressed concerns that a societal 'blame culture' makes organisations risk averse -Lack of clear organisational policy caused concern and frustration (having to resort to personal assessment of situations to guide decision making) -Emphasis on use of risk assessment for individual situations -Sharing responsibility with managers -Influence of actions that prioritise safety needs 	<ul style="list-style-type: none"> +Clear description of analysis process, justification of method -Researcher did not critically examine own role. +Justified use of thematic analysis +Makes recommendations for practice 	16

			-Concerns around vulnerability in relation to personal and sexual relationships, and capacity is perceived as a risk factor for staff		
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Critical Appraisal

Aims

Out of the ten papers reviewed, eight studies had clear and well-defined aims (Banks et al., 2021; Chester et al., 2017; Clifford et al., 2018; Coleman & Sharrock, 2022; Hodges & Northway, 2019; Mottershead & Woodrow, 2019; Niven et al., 2020; Oloidi et al., 2020). These studies explicitly stated their research objectives, ensuring transparency. However, the remaining two studies (Hollomotz, 2021; Jingree, 2015) objectives were unclear. It was possible to make assumptions and inferences about what the aims may have been, but this was not explicitly stated in the articles themselves.

Methodology and design

Given that all the studies appeared to be setting out exploratory aims, looking at subjective experience, qualitative methodology was deemed appropriate to all. Some studies offered justification for their choice of data analysis method (Oloidi et al., 2020; Niven et al., 2020; Coleman & Sharrock, 2022; Hodges & Northway, 2019; Chester et al., 2017), for example describing the features of thematic analysis and how this answers their research question. No studies set out an experimental hypothesis or prediction of any kind to test, that would have required quantitative methods. One mixed methods paper was included in this review however only the qualitative section of the research is being appraised.

Two of the reviewed studies were assessed as unclear regarding the appropriateness of the research design (Banks et al., 2021; Jingree, 2015). This was due to a lack of clear discussion or justification by the researchers for their chosen methods. These methods included 'template analysis' and 'analysis using critical discursive psychology'. These studies did not adequately explain the rationale behind using less commonly employed methods, or the methods themselves, leading to uncertainty about the suitability of their research designs.

Recruitment and data collection

All the studies reviewed were deemed to have appropriate recruitment strategies. The sampling methods employed across the ten studies exhibit a variety

of approaches, reflecting differences in research objectives and practical constraints. Purposive sampling, as used by Banks et al. (2021), Jingree (2015), and Oloidi et al. (2020), ensured that participants had specific characteristics needed to meet the study's focus on learning disabilities and support roles. This method contrasts with Chester et al. (2017) targeted sampling, which specifically sought professionals involved in discharge decision-making, thereby focusing on a narrow, role-specific group. Clifford et al. (2018) use of convenience sampling relied on the availability and accessibility of participants, aiming to gather sufficient data within the researchers' logistical constraints.

Some studies implemented different approaches: Mottershead and Woodrow (2019) employed a questionnaire as part of their mixed methods design, to capture a broad range of multidisciplinary team (MDT) roles, whereas Coleman and Sharrock (2022) analysed meeting minutes, relying on existing documentation rather than direct participant recruitment. Hodges and Northway (2019) recruited by holding information sessions at team bases, professionals were then able to contact researchers afterwards, without team managers awareness, if they wished to take part in the study. They utilised data saturation to determine the sample size, a method ensuring comprehensive data collection by continuing interviews until no new themes emerged; this will be discussed further in the data analysis section of the appraisal. In the study by Niven et al. (2020) the original plan had been to collect data from individuals with learning disability however this shifted to be focused on informants, due to the complexity of self-reporting by the primary participants, thereby collecting secondary data from knowledgeable sources, such as Community Learning Disability Team (CLDT) team leaders and support workers/care staff.

The professional diversity among participants also varied, with some studies, including Chester et al. (2017) and Hollomotz (2021), targeting specific roles such as learning disability nurses and psychologists. While others like Mottershead and Woodrow (2019) included a broader spectrum of MDT roles, including occupational therapists, speech and language therapists, clinical psychologists, psychiatrists, support workers, assistant practitioners and physiotherapists. Recruitment strategies ranged from direct approaches through organisational leads (Oloidi et al. 2020; Hodges & Northway, 2019) to indirect methods such as questionnaire distribution (Mottershead & Woodrow, 2019).

The majority of the reviewed studies exhibited similar designs, with eight out of ten using interviews as their primary method of data collection (Banks et al., 2021; Chester et al., 2017; Clifford et al., 2018; Hodges & Northway, 2019; Hollomotz, 2021; Jingree, 2015; Niven et al., 2020; Oloidi et al., 2020). This approach allowed for a detailed exploration of participant perspectives. This consistency in data collection methods demonstrates the common reliance on interviews in qualitative research to gather in-depth, rich data. The remaining two studies employed different methods: one analysed meeting minutes of the 'Personal relationship advisory group' a meeting offering multidisciplinary advice, while the other analysed free text questionnaire responses, but all of these methods were appropriate to the aims of the studies.

Reflexivity

Reflexivity is a primary strategy for quality control in qualitative research (Berger, 2015) and therefore it is essential for researchers to be clear about their process of reflexivity as part of their work. This can include the researcher's explaining their position, reflecting on their roles in the research or acknowledging their own biases and views on the research.

Minimal reflexivity was found throughout the papers reviewed in terms of researchers explaining their position, with only one study making explicit statements about the position of the researchers (Coleman & Sharrock, 2022). The researchers described their job roles, as well as the context during the COVID-19 pandemic, and their previous experience conducting qualitative research but not of working with people with learning disabilities. Clifford et al., (2018) made limited reflexive commentary, however all other studies do not make any reflexive comments about their position or relation to the research, including any potential biases or views.

Only one of the ten studies reviewed was deemed to consider the relationship between the researcher and the participants (Clifford et al., 2018). The authors acknowledged that they had worked with some of their participants (service managers) in their NHS clinical role and this may have affected the participant's candour. No other study reflected on the relationship between the researchers and the participants. Some of the studies described the researcher's role within the service in which they were conducting the research from (Coleman & Sharrock,

2022; Mottershead & Woodrow, 2019) which could allow the reader to draw inferences about possible bias however there was no direct reflection on this made by the authors of the studies. This lack of reflexivity raises concerns about potential bias in data collection and interpretation, as pre-existing relationships and professional roles may have influenced participants' responses, potentially shaping the findings in ways that were not explicitly acknowledged.

Ethics

The ethical considerations across the studies varied significantly, with some offering more detailed descriptions than others. Mottershead and Woodrow (2019) did not discuss ethics in their paper, while Banks et al. (2021) confirmed that ethical approval was granted by a university ethics committee, but did not elaborate on further ethical considerations. Coleman and Sharrock (2022) and Niven et al. (2020) discussed their engagement with local research and development (R&D) teams, concluding that formal ethical approval was not required; however, Niven et al. also described the use of easy-read consent forms for people with learning disabilities whose parents or carers were being interviewed on their behalf. Chester et al. (2017) provided a thorough account of the consent and participant information process, facilitated through the Integrated Research Application System (IRAS). Clifford et al. (2018) obtained clearance from the NHS R&D department and discussed consent procedures, while Hodges and Northway (2019) clearly outlined the ethical approval granted by a health board. In contrast, Hollomotz (2021) briefly mentioned Health Research Authority (HRA) approval but did not elaborate on the consent process. Oloidi et al. (2020) specified that written consent was obtained, alongside ethical approval. Lastly, Jingree (2015) ambiguously referenced following ethical recommendations from the British Psychological Society, with no further detail provided.

Analysis

Thematic analysis was the most commonly used method, employed by Chester et al. (2017), Clifford et al. (2018), Coleman and Sharrock (2022), Hollomotz (2021), Niven et al. (2020) and Oloidi et al. (2020). Grounded theory was used by Hodges and Northway (2019), while critical discursive psychology was utilised by

Jingree (2015). Mottershead and Woodrow (2019) applied content analysis and Banks et al. (2021) used template analysis.

Whilst it was possible to discern what type of analysis was used in all of the studies, the depth of description and justification varied substantially. Of the studies that conducted thematic analysis, Chester et al. (2017), Clifford et al. (2018), Coleman and Sharrock (2022), and Oloidi et al. (2020) provided more descriptive and rigorous accounts of their analysis compared to others (Hollomotz., 2021; Niven et al., 2020). Chester et al. (2017) gave a description of the thematic analysis process and then clearly presented themes using quotes and tables. Clifford et al. (2018) and Coleman and Sharrock (2022) discussed triangulation between researchers during coding to reduce bias. Oloidi et al. (2020) offered a thorough description, including a thematic map. In contrast, Hollomotz (2021) provided a vague analysis without mention of validation, while Niven et al. (2020) described a generic five-step process that lacked clear application to their study.

The methodological rigour also varied across the studies that did not use thematic analysis. Hodges and Northway (2019) provided an extensive discussion of their grounded theory process, maintaining an audit trail. Although they mentioned that data saturation determined the sample size, the details of how saturation was reached were not provided. Mottershead and Woodrow (2019) used content analysis, with a second researcher reviewing the process to ensure rigour. Banks et al. (2021) employed template analysis but offered a vague description, making the method unclear. Similarly, Jingree (2015) used critical discursive psychology, which appeared to incorporate elements of discourse analysis, but the lack of explicit explanation hindered the assessment of rigour in this critical appraisal.

Findings and value

All studies were peer reviewed, which ideally improves research and promotes rigour (Aly et al., 2023) however this is not an entirely objective process, there is always the possibility of bias occurring in terms of what research is published. Publisher bias can arise from a preference for studies with statistically significant or novel findings, potentially leading to the underrepresentation of null or contradictory results in the literature.

Most studies in this review provided a clear statement of findings, offering readers a good understanding of the results (Banks et al., 2021; Chester et al., 2017; Clifford et al., 2018; Coleman & Sharrock, 2022; Hodges & Northway, 2019; Mottershead & Woodrow, 2019; Niven et al., 2020; Oloidi et al., 2020). However, while Hollomotz (2021) presented relatively clear findings, the lack of an initial aim or research question made it difficult to assess whether the findings met the research goal. This was also the case with Jingree (2015), where the findings were less clear overall.

Almost all of the studies make recommendations for clinical practice (Banks et al., 2021; Chester et al., 2017; Coleman & Sharrock, 2022; Hodges & Northway, 2019; Hollomotz, 2021; Jingree, 2015; Mottershead & Woodrow, 2019; Niven et al., 2020; Oloidi et al., 2020) contributing to the evidence base, and linking any generated themes or theory to real world clinical situations. This adds value to the research by directly benefiting the studied population, making it more impactful and beneficial for service users.

As previously discussed, reflexivity is an important element of qualitative research, and this can be demonstrated in the findings section of studies through consideration of limitations and recommendations for future directions of research. All studies except Jingree (2015) considered limitations of their research and discussed these, highlighting an awareness and ability to reflect. Ideas for future research were suggested and discussed by some studies (Banks et al., 2021; Chester et al., 2017; Coleman & Sharrock, 2022; Hodges & Northway, 2019; Mottershead & Woodrow, 2019; Niven et al., 2020) and briefly suggested by Hollomotz (2021).

Synthesis of themes

Findings were thematically synthesised, informed by the six steps outlined in Braun and Clarke's (2022) reflexive thematic analysis (RTA) process. These steps consist of familiarisation with the data, coding, generating initial themes, developing and reviewing themes, defining and naming themes and then writing up (see Appendix C for process flow chart). In total following this process three themes were developed. It is noted that the researcher has previous clinical experience working

with people who have a learning disability and an interest in seeing less restrictive practices and increased independence where possible for service users.

Balancing risk

The first theme to emerge was around the concept of balancing risk, and how professionals are trying to find the right position between risk averse practices and therapeutic risk taking to promote autonomy. Banks et al. (2021) and Oloidi et al. (2020) bring attention to staff anxiety and concerns regarding risk management, particularly relating to individual vulnerabilities. These concerns are often heightened by a societal blame culture, where fear of being held responsible can influence decision-making; “We live in a blame society don't we and people are afraid....for fear of what's going to happen” (Oloidi et al., 2020). Chester et al. (2017), Hodges and Northway (2019), and Hollomotz (2021) discuss the need for comprehensive risk assessments that are not only robust but also involve a multidisciplinary and holistic approach. They emphasise that effective risk management should integrate input from various professionals, including health and social care teams, to ensure that decisions are made in the best interests of the individual. This approach also aligns with broader safeguarding frameworks, where collaboration between agencies is key.

In a different perception of risk, Niven et al. (2020) and Coleman and Sharrock (2022) focus on the implementation of restrictive practices and enhanced supervision as methods for managing perceived risks. While these practices may address immediate concerns, they highlight the tension between managing risks and supporting individuals to live more independently. This highlights the importance of achieving a balance between protection and empowerment in care settings, ensuring that restrictive measures do not undermine the individual's autonomy or potential for positive outcomes.

Clifford et al. (2018) discuss that while risk-averse approaches often focus on minimising any potential harm, they can also restrict opportunities for growth and development; “I don't want to take any risks even if it's gonna mean this service-user is gonna be happier and more liberated” (Clifford et al., 2018). Therapeutic risk-taking, by contrast, allows individuals to engage in activities that may involve some

level of risk but are ultimately beneficial to their well-being and autonomy. Striking a balance between these two approaches is important, particularly in care settings where the aim is to empower individuals without compromising their safety.

Similarly, Coleman and Sharrock (2022) emphasise that overly harsh restrictions and a lack of proper education can actually exacerbate risks. When individuals are subjected to excessive limitations without adequate understanding of their own capacities and vulnerabilities, it can lead to frustration, non-compliance and increased risk-taking behaviour. This highlights the importance of adopting a balanced approach to risk management that considers the individual's abilities, promoting education and self-awareness alongside appropriate safeguards. By empowering individuals to understand and manage their own risks, care providers can foster greater independence while still ensuring safety.

Importance of experience and appropriate professional input

Experienced staff are highly valued in community learning disability care settings for their ability to manage risks effectively, as noted by Banks et al. (2021). Their expertise and confidence allows them to navigate complex situations, particularly when managing risk and vulnerability such as behaviour that challenges, including physical aggression, ensuring that risks are identified and addressed in a timely and appropriate manner. This experience also helps to mitigate staff anxiety and contributes to more informed decision-making. Additionally, the involvement of the right professionals and agencies plays a crucial role in successful risk management and safeguarding, as highlighted by Hodges and Northway (2019) and Chester et al. (2017); "I would always want to do this through a multi-disciplinary, multi-agency meeting where possible." This was deemed important as specific guidance could be offered by different agencies or teams in relation to risk management, based on their assessments, knowledge and service remit.

Effective decision-making requires collaboration between various professionals, including health, social care, and specialist teams, to ensure that different perspectives are considered. A multidisciplinary approach helps in creating more comprehensive risk assessments and strategies, providing a holistic view of the individual's needs and circumstances. This collaborative effort not only supports

better outcomes but also reinforces the risk management process by ensuring that no single professional holds the responsibility of decision-making alone.

Policy, Support systems and Education

This theme describes the importance of policy, support systems and education for professionals around risk management and the challenges that can arise when this is not available. Hodges and Northway (2019) and Oloidi et al. (2020) highlight staff frustrations regarding the decision-making process in relation to risk management, particularly due to the absence of specific legislation and clear organisational policies; “The most frustrating thing is, is that we don’t have that legislation.. Yeah, I don’t know, I suppose because we haven’t had it, you work with what you’ve got” (Hodges & Northway, 2019). This lack of guidance often leaves staff feeling unsupported, leading to uncertainty and inconsistency in how decisions are made. Without clear frameworks to follow, professionals may struggle to make confident, well-informed decisions, increasing their anxiety about potential repercussions. These frustrations evidence the need for more structured policies and legal frameworks that offer clarity and direction in risk management practices. The absence of such guidance can also negatively impact service users, as inconsistent or overly cautious decision-making may lead to unnecessary restrictions, reduced autonomy, or delays in accessing appropriate support.

Similarly, Jingree (2015) and Mottershead and Woodrow (2019) emphasise the importance of having tools and frameworks in place to support consistent and defensible clinical decisions. These frameworks provide professionals with a structured approach to decision-making, ensuring that their actions are both evidence-based and justifiable. Tools that guide clinical decisions can help mitigate risks, reduce variability in practice, and ensure that decisions align with best practices. This not only protects the individuals receiving care but also offers reassurance to staff, knowing that their decisions are supported by reliable systems and processes.

Hollomotz (2021) and Coleman and Sharrock (2022), stressed the importance of ongoing support and education for both staff and service users. Continuous professional development helps staff to stay informed about best practices,

equipping them to handle complex situations and make well-informed decisions in relation to risk management. Equally, educating service users about their own care and risk management promotes autonomy and encourages active participation in their own safety. This dual focus on education for both parties creates a more informed, proactive environment, reducing risks and improving outcomes.

Mottershead and Woodrow (2019) and Hollomotz (2021) also identify the value of practical tools and training to enhance clinical judgment and risk management. Access to structured tools and frameworks allows staff to approach risk management with greater confidence and consistency, ensuring that their decisions are both defensible and aligned with best practice; one study discussed the Dynamic Support Database RAG rating tool (a risk assessment tool) and commented: "I think the DSR is a very helpful tool to aid clinical reasoning when working with someone [...]" (Mottershead and Woodrow, 2019). Practical training not only strengthens clinical skills but also supports staff in applying theoretical knowledge to real-world situations, ultimately improving their ability to manage risk and provide safer, more effective care.

Discussion

The findings from this review provide insights into how professionals manage clinical risks in community care settings for individuals with learning disabilities. As discussed at the start of this review, there is a need for robust risk management and clinical support to ensure successful transitions from institutional care to community settings (NHS England, 2017). Risk perception, which is one element of the theme of balancing risk, aligns with this; as many studies emphasise how varying perceptions of risk can influence the approaches used by professionals (Banks et al., 2021; Oloidi et al., 2020). Concerns about individual vulnerabilities, combined with a societal blame culture, were shown to heighten staff anxiety and sometimes lead to overly cautious decision-making. These findings stress the importance of having clear guidelines and support systems that not only prioritise safety but also allow for a more person-centred approach to care, as emphasised in the "Transforming Care" agenda (Department of Health, 2012).

The theme of 'Balancing risk' that emerged in this review can be compared to previous research and policy which identifies the importance of balancing safety and

empowerment in community care settings (Mencap, 2019). Clifford et al. (2018) discuss the limitations of risk-averse approaches, which can sometimes restrict opportunities for personal growth and autonomy. Alternatively, therapeutic risk-taking allows individuals to engage in activities that, while involving some degree of risk, can lead to better outcomes for their independence and well-being. This tension highlights the need for care providers to navigate the balance between protecting individuals and supporting them to take positive risks, empowering individuals while ensuring their safety through effective risk management strategies.

The findings also highlighted that experienced staff and multidisciplinary working are critical to managing clinical risks effectively, which aligns with current recommendations about the need for specialist staff and collaboration between health and social care teams. Several studies highlighted the value of experience in making informed decisions and mitigating risks, with Banks et al. (2021) proposing that experienced staff are better equipped to manage complex, higher risk situations. Chester et al. (2017) and Hodges and Northway (2019) also emphasised the importance of involving different professionals to ensure that all perspectives are considered, leading to more comprehensive risk assessments. This collaborative approach mirrors the policy framework suggested by the Care Quality Commission, (2021), where agencies work together to promote better outcomes for individuals with learning disabilities.

The review also identifies significant challenges for professionals, particularly around the lack of clear policies and legislation, which echoes previous research calls for more structured risk management frameworks. Hodges and Northway (2019) and Oloidi et al. (2020) highlight the frustrations of professionals who often feel unsupported by the absence of specific guidelines. This uncertainty not only increases anxiety among staff but also leads to inconsistencies in decision-making. These findings suggest that clearer policies, such as those mentioned in the "Building the Right Support" action plan (House of Commons Library, 2023), could help address these challenges, enabling professionals to make more confident and well-informed decisions.

The theme of 'Policy, Support systems and Education' also highlights the need for ongoing staff development and training. Studies by Hollomotz (2021), and

Coleman and Sharrock (2022) stress the value of continuous professional development and education for both staff and service users. By providing ongoing training, care providers can ensure that staff remain updated on best practices and are better equipped to manage risks. This, in turn, promotes a more proactive and informed care environment, which enhances the overall quality of community care services and aligns with the broader goals of learning disability care services, particularly in relation to promoting independence and person-centred care for service users.

This review identifies several key factors; balancing risk, clinician experience, collaboration between agencies, challenges arising from lack of policy, and the need for education, that are vital for managing clinical risks in community care settings for individuals with learning disabilities. These findings highlight the need for a balanced approach to risk management, where safety and empowerment are prioritised equally, and where clear policies and professional support systems are in place to guide decision-making.

Clinical implications

The review highlights several key factors that can be considered as having clinical implications for professionals in learning disability services. The importance of a multidisciplinary team, including experienced clinicians, in ensuring comprehensive and informed decision-making. Supporting staff around risk management is essential, as they often face complex situations that may require additional guidance or confidence. This support can be enhanced by having clear, accessible policies and tools that staff can easily refer to when making risk related decisions. Additionally, there may be a need to review current organisational tools and policies, alongside providing further training for all members of staff. Such training should focus on achieving a balance between positive risk-taking and ensuring safety, equipping staff with the skills to manage risks while promoting independence and growth for service users.

Strengths and Limitations

The strengths of this review include the relatively good quality of the literature included, with the majority of scores on the quality appraisal tool being high and positive factors such as researcher triangulation, clear aims and ethical

considerations well explained in most studies. This review was also conducted by a clinician with previous experience in the learning disability clinical area and therefore some familiarity with the topics and supervised by a research supervisor who has clinical and research expertise in this area.

The limitations of this review include the fact that the literature was centred on staff and carer perspective of risk management and therefore the voice of the service user was not captured. Attempts were made by one of the studies reviewed (Niven et al., 2020) to initially involve service users as direct participants however this was ultimately not deemed possible. All papers were also reviewed by a single researcher and therefore it is possible that bias occurred, however this was attempted to be mitigated by discussions with the research supervisor.

Further research and recommendations

Further research could investigate how professionals working with people with a learning disability manage specific risks in the community, as this review looked at a range of clinical risk management. A second research recommendation would be to explore service user's perception and experience of risk management, and how this compares to the current experience of staff who support people with learning disabilities.

Some studies included recommendations for future research. Hodges and Northway (2019) suggested exploring whether the factors identified in their study impact safeguarding practices for people with learning disabilities in other regions and countries, as well as how these factors influence the safeguarding of other vulnerable groups. Coleman and Sharrock (2022) highlighted the need for further research on supporting individuals with learning disabilities in navigating personal sexuality, different types of relationships and internet safety, particularly in relation to online dating and accessing relationships through digital platforms.

Conclusion

Overall, the quality of the research was found to be good, with the consistent limitation in almost all of the studies being the lack of consideration from the researcher between themselves and the participants. The three key themes found from the literature were; (1) Balancing risk, (2) Importance of experience and

appropriate professional input and (3) Policy, support systems and education.

Further research could include how professionals working with people with a learning disability manage specific risks in the community, and how people with a learning disability experience risk management practices.

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Paper 2: Empirical Paper

Working with Sexual Vulnerability: The Experiences of NHS Clinicians supporting People with Learning Disabilities

Word count: 7880

This paper has been written in accordance with University requirements for thesis submission, with the intention of submission for publication in the Journal of Applied Research in Intellectual Disabilities. Author guidelines for manuscript submission can be found in Appendix D.

Key words: Sexual vulnerability, Learning disabilities, Reflexive thematic analysis, Community learning disability teams

Abstract

Introduction

People with learning disabilities are disproportionately sexually vulnerable, facing barriers such as societal prejudice, lack of education, and communication difficulties when accessing support. This study explores clinicians' experiences in supporting individuals with learning disabilities around issues of sexual vulnerability, focusing on the challenges they encounter and the implications for practice.

Method

This qualitative study employed semi-structured interviews with 11 clinicians from Community Learning Disability Teams (CLDTs) in NHS Trusts across Staffordshire and Shropshire. Participants included registered nurses, occupational therapists, and clinical psychologists, all with at least one year of experience supporting individuals with learning disabilities. Data was analysed using Reflexive Thematic Analysis (Braun & Clarke, 2022).

Findings

Five themes were produced from the analysis:

1. Ignorance is not bliss: Lack of education
2. The internet: Fresh challenges in sexual vulnerability
3. Protection or people's rights: What is the bottom line?
4. Risk focused mindsets: Negative attitudes toward sexuality and relationships
5. Polarity of multiagency working

Conclusion

This study found that professionals are strongly motivated to advocate for the rights of people with learning disabilities to engage in safe and fulfilling sexual relationships, despite facing significant barriers such as societal stigma, limited education, and the complexities of online risks. Their persistent advocacy highlights a need for systemic change to better support inclusive, rights-based sexual health practices.

Introduction

A learning disability is defined by three core criteria: lower intellectual ability (usually an IQ of less than 70), significant impairment of social or adaptive functioning (such as problem solving, planning and abstract thinking), and onset in childhood (National Institute for Health and Care Excellence, 2015). Different terminology is used internationally, with “intellectual disability” commonly used in regions such as North America, Australia, and parts of Europe. However, as this study was conducted in the UK, the term “learning disability” will be used throughout, in line with terminology adopted by UK services, including the NHS. In the UK, it is estimated that approximately 1.5 million people have a diagnosis of a learning disability (Mencap, 2024), with significant variability in the level of support required to navigate daily life and maintain autonomy. Individuals with learning disabilities continue to face substantial barriers in accessing appropriate healthcare services, leading to increased vulnerability to harm (Women and Equalities Committee, 2024).

People with learning disabilities have been shown to be at risk of powerlessness, lack of choice and inhumane treatment from others (O’Hara, 2019). This includes the risk of sexual abuse, with studies reporting figures such as one in three adults with learning disabilities experiencing some form of sexual abuse in adulthood (Tomsa et al., 2021), and children with a learning disability are at four times greater risk of experiencing sexual abuse than children without a learning disability (Sullivan & Knutson, 2000). However, disclosing abuse or sexual violence can be particularly challenging for this population due to communication difficulties, having to navigate a complex system which focuses on victim behaviour and witness credibility and a lack of inclusive practices from agencies that are meant to support disclosures (Jobe & Williams, 2020). As a result, cases of abuse are often underreported (Willott et al., 2020) and the voices of people with learning disabilities may be overlooked in safeguarding or criminal justice processes.

There is not a universally accepted definition of sexual vulnerability, different definitions are proposed. The World Health Organisation (WHO) (2023) state that sexual vulnerability can be defined in relation to sexual exploitation or abuse of a person of less power than another person. This framing places emphasis on the

power differential between parties, suggesting that vulnerability arises externally, through the actions of others who hold more power, and can manifest in forms such as harassment, coercion, or sexual assault. In contrast, Hollomotz (2011) proposes a more nuanced, contextual definition, arguing that sexual vulnerability stems from a combination of risk factors embedded within the individual's wider social context. These include access to sex education, the ability to exercise self-determination, opportunities for friendships and sexual relationships, and the level of social inclusion experienced.

These two definitions reflect different conceptualisations: the WHO (2023) focuses on vulnerability as situational and relational, while Hollomotz (2011) highlights the systemic and social factors that may render someone vulnerable over time. Hollomotz's perspective highlights the paradox that labelling someone as 'vulnerable' can lead to protective restrictions, such as withholding sex education, which may unintentionally increase risk. Research supports this concern, showing that people with learning disabilities often receive limited or inconsistent education on relationships and consent (McCarthy, 2014), leaving them less equipped to navigate potential risks.

Additionally, sexual health is an area of health inequality for people with learning disabilities in the UK (Public Health England, 2023). It has been proposed that this could be due to societal stigma and the potential infantilising of people with learning disabilities (Grieve et al. 2009) meaning that carers, family or even clinicians believe it would be 'inappropriate' for a person with a learning disability to engage in, or receive education and support around, sexual relationships. This taboo nature appears to lead to this topic becoming an area of possible unease for healthcare professionals (Doughty et al. 2017) which may affect the service that is available for people with learning disabilities to find support around their sexual health.

The potential impact of sexual abuse on individuals with learning disabilities can be profound, with evidence reporting increased rates of post-traumatic stress symptoms, social withdrawal, behavioural and mental health problems (Sequeira et al., 2003). Despite this, healthcare professionals often face challenges when addressing sexual health and vulnerability with this population. A lack of access to appropriate resources along with the sensitive nature of the topic can contribute to

hesitation in addressing these issues (Doughty et al., 2017). This information is concerning to staff supporting people with learning disabilities, with studies reporting 68% of staff surveyed believe people with a learning disability are at higher risk of sexual abuse, and due to this level of concern, 88% of staff members surveyed felt that further information pertaining to this concern should be provided in their workplace, in order for them to feel better informed and able to support (Allington, 1992).

Limited previous research has explored the experiences of staff working with people with learning disabilities in relation to sex and relationships. Bates et al. (2020) conducted latent thematic analysis using data collected from 26 participants through focus groups, which explored staff experiences of supporting service users in forming and maintaining relationships. The study identified key themes including organisational barriers, the challenges staff face when offering support, and the emotional needs of service users. Similarly, Maguire et al. (2019) employed Interpretative Phenomenological Analysis (IPA) to examine how support workers understand and navigate their role in supporting the sexuality of people with learning disabilities. Based on interviews with six participants, the study identified themes such as the perception of sexuality as a minor part of their role, tensions between facilitating and protecting, and the absence of clear guidance or a 'rulebook' when dealing with these issues. Both studies focused on the perspectives of support workers and were conducted through social care ethical processes. In contrast, the present study seeks to explore the experiences of a broader range of healthcare professionals working in NHS Community Learning Disability Teams (CLDTs). To date, there appears to be a lack of research capturing the views of qualified NHS professionals on this topic, representing a significant gap in the literature that this study aims to address.

In summary, the research discussed demonstrates that clinicians supporting people with learning disabilities feel that the people they support are at higher risk of sexual abuse and that further guidance and information is required. Addressing these gaps in knowledge is crucial to ensure that individuals with learning disabilities can access safe and supportive care. In combination with a lack of a universally accepted definition of sexual vulnerability and the taboo nature of the topic, the

resulting stigma and health inequality has led to an under-researched area of clinical practice.

The current study

This study will contribute new information to the evidence base around sexual vulnerability in people with learning disabilities by gathering the perspectives of clinicians currently supporting people in this area. Potential outcomes with clinical impact may include providing evidence for further training if this is highlighted as an area of need, or potential contributions to resources used to support clinicians in this area of work.

What are the experiences of clinicians working with adults who have a learning disability and have experienced sexual vulnerability?

Design and Methodology

The researcher's reflexive position

The researcher is a Trainee Clinical Psychologist with previous experience working in a CLDT and a strong interest in advocating for and supporting people with learning disabilities. Through clinical experience in the area of sexual vulnerability, the researcher holds a commitment to safeguarding service users while also advocating for the rights of people with learning disabilities to express their sexuality and engage in sexual relationships if they choose to.

Data analysis was conducted from a critical realist position, acknowledging that the data collected is the participant's reflection of reality, as influenced and shaped by their context (Willig., 2013). An epistemological perspective of postpositivism is taken by the researcher, moving away from a positivist assumption of an objective knowledge towards consideration of the influence that individual values and culture bring (Braun & Clarke, 2022).

Design

The current qualitative study employed semi structured interviews to gather rich data about participants experiences which could then be analysed using Reflexive Thematic Analysis (Braun & Clarke, 2022).

Sample

Participants were recruited from Community Learning Disability Teams (CLDTs) within NHS Trusts in the Staffordshire and Shropshire area. The inclusion criteria required clinicians to be qualified professionals, rather than students, with a minimum of one year's experience working within the team. One year was decided as an adequate time period for clinicians to have worked with a range of service users and have gained experience in this specific context. Additionally, participants were required to self-identify as working with service users with a learning disability who had experienced sexual vulnerability. Potential participants were provided with an information sheet (Appendix E) about the study, which was disseminated by email through team managers to facilitate recruitment.

Qualitative research often employs the concept of data saturation as a guide for researchers as to when to stop data collection, however this concept is problematic as it is not consistent with the values and assumptions of reflexive thematic analysis (Braun & Clarke, 2019). Instead, the idea of information power is proposed, encouraging researchers to decide when to conclude data collection with an adequate sample based on a number of factors, including study aim, sample specificity, use of established theory, quality of dialogue and analysis strategy (Malterud et al., 2016).

Data collection concluded after a total of 11 interviews with participants from diverse professional backgrounds, including registered nurses (n = 5), occupational therapists (n = 2), and clinical psychologists (n = 4). All participants had been working with service users in CLDT's around issues of sexual vulnerability for at least one year, this included providing education, risk assessment and multi-agency liaison work as well as a variety of other clinical work. To ensure confidentiality and maintain participant anonymity, all individuals were assigned pseudonyms and any identifying details were omitted from the study.

Interview

The interview conducted was semi-structured, to allow for flexibility within each interview to follow the participant's lead in terms of topics discussed, whilst still maintaining focus on the research objective (Adams, 2015). An original four questions were developed (Appendix F) through discussion with the researcher's

academic supervisor and reading of background literature, with scope to add follow up questions such as “you mentioned X topic, could you tell me a bit more about that?” The first question asked participants about their understanding of sexual vulnerability, aiming to explore clinicians interpretation of this term, hence it was not defined to participants as part of the research process.

Data collection

Prior to interviews, participants were able to ask any questions regarding the study, and written informed consent was obtained (Appendix G). Data was collected through semi-structured interviews, which provided participants with the flexibility to elaborate on topics they deemed significant while allowing the researcher to adapt the interview accordingly. Interviews were conducted either via Microsoft Teams video conferencing software or face-to-face at an NHS base selected by the participant. All interviews were audio and video recorded using Microsoft Teams and subsequently transcribed. To ensure the accuracy of the data, transcriptions were reviewed before analysis, with any identifying details removed to maintain participant confidentiality. Following the interview, participants were provided with a debrief (Appendix H) to discuss any concerns and receive information about how to withdraw their data if they wished. Sources of support, in addition to the researcher, were provided in the event that any aspects of the interview had been found to be distressing. This approach ensured that ethical considerations were upheld throughout the data collection process, safeguarding the well-being and privacy of participants.

Data analysis

Braun and Clarke’s (2022) Reflexive Thematic Analysis (RTA) model was chosen for this research as it could be aligned with the researchers’ philosophical positions as well as desired approaches. As the research question focused on the perspectives of clinicians, RTA was conducted in an experiential, inductive approach in order to capture these views. The analysis process consisted of six phases: (1) dataset familiarisation, (2) data coding, (3) initial theme generation, (4) theme development and review, (5) theme refining, defining and naming and (6) writing up. Coding of the data took place using NVIVO software (see Appendix L. for extract of coded transcript) and codes were subsequently organised on a separate

spreadsheet to allow for themes to be refined and defined (Appendix M). Themes were produced from the researcher's systematic engagement with the data, incorporating ongoing reflexive processes: discussions with supervisors, and a reflexive journal (Appendix P) allowed the researcher to hold their own position and views in mind when analysing the data. The researcher also attended an RTA group with other researchers, to present their working ideas, and discuss this in a reflexive capacity.

Ethical considerations

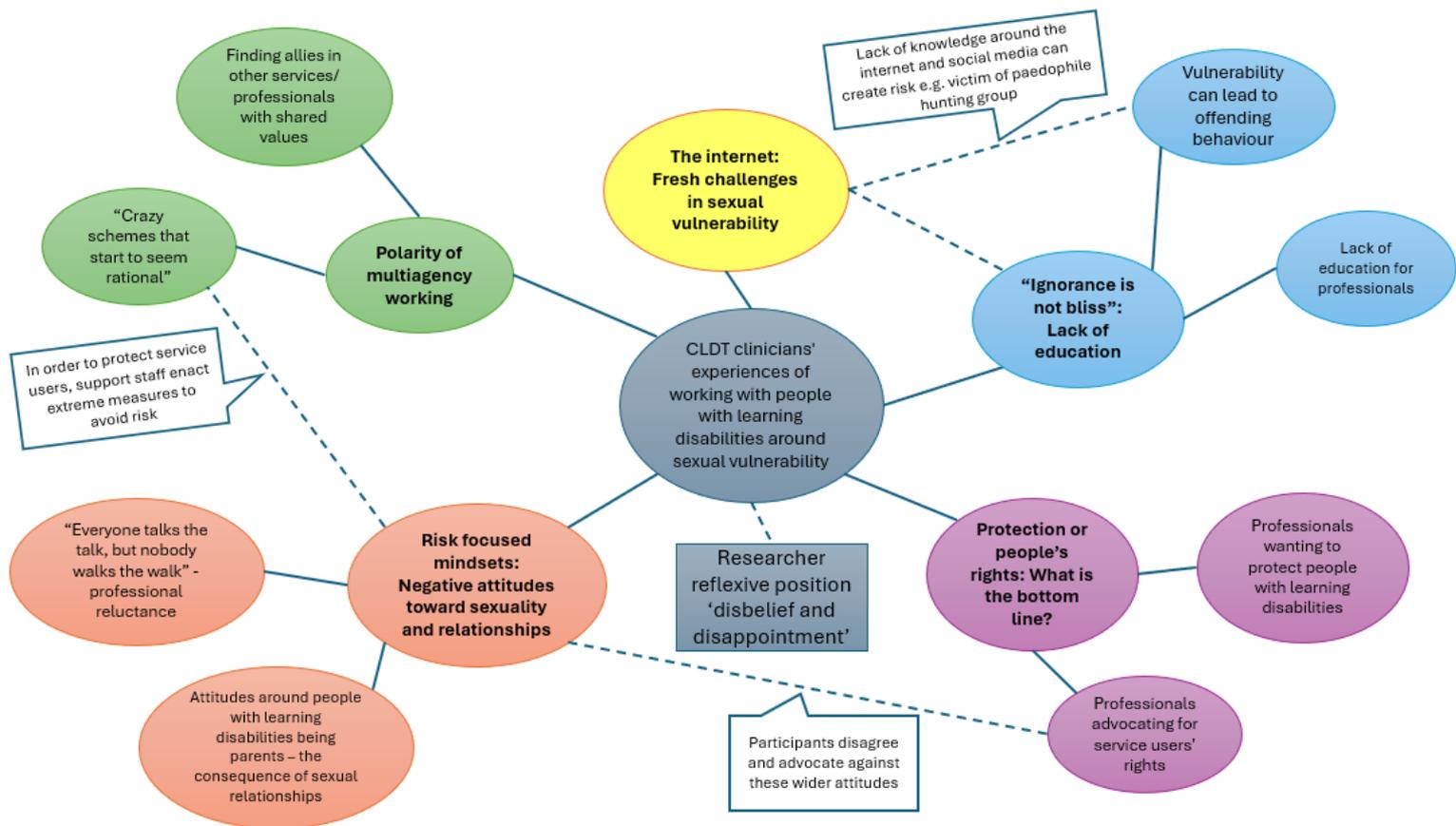
Ethical approval was first granted by the University of Staffordshire ethics committee (Appendix I) following which approval was granted by the Health Research Authority (HRA) through the Integrated Research Application System (IRAS) process (Appendix J). Both NHS Trusts in which participants could be recruited from granted approval to conduct the study (Appendix K).

Results

Five themes describe elements of the clinicians' experiences of working with people with learning disabilities around sexual vulnerability. These themes contained further sub themes which can be seen in the thematic map below (Figure 1). Although distinct themes, there are links between themes which can also be seen on the thematic map and will be described further throughout. Additional supporting quotes can be found in Appendix N.

Figure 1

Thematic map displaying themes, sub-themes and the links between these.



Ignorance is not bliss: Lack of education

Clinicians described how service users with learning disabilities often lacked education around sex and relationships, framing this absence as a systemic failure and a denial of rights to that education. This lack of knowledge was attributed largely to shortfalls in the education system, leaving professionals to address significant gaps in adulthood. Participants highlighted their role in providing this delayed education, often working to 'catch up' in order to address areas of potential vulnerability.

"Throughout education right from the early age, they're denied key pieces of information because they're not... They don't have the same access to the general curriculum as the mainstream pupils. So that puts them at a disadvantage." –

Participant 5, p.1

“But special schools do still exist. And I'm just hoping they've modernised that part of the curriculum as well as everything else, and it is keeping pace with things like social media, internet pornography, because if it's not, then again, people aren't being afforded the same opportunities as people without a learning disability. So, if you don't know, ignorance is usually not bliss, there can be big gaps for people that can be problematic.” – Participant 10, p.12

Lack of education for professionals

Participants highlighted a widespread lack of education around sex and relationships, with this subtheme describing issues not only for people with learning disabilities but also for clinicians themselves. This gap was described as a systemic failing, with insufficient training and resources leaving staff underprepared to support service users effectively. Clinicians reflected on the need for improved education provision across services in order to deliver informed, confident care.

“I guess having your own education and awareness and we don't always like, I can't speak for other disciplines but as an LD nurse, you don't always have a specific training on sexual health like you don't have the sexual health experts come in and educate you, so that is potentially a challenge as well.” – Participant 4, p.10

“I guess like professionals need a lot of education and support in order to know how to support people best. Really, don't they? That's like, you know, so that we can support families and carers and all the rest of it to support our clients to have as good a life as they can have, isn't it so it's not just about education for our clients, it's about education for us as well. Education for all of us.” - Participant 11, p.15

Vulnerability can lead to offending behaviour

Participants spoke about the potential risks of not educating people with learning disabilities about their own vulnerability, describing incidents of service users being ‘caught by paedophile hunting groups’ due to a lack of understanding of their own behaviour online along with other potential offending behaviour arising from a lack of education.

“So if something perhaps happened due to a lack of understanding or lack of education, or possibly just not the opportunity to express themselves sexually and so they were you know, I don't know for instance, sexually touching another male in a

toilet at a day service. Once they've got that label of being a sexual risk the opportunities for relationships for the rest of their life may then be affected because it may be that they're considered to be a risk for the rest of their life” – Participant 3, p.10

“So you know, there are younger males who have set up groups to groom her and she believes that she's speaking to someone of her own age when she's actually speaking to, like 11 or 12 year olds sometimes and agreeing to meet them, but then creating this, like, whole drama about her being a paedophile and all of that. So that has a flip side to it for her as well, because she then gets herself into bother with police. And so, yeah, but it is purely because she's so vulnerable and doesn't understand what they're doing.” – Participant 8, p.2

The internet: Fresh challenges in sexual vulnerability

As alluded to in Theme 1, the internet and social media have emerged as significant and evolving factors in clinical work. Participants described how online platforms present new challenges and increase the sexual vulnerability of people with learning disabilities, highlighting the need for updated approaches and digital safeguarding strategies. Clinicians raised concerns about dangers such as online grooming, the misuse of artificial intelligence, and the sharing of indecent images.

“I guess a very 21st century vulnerability, sexual vulnerability is one we came across recently where a woman who, she lives in a 24 hour staffed home. And she spends long long periods of time on the internet and sometimes she won't join in activities. She's there isolating herself, she generally eats, but it can be late for meals and stays up late. And these kind of things. And as it turns out, she's got a virtual boyfriend.” – Participant 5, p.8

“So she is making friends online. And these friends, in inverted commas, are asking her to send pictures of herself, you know, in various states of undress which she has been doing. So that is kind of like sexual vulnerability because like you know police have to be involved. She is now having to sort of like be supported to use the internet in a different way. The police are having to follow through with, you know, a court case to see whether or not they can prosecute any of the people who've been exploiting her.” – Participant 11, p.3

“We've also had the move forward with the social media and all the other aspects that come alongside that. And the added complications that yes, it gives lots of opportunities, but at the same time, it's also given us fresh challenges that are quite complex I think to deal with. So I can see a lot of changes.” – Participant 6, p.18

“But people do need to be able to do it, but in a safe way and that's about education. And it might be for some people. It might be about getting the right support to make sure that they're safe on the Internet, but people get into all sorts of bother and, you know, accept all sorts of random people who don't have their best interests at heart and you know, pretend to be a friend and you know, like I say, very high profile professional people have been caught, haven't they? So it's not sort of too far stretched to think that our client group will be.” – Participant 11, p.8

Participants emphasised the importance of enabling service users to access the internet safely, advocating for supported digital inclusion rather than restriction. As seen on the thematic map there are links between the theme of lack of education, risk of offending and the internet. Denied education around internet use and social media can result in a lack of knowledge that places service users at risk of engaging in offending behaviour, sometimes without fully understanding the consequences. One example raised was the risk of individuals unknowingly becoming involved in illegal online activity or being targeted by paedophile hunting groups, further compounding their vulnerability.

Protection or people's rights: What is the bottom line?

This theme describes the conflict professionals experience between protecting service users and advocating for their rights to autonomy and sexual expression. Participants frequently spoke about the complexity of navigating this 'fine line', describing how challenging it can be to weigh up safety concerns against the importance of supporting individuals' rights. Many reflected on the balance involved and highlighted how this decision-making process is rarely straightforward. As a potential solution, participants discussed the concept of positive risk-taking, supporting service users to engage in relationships and sexual expression while putting reasonable safeguards in place. This approach was seen as a way to uphold rights without overlooking genuine risks, though participants acknowledged it required careful, considered judgment in each individual case.

“For me, it's about how do you keep people safe in this context, in a way that isn't sort of like treading on their rights to have a, you know, a social life, if you know what I mean.” – Participant 11, p.10

“I think you know the biggest challenge is getting that balance between the risk taking and the protection.” – Participant 7, p.11

“Yeah, you know, looking at how we enable people, but bearing in mind the sort of safeguarding the safety and the other elements and what we need to and it's about positive risk taking as well, isn't it?” – Participant 6, p.14

“It's having that balance, isn't it? And having that trust in people but they can make decisions and take calculated risks and what have you.” – Participant 7, p.8

Professionals wanting to protect people with learning disabilities

Participants discussed ‘the bottom line’ of keeping people safe and protecting service users from harm, inferring that this element of protection is the most important consideration and must come before anything else. This could arise from a duty of care embedded in professional guidelines, as well as safeguarding procedure. However, discussion arose around where this can stray into overprotection, sometimes meaning people with learning disabilities are not able to experience a natural learning process by making a mistake.

“Yeah, but I suppose it does go back to sort of this fine line, doesn't it? You've got to keep people safe. That is the bottom line. We have to keep people safe. And you know, if that means taking away someone's liberty in certain areas of their life, we have to do that to keep them safe. And you know, we have that duty care to be alerting, you know, social services or the police if we've got concerns about what's happening and so that is the bottom line really. So you have to protect.” – Participant 11, p.10

“Yeah, it can at times lead to kind of an over protection and people not maybe being allowed to make the mistakes that other people make, or maybe teenagers make in terms of relationships and sex and what have you.” – Participant 7, p.7

“And I guess the other thing is that it's uncomfortable for you as a professional. So that woman that I mentioned earlier who's having lots of sexual partners, you kind of

want to do something to stop her from putting herself at risk because whether she was being harmed or not, she was putting herself in really vulnerable positions.” – Participant 9, p.8

Professionals advocating for service users rights

Participants were passionate in their views on advocating for the rights of people with learning disabilities to have safe sexual expression or a relationship if they choose to. This arose largely from witnessing barriers and injustices service users had faced in this area. Clinicians described feeling they had to “fight” to ensure service users' voices were heard and their rights upheld, whilst also dispelling myths that every person with a learning disability is sexually vulnerable and therefore should have this part of their life restricted in some way.

“I think because you know the biggest part of our role isn't it is advocating on behalf of the service user and making sure that you know that that everything's OK for them.” – Participant 8, p.15

“So we're trying to advocate for the clients that not everyone is sexually vulnerable, but equally recognising where there are areas.” – Participant 1, p.12

“And I think it comes down to sort of human rights really and the right that people have to be part of society to make decisions about their lives. And to be empowered, really, I suppose, to be like anyone else. And I think like sexual needs are just part of that.” – Participant 9, p.19

“And the fact that people were so disregarded or misunderstood or so vulnerable and why shouldn't somebody with a learning disability have, you know, a healthy sexual relationship as somebody without? And I found that concept very difficult to understand, and I've battled with that concept.” – Participant 2, p.3

Risk focused mindsets: Negative attitudes toward sexuality and relationships

This theme describes how participants experience the attitude of others, towards people with learning disabilities around sex and relationships, including other professionals and people within the wider systems around service users. Particular topics that arose included participants reporting encountering the attitude

that sex is something that people with learning disabilities should not, or do not do and how this is held as an 'automatic assumption' by some people.

"You're not interested in sex if you've got a disability. And it's just not something that you do." – Participant 9, p.13

"So you're talking about Epilim and Sodium Valproate and why this is, and there's lots of people who'll sort of say, well, they don't have sex. Does it matter? Well, yes, it does matter, because it's the principle of the matter...Yeah, yes, yes. There's a massive assumption, in that people with a learning disability can't have sex, or they shouldn't have children." – Participant 2, p.16

"That's the challenge in that the lack of education and training in other services to understand that automatic assumption that people are so limited that it can't possibly be the same, you know, they can't possibly, I don't know have sex or have sexual desires or you know, feel sexually frustrated or wish to access porn, or want a one night stand or whatever. It's almost like that part of life it's just assumed doesn't exist for someone because they have a learning disability." – Participant 3, p.18

On the thematic map, a connection is shown between the sub-theme of advocacy and the theme of risk-focused mindsets. This reflects how participants often challenged dominant, risk-averse attitudes, leading to frequent tensions as part of their clinical work. Their advocacy for service users' rights regularly brought them into conflict with wider systems and other professional groups.

Attitudes around people with learning disabilities being parents: The consequence of sexual relationships

Participants discussed the difficult experiences of supporting service users through pregnancies and child protection processes, with almost all discussing the removal of the child and challenging interagency working. Participants attributed this difficulty to the attitudes held towards people with learning disabilities being parents and how this is something they feel society, and some professionals, do not seem to think is acceptable.

"Well, I used to say that sex and relationships was the last taboo for people with a learning disability, but it's not, it's the second to last taboo. The last taboo is child rearing, and that's the vulnerability. That's the risk, the ultimate risk that they think will

occur. And that's the thing that they're absolutely... professionals are 100% convinced that no one with a learning disability would be able to bring up a child successfully.” – Participant 5, p.6

“So I think there's a lot of a fear around as well. I mean we're talking about sort of vulnerability, but a lot of fear still about women with learning disabilities having sex because, oh my god, they might get pregnant and then what? And then people are in almost an overprotection sort of mode, you know. It's that word. Vulnerable, isn't it?” – Participant 7, p.7

“I'm thinking about someone else who has successfully managed to be a single parent and you know, despite huge professional involvement, has actually sort of done very well and achieved a lot in her life, despite a really traumatic history. But also, despite being patronised, despite being condescended to despite being shown up and made to feel small and belittled and all the rest of it, you know actually showing you know professionals that they can go on to be a good enough parent.” – Participant 11, p.6

Everyone talks the talk, but nobody walks the walk: Professional reluctance

Participants described how risk-averse attitudes often translated into reluctance from other professionals to actively support people with learning disabilities in expressing their sexuality or engaging in safe relationships. While there was frequent talk of support, participants noted a lack of meaningful action, with service users often facing persistent barriers.

“Everybody talks the talk, but very few people are willing to walk the walk when it comes to actually enabling people with a learning disability to express their sexuality and to have a sexual relationship, and because nobody knows how to do it and that it's as much as people with a learning disability are vulnerable, that that vulnerability is enabled by the professionals and created by them.” – Participant 5, p.2

“So even when they've directly received reports about specifically recommending give person X a weekly opportunity to discuss any thoughts or feelings that they have around sex and relationships that they might want to discuss or you know remind person X that it is OK for them to talk about masturbation in private if they have any more queries or concerns you know and also reminding them that that's

something for a private space you know, so sometimes professionals are directly inviting support teams to really invite that openness and even then they're very reluctant, I think, they're kind of like oh that's none of our business that's too private."

– Participant 3, p.8

"So what we've got is that professionals are very earnest in their desire for people with a learning disability to be able to express their sexuality right down to the point where it comes down to the nitty gritty and actually demonstrating that or providing a sex positive environment." – Participant 5, p.2

Polarity of multiagency working

This theme captures the varied experiences of participants in multiagency working, which were often described as existing at two extremes. On one end, participants reported strong disagreements with the measures implemented by other agencies, which they felt conflicted with their own clinical judgment and values. On the other, they highlighted positive experiences when collaboration with like-minded professionals led to constructive outcomes for service users. These contrasting elements reflect the polarity of multiagency work, ranging from frustrating conflicts to highly supportive, value-aligned partnerships. This theme, supported by the data, is explored through two sub-themes, with the overarching theme reflecting the researcher's analysis of the contrasting extremes experienced in multiagency working.

Crazy schemes that start to seem rational

Participants expressed disbelief and frustration at some of the practices enacted by other teams or agencies around service users whilst 'supporting' them in matters of sexual vulnerability. This was often rooted in a perceived disconnect between the intended aim of protecting individuals and the actual impact of the actions taken, frequently experienced as undermining service users' dignity, rights, and autonomy.

"The example of someone who has capacity to have a sexual relationship but the staff must remain outside the door and listen. They're not to enter. The person themselves can have that the sexual partner in the room with the door shut, but the staff must listen outside the door to be able to dash in immediately if they need to,

because of the vulnerability of being exploited sexually and they provided her with an alarm, but she can shout also for the staff too to burst in Batman like. And do you remember me talking a little bit about or mentioning about these maladaptive practises that build up around people and the crazy schemes that people come up with that start to seem rational and proportionate.” – Participant 5, p.7

“The courts are basically asking the staff to vet their sexual partners.” - Participant 1, p.5

“But sometimes it's not even about risk, like there was one guy who I remember he wanted to go to a lap dancing club for his birthday and people panicked about this... he was on the [clinicians] wait list for ages. And then we did the waitlist review and he was like, well, that was like a year, you know, year ago. I don't want to go to a lap dancing club anymore.” – Participant 9, p.11

“Yeah. And I think that's where other agencies, you know, have that lack of understanding of someone with a learning disability and the vulnerabilities, you know, I mean, she didn't intentionally go out and get pregnant and, you know, just ditch a child. She tried her very, very best. And I think that's, that's where it becomes like you know, it was really sad. But yeah, she was she was very vulnerable, very and remains vulnerable.” – Participant 8, p.7

On the thematic map, a link is made between the theme of Risk-Focused Mindsets and the sub-theme Crazy schemes. In an attempt to protect service users, support staff were described as enacting extreme and intrusive measures to avoid perceived risk. These actions often appeared to stem from underlying negative attitudes towards people with learning disabilities engaging in sexual expression or relationships

Finding allies in other services: Professionals with shares values

At the other end of the spectrum of multiagency working, participants described positive experiences that they actively sought out. Finding like-minded professionals in other agencies was particularly meaningful, with shared values around advocacy often acting as the key to successful collaboration. Effective communication and a mutual commitment to supporting service users' rights were seen as essential components of constructive inter-agency relationships.

Disappointment was expressed when previously helpful roles, such as a Learning Disability Liaison Police Officer, were defunded.

“But I think the joined up working is really important in the multi agency approach. It's a good fit where we can get that, you can get some good team working, but it's not always that easily achievable and not everybody's on the same mindset always. Or you have to find somebody with an interest that you can then link and drive it forward that way” – Participant 6, p.15

“We used to have a police officer who was specifically employed by the police locally to work with adults with learning disabilities and then the post got defunded and things have been very bad since. If you ask me because when that policeman was involved he was very good. He got to know people, he kind of got to understand them. He worked very well with all the local social and healthcare teams, I think it was really, really good. But then that post went.” – Participant 11, p.11

“So I think there's something that's really important about the quality of communication that we have with our partner agencies when it's about really sensitive issues like this, there is also something about the people's experience and knowledge and openness to joint working.” – Participant 10, p.7

Discussion

Through an analysis process of RTA (Braun & Clarke, 2022) using data collected from 11 participants working in CLDT's with service users around issues of sexual vulnerability, this research produced five key themes; lack of education, the challenges of the internet, protection or peoples rights, risk focused mindsets and the polarity of multiagency working. The themes are distinct, but hold a degree of overlap, in that within all of them an element of stigma around people with learning disabilities engaging in sexual expression or sexual relationships can be found. These findings are unfortunately in accordance with previous research which highlighted the challenges people with learning disabilities face in this area due to the taboo nature of the topic (Grieve et al., 2009; Doughty et al., 2017). As a researcher and clinician holding personal and professional values around advocacy and equal rights for people with learning disabilities, feelings of disbelief and

disappointment were prominent whilst listening to the difficult experiences both service users and clinicians had faced whilst trying to advocate for the people they were supporting. In contrast, a sense of hope emerged from the compassion and determination with which participants spoke about their work.

A key theme identified in this study was the lack of education around relationships and sexual health for people with learning disabilities, which participants highlighted as a significant concern. Participants expressed unease that withholding this information may increase the sexual vulnerability of individuals they support, a concern that supports ideas proposed by Hollomotz (2011). It was suggested that limiting access to appropriate sexual education, often in an attempt to protect, can in fact have the opposite effect, by increasing vulnerability to abuse and, in some cases, contributing to inappropriate sexual behaviours or risk of offending. What clinicians are observing in practice reflects these theoretical concerns, reinforcing the idea that educational deprivation does not reduce risk but can exacerbate it. This lack of provision was often linked to stigma and negative perceptions of people with learning disabilities engaging in sexual relationships, which participants felt contributed to poor decision-making, such as the denial of education or the implementation of extreme 'protective' measures, that inadvertently increase vulnerability and further undermine individual rights.

The theme of internet use and the ever-evolving challenges it presents in relation to sexual vulnerability was a clear finding within this research. Participants voiced concerns about the complex risks that digital platforms pose including a lack of accessibility and the potential for other predatory users to remain anonymous, particularly for individuals with learning disabilities who may lack the skills or support to navigate online spaces safely. This finding aligns with previous research which highlighted a gap in the training and guidance available for support workers supporting people with learning disabilities to use the internet for personal and sexual relationships (Lines et al., 2020). Batey and Waine (2015) emphasise the need for professionals to establish 'digital professionalism' a term also recognised by the Nursing and Midwifery Council (2015). This competency is argued as necessary in order to support service users with their potential sexual vulnerability as well as minimising the risk of offending sexually online. The current reported lack of structured training can leave professionals feeling ill-equipped to address the unique

and rapidly shifting risks associated with online interactions, reinforcing the broader theme of inadequate education and resources for professionals. As technology continues to advance, the need for robust, up-to-date guidance and education becomes increasingly urgent to ensure safe and empowering digital engagement for people with learning disabilities.

Recent research exploring the experiences of people with learning disabilities using online platforms found that participants actively described attempts to protect themselves and avoid online dangers. However, they also expressed confusion and concerns, alongside a clear desire to learn and develop new skills to independently stay safe online (Chadwick, 2022). If this is a direct wish from service users, they should be supported, not restricted. Promoting digital literacy through education and appropriate support respects their rights and offers a more empowering way to reduce vulnerability.

Participants described encountering conflicting attitudes from others in service users support system, regarding the sexual relationships of people with learning disabilities. One particularly poignant and emotionally charged area emerged when such relationships resulted in pregnancy. Several participants reflected on the emotional toll of supporting service users through intense scrutiny as prospective parents, only to witness the removal of their children, often in what felt like predetermined decisions rooted in prejudice. Disappointingly, statistics support these anecdotal reports, with parents with learning disabilities over-represented in child protection processes, care proceedings and experiencing the permanent removal of their children (Booth & Booth, 2005). It could be hoped that practice and attitudes have progressed over the past two decades; however data produced as recently as last year does not support that hope. Study findings indicated the likely high prevalence of learning disabilities or difficulties among parents involved in care proceedings regarding babies (Burch et al., 2024) suggesting that systemic bias and lack of appropriate support may still be influencing outcomes today.

The theme of polarity of multi-agency working encapsulated participants' experiences of both challenging and positive interactions with other professionals. On one hand, participants recounted instances where they disagreed with what they perceived as extreme measures taken by other agencies, leading to tension and

frustration. Conversely, positive experiences were characterised by effective communication and shared values among professionals. Notably, roles such as the Learning Disability Police Liaison Officer were highlighted in facilitating understanding and collaboration between services. However, participants expressed disappointment over the recent defunding of this role, viewing it as a significant loss to multi-agency efforts. This concern aligns with a review of policy and practice which emphasised the importance of specialised roles in improving police responses to individuals with learning disabilities (Jacobson, 2008). The removal of specialised liaison roles may hinder such collaborative efforts, potentially impacting the quality of support provided to individuals with learning disabilities around issues of sexual vulnerability.

The findings from this research highlight a disconnect between current practice and government policy. According to the Department for Education (2021), relationships and sex education (RSE) must be made accessible for all pupils, with particular emphasis on those with special educational needs and disabilities (SEND). The statutory guidance highlights that some pupils may be more vulnerable to exploitation or abuse and that these subjects are particularly important for individuals with learning disabilities. The guidance advocates for tailored, developmentally appropriate teaching to meet the diverse needs of SEND pupils. The gap between policy and practice, suggests an area for development in both educational and clinical contexts. It is not only in the theme of education that a gap exists between policy and practice. Mencap (2025), the UK's leading learning disability charity, clearly advocates that people with learning disabilities have the same rights as anyone else to express their sexuality and form sexual relationships if they choose to. However, the denial of privacy seen in the theme of 'crazy schemes' and the negative attitudes towards sexuality along with the potential of relationships ending in pregnancies in the theme of 'parenting' and 'professional reluctance' shows that these rights are not consistently upheld in practice.

Strengths and Limitations

A key strength of this study is the topic itself, which is often stigmatized and avoided. Overcoming ethical and societal barriers to address important clinical and

research areas such as this work to improve the lives of people with learning disabilities.

A limitation of this research includes the lack of demographic information collected from participants, and how this may have influenced views e.g. age, gender etc. This was not collected due to concerns around protecting the confidentiality and anonymity of participants, with the participants of the research coming from small, specialist teams and being potentially identifiable. However it may have been possible to report this data in such a way that this information was protected.

Ideally the working themes would have been presented back to the participants for member checking to increase the rigour of the method and the credibility of the findings from a participant perspective. This limitation was mitigated to some extent through regular discussions with academic supervisors and by presenting the developing findings to a Reflexive Thematic Analysis (RTA) discussion group, attended by doctoral peers using the same methodology and research tutors from the clinical doctorate team. The researchers personal and professional experience in this field enabled them to be aware of their position, leading to rigorous engagement with the methodological process enhancing the reflective analysis.

Finally, while this study intentionally focused on the experiences of clinicians, a limitation lies in the lack of involvement of people with learning disabilities in shaping the research design. Involving individuals with lived experience in the development of the research design could have enhanced the relevance and impact of the study. Involvement at the design stage would have ensured that the research remained closely aligned with the priorities of those it ultimately seeks to benefit.

Future research and clinical implications

A key recommendation for future research is the inclusion of individuals with learning disabilities in order to explore their own perspectives on how they are supported around issues of sexual vulnerability. Additionally, given the constantly evolving use of the internet in the lives of people with learning disabilities, further research is warranted into the potential sexual vulnerability associated with online activity, including social media. This could extend to exploring how digital environments themselves can be made safer and more inclusive, to promote more

equitable online access. Another valuable area for investigation is the evaluation of sex and relationship education within special educational needs (SEND) schools and colleges, particularly in relation to its effectiveness and accessibility for young people with learning disabilities.

From a clinical perspective, the research highlights the need for improved resources and training to enhance other clinicians' confidence and competence in addressing sexual vulnerability. Currently, a small number of specialised professionals take on this work; therefore, developing peer-to-peer or even multiagency education initiatives may help to normalise the topic, reduce stigma, and broaden the cohort of professionals equipped to support service users in this area. Such efforts have the potential to improve access to timely and appropriate support for people with learning disabilities. Specialist liaison roles were also highlighted as invaluable but unfortunately had recently been defunded. This research provides evidence for the importance and utility of such roles in joined up working for the benefit and safeguarding of service users.

Conclusion

People with learning disabilities are disproportionately sexually vulnerable, and the professionals who participated in this research expressed a strong commitment to advocating for the rights of these individuals to engage in safe and healthy sexual expression and relationships. The research highlighted several barriers to providing adequate support in this area, including a lack of education, which may be influenced by societal prejudice, and the evolving challenges presented by the internet. Additionally, some other professionals and agencies reluctance to engage with this topic further complicates the issue. Despite these challenges, the participants in this study were driven by a powerful sense of advocacy and determination to fight for the rights of people with learning disabilities. This sense of purpose serves as a source of motivation, enabling these professionals to persist in their work and continue to strive for positive change in this important area of practice.

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Paper 3: Executive Summary

A summary of research conducted that is outlined in Paper 2.

Working with Sexual Vulnerability: The Experiences of NHS Clinicians supporting People with Learning Disabilities

This executive summary is intended for clinicians working in Community Learning Disability Teams (CLDTs) and provides a concise overview of the full research report. It highlights the key findings and implications for practice. Following discussions with participants, it was noted that while there was strong interest in receiving the full report, a shorter, more accessible version would be beneficial due to the time constraints commonly faced by NHS clinicians in their day-to-day roles.

Word count: 2272

Introduction

A learning disability is defined by lower intellectual ability (typically an IQ below 70), significant impairments in adaptive functioning, and onset during childhood (National Institute for Health and Care Excellence, 2015). In the UK, around 1.5 million people have a learning disability (Mencap, 2024), and many face substantial healthcare barriers, leading to increased vulnerability (Women and Equalities Committee, 2024). One significant concern is sexual vulnerability, with high rates of abuse reported; one in three adults with learning disabilities experience sexual abuse (Tomsa et al., 2021), and children are four times more likely to be abused than their peers (Sullivan & Knutson, 2000). Disclosure is often difficult due to communication challenges and systemic barriers, leading to underreporting and exclusion from safeguarding and justice processes (Jobe & Williams, 2020; Willott et al., 2020).

There is no universally agreed definition of sexual vulnerability. The WHO (2023) frames it in terms of power imbalances and external threats, while Hollomotz (2011) proposes a contextual view, highlighting systemic and social factors such as education, autonomy, and inclusion. Hollomotz also cautions that labelling individuals as 'vulnerable' can lead to restrictive practices that heighten rather than reduce risk. In practice, people with learning disabilities often receive inconsistent sex education (McCarthy, 2014), compounding their vulnerability.

Sexual health is a recognised health inequality for people with learning disabilities (Public Health England, 2023), often linked to stigma and infantilisation (Grieve et al., 2009), which can lead to professional discomfort (Doughty et al., 2017). Staff express concern about this risk, with many calling for more guidance (Allington, 1992). While some research has explored support workers' experiences (Bates et al., 2020; Maguire et al., 2019), few studies focus on qualified NHS clinicians. This study addresses that gap by exploring the views of professionals in Community Learning Disability Teams (CLDTs).

What are the experiences of clinicians working with adults who have a learning disability and have experienced sexual vulnerability?

Design and Methodology

This qualitative study explored NHS clinicians' experiences of supporting people with learning disabilities around sexual vulnerability, drawing from the researcher's

reflexive position as a Trainee Clinical Psychologist with relevant clinical experience and a commitment to both safeguarding and advocacy. Positioned within a critical realist framework and informed by a postpositivist epistemology (Willig, 2013; Braun & Clarke, 2022), the study recognised participants' accounts as contextual and shaped by individual and cultural values.

Semi-structured interviews were conducted with 11 qualified clinicians working in Community Learning Disability Teams (CLDTs) in the Staffordshire and Shropshire area. Participants included registered nurses (n = 5), occupational therapists (n = 2), and clinical psychologists (n = 4), all with at least one year's experience supporting individuals with learning disabilities who had experienced sexual vulnerability. Recruitment was facilitated via team managers, and ethical approval was secured from both the University and Health Research Authority.

Interviews were conducted face-to-face or via Microsoft Teams, audio/video recorded, and transcribed. Participants were provided with written information, gave informed consent, and received a debrief to ensure ethical standards and wellbeing were upheld.

Data was analysed using Reflexive Thematic Analysis (RTA) as outlined by Braun and Clarke (2022). The phases of analysis included familiarisation, coding (using NVIVO software), and theme development. Reflexivity was central throughout, supported by supervision, journaling, and participation in an RTA discussion group. In line with RTA values, the concept of 'information power' (Malterud et al., 2016) guided the decision to conclude data collection, rather than aiming for data saturation.

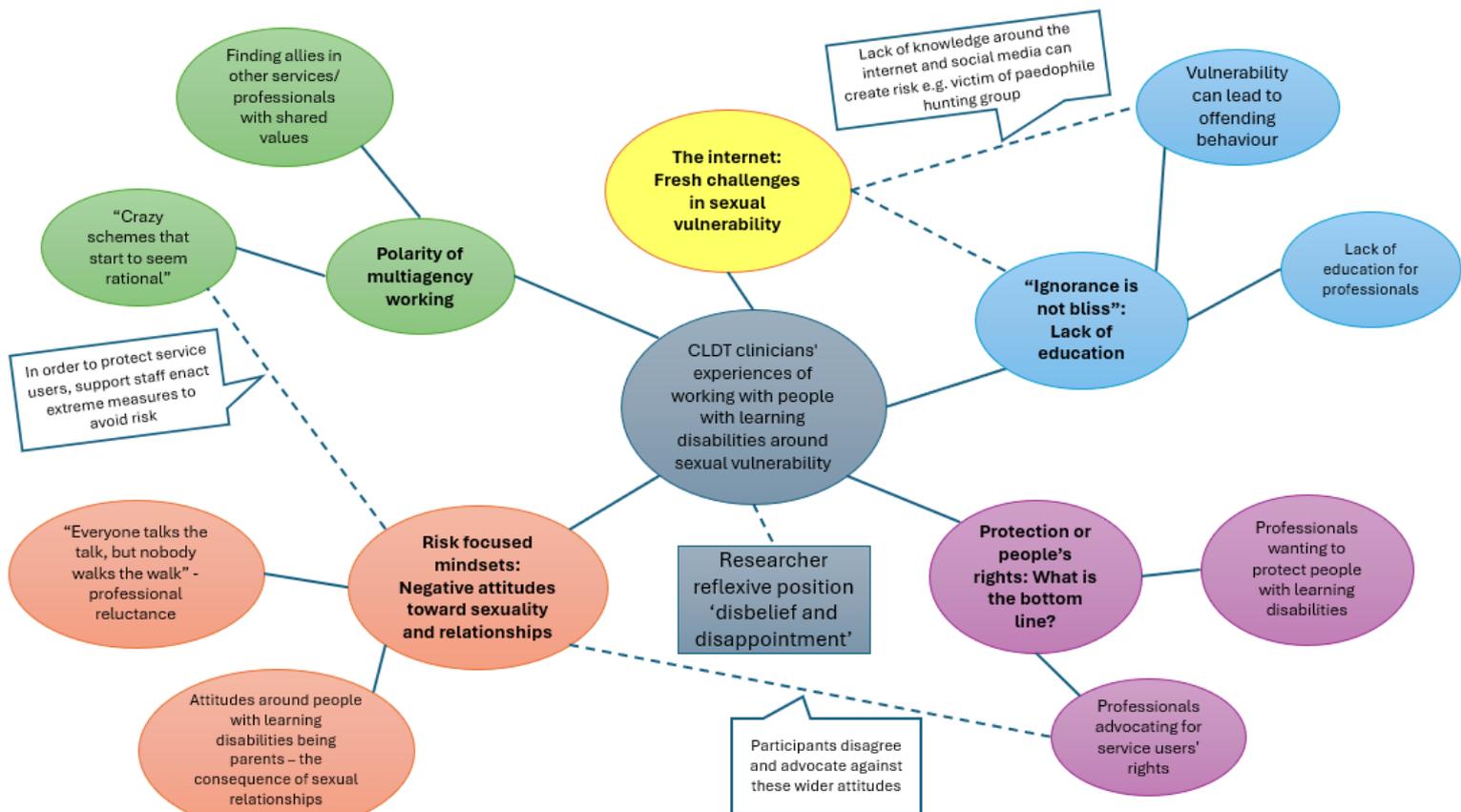
This method allowed for rich, contextually grounded insights into how healthcare professionals understand and navigate the complexities of sexual vulnerability in their work with individuals with learning disabilities.

Findings

Five themes describe elements of the clinicians' experiences of working with people with learning disabilities around sexual vulnerability. These themes contained further sub themes which can be seen in the thematic map below (Figure 1). Although distinct themes, there are links between themes which can also be seen on the thematic map.

Figure 1

Thematic map displaying themes, sub-themes and the links between these.



Ignorance is not bliss: Lack of education

Participants discussed the lack of sex and relationships education for people with learning disabilities as a systemic failure, leaving professionals to fill critical knowledge gaps in adulthood to reduce vulnerability.

“Throughout education right from the early age, they're denied key pieces of information because they're not... They don't have the same access to the general curriculum as the mainstream pupils. So that puts them at a disadvantage.” – Participant 5

Lack of education for professionals

Participants identified a systemic lack of sex and relationships education for clinicians also, emphasising the need for better training and resources to enable confident, informed support.

“I guess having your own education and awareness and we don't always like, I can't speak for other disciplines but as an LD nurse, you don't always have a specific training on sexual health like you don't have the sexual health experts come in and educate you, so that is potentially a challenge as well.” – Participant 4

Vulnerability can lead to offending behaviour

Participants reported that lacking education on these areas left people with learning disabilities at risk of exploitation and unintentional offending, a consequence which would be irreversible.

“So if something perhaps happened due to a lack of understanding or lack of education, or possibly just not the opportunity to express themselves sexually and so they were you know, I don't know for instance, sexually touching another male in a toilet a day service. Once they've got that label of being a sexual risk the opportunities for relationships for the rest of their life may then be affected because it may be that they're considered to be a risk for the rest of their life” – Participant 3

The internet: Fresh challenges in sexual vulnerability

The internet and social media were seen as growing challenges in clinical work, with participants highlighting increased sexual vulnerability, risks of online grooming, misuse of AI, and sharing of indecent images, emphasising the need for updated professional guidance around digital issues.

“We've also had the move forward with the social media and all the other aspects that come alongside that. And the added complications that yes, it gives lots of

opportunities, but at the same time, it's also given us fresh challenges that are quite complex I think to deal with. So I can see a lot of changes.” – Participant 6

Protection or people’s rights: What is the bottom line?

This theme captures the complex balance professionals face between safeguarding and supporting service users’ rights to autonomy, with positive risk-taking identified as a potential way to uphold both safety and sexual expression.

“Yeah, you know, looking at how we enable people, but bearing in mind the sort of safeguarding the safety and the other elements and what we need to and it's about positive risk taking as well, isn't it?” – Participant 6

Professionals wanting to protect people with learning disabilities

Participants emphasised that safety is the top priority in practice, driven by duty of care and safeguarding procedures, though some acknowledged this can lead to overprotection that limits opportunities for learning through experience.

“Yeah, but I suppose it does go back to sort of this fine line, doesn't it? You've got to keep people safe. That is the bottom line. We have to keep people safe. And you know, if that means taking away someone's liberty in certain areas of their life, we have to do that to keep them safe. And you know, we have that duty care to be alerting, you know, social services or the police if we've got concerns about what's happening and so that is the bottom line really. So you have to protect.” – Participant 11

Professionals advocating for service users rights

Participants strongly advocated for the rights of people with learning disabilities to engage in safe sexual expression and relationships, challenging restrictive attitudes and working to overcome systemic barriers and misconceptions about vulnerability.

“And I think it comes down to sort of human rights really and the right that people have to be part of society to make decisions about their lives. And to be empowered, really, I suppose, to be like anyone else. And I think like sexual needs are just part of that.” – Participant 9

Risk focused mindsets: Negative attitudes toward sexuality and relationships

This theme highlights how participants encountered widespread assumptions that people with learning disabilities should not, or do not, engage in sex or relationships.

“That's the challenge is that the lack of education and training in other services to understand that automatic assumption that people are so limited that it can't possibly be the same, you know, they can't possibly, I don't know have sex or have sexual desires or you know, feel sexually frustrated or wish to access porn, or want a one night stand or whatever. It's almost like that part of life it's just assumed doesn't exist for someone because they have a learning disability.” – Participant 3

Attitudes around people with learning disabilities being parents: The consequence of sexual relationships

Participants shared the challenges of supporting service users through pregnancies and child protection processes, which they attributed to societal and professional attitudes that question the acceptability of people with learning disabilities as parents.

“Well, I used to say that sex and relationships was the last taboo for people with a learning disability, but it's not, it's the second to last taboo. The last taboo is child rearing, and that's the vulnerability. That's the risk, the ultimate risk that they think will occur. And that's the thing that they're absolutely... professionals are 100% convinced that no one with a learning disability would be able to bring up a child successfully.” – Participant 5

Everyone talks the talk, but nobody walks the walk: Professional reluctance

Participants noted that risk-averse attitudes led to reluctance from professionals to support people with learning disabilities in expressing their sexuality or forming relationships, with frequent barriers remaining despite verbal support.

“So even when they've directly received reports about specifically recommending give person X a weekly opportunity to discuss any thoughts or feelings that they have around sex and relationships that they might want to discuss or you know remind person X that it is OK for them to talk about masturbation in private if they have any more queries or concerns you know and also reminding them that that's something for a private space you know so sometimes professionals are directly inviting support teams to really invite that openness and even then they're very

reluctant, I think, they're kind of like oh that's none of our business that's too private."

– Participant 3

Polarity of multiagency working

This theme highlights the extremes of multiagency working, with participants experiencing both conflicts with other 'support' measures and at the opposite end of the scale, positive collaborations with like-minded professionals leading to beneficial outcomes for service users.

Crazy schemes that start to seem rational

Participants expressed frustration with practices by other teams or agencies that, despite aiming to protect service users, often undermined their dignity, rights, and autonomy, highlighting a disconnect between intent and reality.

"The courts are basically asking the staff to vet their sexual partners." - Participant 1

Finding allies in other services: Professionals with shares values

On the positive end of multiagency working, participants valued finding like-minded professionals with shared advocacy values, noting that effective communication and a mutual commitment to service users' rights were crucial for successful collaboration.

"But I think the joined up working is really important in the multi agency approach. It's a good fit where we can get that you can get some good team working, but it's not always that easily achievable and not everybody's on the same mindset always. Or you have to find somebody with an interest that you can then link and drive it forward that way" – Participant 6

Conclusion

People with learning disabilities are often, but not always, sexually vulnerable and the professionals who took part in this research showed a strong dedication to advocating for their right to engage in safe and fulfilling sexual expression and relationships. The study highlighted several challenges in providing adequate support, including a lack of education, the conflicting negative attitudes of others and the evolving risks posed by the internet. Additionally, the reluctance of certain professionals and agencies to address issues of sexual vulnerability creates further

barriers. However, despite these difficulties, the participants were driven by a strong sense of advocacy and commitment, which motivated them to continue fighting for the rights of individuals with learning disabilities and work towards meaningful improvements for the people they support.

Limitations

- Lack of member checking with participants to enhance rigour and credibility however this was somewhat mitigated through discussions with academic supervisors and a Reflexive Thematic Analysis (RTA) group.
- Focused on clinicians' experiences, excluding individuals with learning disabilities in shaping the research design - involvement of people with learning disabilities at the design stage could have enhanced relevance and impact.

Future research and clinical implications

- Future research should include individuals with learning disabilities to explore their perspectives on sexual vulnerability support.
- Further investigate the sexual vulnerability associated with online activity, including social media, and ways to make digital environments safer and more inclusive.
- Evaluate the effectiveness and accessibility of sex and relationship education in SEND schools and colleges for young people with learning disabilities.
- Participants described a need for improved resources and training to increase all clinicians' confidence in addressing issues of sexual vulnerability.
- Potential to develop peer-to-peer or multiagency education initiatives to normalise the topic, reduce stigma, and broaden the professional support network.
- Evidence for importance of specialist liaison roles such as learning disability Police Liaison role, for joined up working.

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Appendices

Appendix A. CASP Critical appraisal Qualitative checklist used to appraise literature



CASP Checklist:
For Qualitative Research

Reviewer Name:	
Paper Title:	
Author:	
Web Link:	
Appraisal Date:	

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the “Can’t tell” response box. If you can’t tell, at best it means the researchers have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you’ve finished the critical appraisal, if there are a large number of “Can’t tell” responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p><i>CONSIDER:</i></p> <ul style="list-style-type: none"> • <i>what was the goal of the research?</i> • <i>why was it thought important?</i> • <i>its relevance</i> 	
2. Is a qualitative methodology appropriate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p><i>CONSIDER:</i></p> <ul style="list-style-type: none"> • <i>If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants</i> • <i>Is qualitative research the right methodology for addressing the research goal?</i> 	
3. Was the research design appropriate to address the aims of the research?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p><i>CONSIDER:</i></p> <ul style="list-style-type: none"> • <i>if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)</i> 	

4. Was the recruitment strategy appropriate to the aims of the research?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p><i>CONSIDER:</i></p> <ul style="list-style-type: none"> <i>If the researcher has explained how the participants were selected</i> <i>If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study</i> <i>If there are any discussions around recruitment (e.g. why some people chose not to take part)</i> 	
5. Was the data collected in a way that addressed the research issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p><i>CONSIDER:</i></p> <ul style="list-style-type: none"> <i>If the setting for the data collection was justified</i> <i>If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)</i> <i>If the researcher has justified the methods chosen</i> <i>If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)</i> <i>If methods were modified during the study. If so, has the researcher explained how and why</i> <i>If the form of data is clear (e.g. tape recordings, video material, notes etc.)</i> <i>If the researcher has discussed saturation of data</i> 	
6. Has the relationship between researcher and participants been adequately considered?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p><i>CONSIDER:</i></p> <ul style="list-style-type: none"> <i>If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location</i> <i>How the researcher responded to events during the study and whether they considered the implications of any changes in the research design</i> 	
<p>Section B: What are the results?</p>	
7. Have ethical issues been taken into consideration?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell

<p>CONSIDER:</p> <ul style="list-style-type: none"> • <i>If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained</i> • <i>If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)</i> • <i>If approval has been sought from the ethics committee</i> 	
8. Was the data analysis sufficiently rigorous?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p>CONSIDER:</p> <ul style="list-style-type: none"> • <i>If there is an in-depth description of the analysis process</i> • <i>If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data</i> • <i>Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process</i> • <i>If sufficient data are presented to support the findings</i> • <i>To what extent contradictory data are taken into account</i> • <i>Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation</i> 	
9. Is there a clear statement of findings?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p>CONSIDER:</p> <ul style="list-style-type: none"> • <i>If the findings are explicit</i> • <i>If there is adequate discussion of the evidence both for and against the researcher's arguments</i> • <i>If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)</i> • <i>If the findings are discussed in relation to the original research question</i> 	
<p>Section C: Will the results help locally?</p>	
10. How valuable is the research?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Can't Tell
<p>CONSIDER:</p> <ul style="list-style-type: none"> • <i>If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature)</i> 	

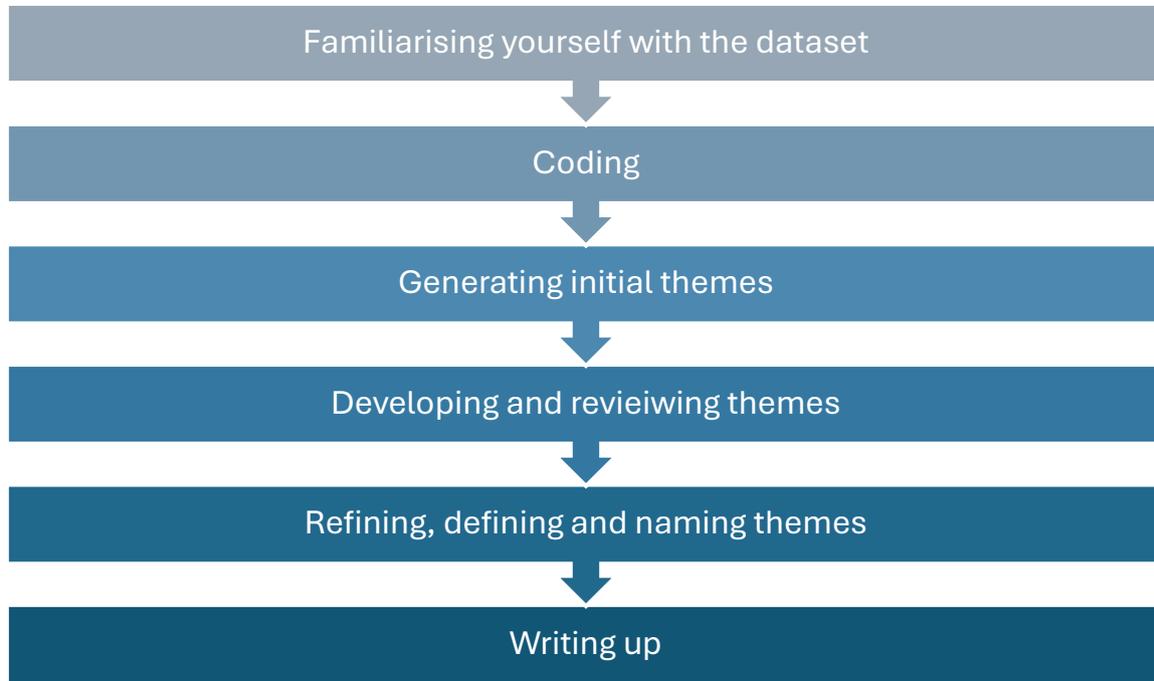
- *If they identify new areas where research is necessary*
- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

Appendix B. Quality appraisal using CASP tool

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Total quality score
Banks et al. (2021)	2	2	1	2	2	0	2	2	2	15
Chester et al. (2017)	2	2	2	2	2	0	2	2	2	16
Clifford et al. (2018)	2	2	2	2	2	2	2	2	2	18
Coleman & Sharrock (2022)	2	2	2	2	2	0	0	2	2	14
Hodges & Northway (2019)	2	2	2	2	2	0	2	2	2	16
Hollomotz (2021)	1	2	2	2	2	0	2	1	2	14
Jingree (2015)	1	2	1	2	2	0	1	1	2	12
Mottershead & Woodrow (2019)	2	2	2	2	2	0	0	2	2	14
Niven et al. (2020)	2	2	2	2	2	0	2	1	2	15
Oloidi et al. (2020)	2	2	2	2	2	0	2	2	2	16

Appendix C. Reflexive Thematic Analysis process flow chart (Braun & Clarke, 2022)

These steps informed a thematic synthesis that was used to produce the findings of this review. Coding of results and discussion sections of articles took place, as opposed to full papers.



Appendix D. Submission guidelines for the Journal of Applied Research in Intellectual Disabilities

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, new submissions should be made via the Research Exchange submission portal: <https://wiley.atyponrex.com/journal/JAR>. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at anytime by logging in to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our [FAQs](#) or contact submissionhelp@wiley.com.

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2. AIMS AND SCOPE

JARID is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.

In order for a paper to be considered for publication, it must be about people with intellectual disabilities. Manuscripts which focus upon autism will be considered only when the focus is also upon intellectual disabilities. Papers which focus upon autism and exclude people with intellectual disabilities will not be considered.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision.

Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Original Articles, including Clinical Trials (see guidance within section 5), **Review Articles** and **Brief Reports** are accepted by the Journal. **Theoretical Papers** are also considered, provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Authors who are submitting original articles where qualitative methods have been used must ensure that their choice of method is well justified and issues relating to methodological rigor are effectively addressed.

Articles and **Theoretical Papers** should not exceed 6000 words;

Review Articles should not exceed 7000 words;

Brief Reports should not exceed 2000 words.

All word limits are inclusive of the abstract. References, Words in Tables, Captions/Legends, Figure and Figure captions/legends are excluded from the word limits.

Please note that papers submitted for Special Issues should also not exceed 6000 words.

4. PREPARING THE SUBMISSION

Use of Language

The language used to describe disability differs across countries, cultures and disciplinary fields, and continues to evolve. All manuscripts submitted to JARID must use language that promotes the value of all people as full members of our shared society. Pejorative language inclusive of euphemisms must not be used. For JARID this includes the use of older language that has been used to describe people with intellectual disabilities such as “retarded”, “special needs”, “disease”, “handicapped”, or “mentally handicapped”. Using any terms which are offensive, or patronising may lead to rejection of your submitted manuscript.

JARID recommends using person-first and/or identity-first language thoughtfully and appropriately. For example, the language used to describe both people with intellectual disabilities and autistic people has evolved based on recent advocacy efforts. When referring to people with autism, it is acceptable to use either identity-first language (e.g., “autistic people”) or person-first language (e.g., “people with autism”), while identity-first language is not used to describe people with intellectual disabilities, where person-first language is preferred. Thus, people with intellectual disabilities should be referred to as people with intellectual disabilities.

We have consulted with over 40 self-advocates through Learning Disability England which included the North West Self-Advocacy Group, as well as Self-Advocacy Together and asked them what language we should use when writing about people with intellectual disabilities.

People with intellectual disabilities said that they do not like to be referred to by acronyms or abbreviations. Authors must therefore not use an abbreviation to describe intellectual disabilities such as “ID” or “LD”. Instead, use person-first language such as children, teenagers, adults, or people with intellectual disabilities, avoiding acronyms or abbreviations.

The terms “learning disabilities” and “learning difficulties”, though used in some countries to refer to people with intellectual disabilities, can cause confusion among readers. These terms are not used by the journal to refer to people with intellectual disabilities. Authors must only use the term “learning disabilities or difficulties” where this refers to a specific learning disability/disorder– such as a specific learning difficulty in reading, written expression or mathematics. **If “learning disabilities” or “learning difficulties” are used, authors must not use an abbreviation.**

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- Figures and tables should have legends. Figures should be uploaded in the highest resolution possible.
- References may be submitted in any style or format, as long as it is consistent throughout the manuscript.
- Supporting information should be submitted in separate files. [Click here](#) for Wiley's FAQs on supporting/supplemental information.
- Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper
- An ORCID ID, freely available at <https://orcid.org> (Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)
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- funding statement
- conflict of interest disclosure
- ethics approval statement
- patient consent statement
- permission to reproduce material from other sources
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JARID has a double-anonymized peer review process so please ensure that all identifying information such as author names and affiliations, acknowledgements or explicit mentions of author institution in the text are on a separate page.

Abstract

All papers should have a structured abstract (maximum 150 words) as follows: Background, Method, Results, and Conclusions. The abstract should provide an outline of the research questions, the design, essential findings and main conclusions of the study. We kindly request that authors place the abstract and title at the beginning of the main manuscript document.

Lay Summary

Please provide 3 or 4 bullet points summarizing the main finding of your work, the impact of it for people with intellectual disabilities and for the research community.

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Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

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Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the section 'Conflict of Interest' in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

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The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results.

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The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

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For queries about submissions, please contact the *JARID* Editorial Office.

jarid.office@wiley.com

Author Guidelines Updated January 2024

Appendix E. Participant Information Sheet

INFORMATION SHEET FOR PARTICIPANTS

IRAS ID: 338379



Title of study

What are the experiences of clinicians working with adults with learning disabilities who have experienced sexual vulnerability?

Invitation Paragraph

My name is Georgina Fox and I am a Trainee Clinical Psychologist on the University of Staffordshire Professional Doctorate in Clinical Psychology course and I am undertaking research as part of my doctoral research on the experiences of clinicians who work with people with learning disabilities and experiences of sexual vulnerability.

I would like to invite you to participate in this research project. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information (my contact details are noted at the end of this information sheet).

What is the purpose of the study?

The aim of this research is to capture the experiences of clinicians working with adults with a learning disability who have experienced sexual vulnerability.

Why have I been invited to take part?

You have been invited to take part because you are an NHS clinician working within a community learning disability team, who may have worked with clients who have experienced sexual vulnerability. To take part you must be an employee of either North Staffordshire Combined Healthcare Trust or Midlands Partnership Foundation Trust and self-identify as having worked with clients who have experienced sexual vulnerability.

What will happen if I take part?

If you choose to take part then the study will consist of an interview using open questions about your experiences of working with individuals with a learning disability who have experienced sexual vulnerability.

The interview will take place either face to face at an NHS base of your choosing in a private room, or online via Microsoft Teams. The interview will last approximately one hour.

If you consent to take part then the interview will be audio recorded if taking place in person or video recorded via MS Teams if online for the

purposes of transcription. You will be assigned a pseudonym (fake name) to protect your anonymity. The researcher will clearly explain when the recording begins and ends and you may choose to stop the interview and withdraw from the research at any point during the interview.

Direct anonymised quotes may be used as part of the final report when sharing results.

Do I have to take part?

No. Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

There is a possibility that you may find some of the information discussed in the interview sensitive and therefore you should carefully consider if you wish to take part. You may choose to pause the interview or stop completely at any point if you feel distressed and there will be signposting to staff wellbeing services available.

Staff support and counselling service – North Staffs Combined:

0300 124 0104

staffsupportandcounsellingservice@combined.nhs.uk

Staff Psychological wellbeing hub – North Staffs Combined:

0300 303 5406

twb.staffwellbeinghub@nhs.net

Staff Psychological wellbeing hub - MPFT

07890 066445

stwstaffwellbeing@mpft.nhs.uk

What are the possible benefits of taking part?

There are no direct benefits in taking part in this research other than to share your experiences of these topics if that is something you wish to do and therefore contributing to this area of research.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your name, job role and length of time you have worked in the CLDT. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

The University of Staffordshire is the sponsor of this research, and is responsible for looking after your information. We will keep all information about you safe and secure following data handling and confidentiality procedures, please see below for detail.

International transfers

Your data will not be shared outside the UK.

Data handling and confidentiality

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

The interview data will be assigned a pseudonym and will be transcribed by the researcher on a password protected NHS laptop and the audio or online recordings will then be deleted. Hard copies of the consent forms will be stored separately to any transcription data to maintain participant anonymity by the academic research supervisor in a locked cabinet on University premises. The transcriptions will be stored as password protected documents. Only the researcher and the research supervisors will have access to anonymised data for the purposes of checking data analysis. After study completion, and in keeping with University guidelines, the data will be stored securely for 10 years and destroyed thereafter.

Data Protection Statement

The data controller for this project will be the University of Staffordshire. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Staffordshire's Data

Protection Officer, contactable at dataprotection@staffs.ac.uk. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until the point of analysis after which withdrawal of your data will no longer be possible due to the data being combined and anonymised as part of the analysis.

If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study.

What will happen to the results of the study?

The results of the study will be written up as part of the researcher's doctorate thesis submission to the university. It is also the aim to submit the report for publication in peer reviewed journals which would make the results publicly available.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

F026011j@student.staffs.ac.uk

Georgina.fox@combined.nhs.uk

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Co-Chair of the University of Staffordshire Ethics Committee for further advice and information:

Professor Sarah Jane Jones

sarahjane.jones@staffs.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix F. Participant Interview schedule

Can you tell me about your understanding of what sexual vulnerability in relation to adults with learning disabilities means?

Can you tell me about your experiences of working with people who have a learning disability and experience sexual vulnerability?

What are some of the challenges you have encountered whilst working with adults with learning disabilities who have experienced sexual vulnerability?

Are there any positive experiences you could share that have occurred whilst working with adults with learning disabilities who have experienced sexual vulnerability?

Appendix G. Participant Consent Form

RESEARCH PROJECT CONSENT FORM

IRAS ID: 338379



Title of Project: What are the experiences of clinicians working with adults with learning disabilities who have experienced sexual vulnerability?

Researcher: Georgina Fox

I have read and understood the information sheet.	Yes	No
I have been given the opportunity to ask questions, and I have had any questions answered satisfactorily.	Yes	No
I understand that my participation in this study is entirely voluntary and that I can withdraw at any time without having to give an explanation	Yes	No
I understand that the interview will be audio-recorded if in person and video recorded if conducted on MS Teams	Yes	No
I consent that data collected could be used for publication in a scientific journals or could be presented in scientific forums (conferences, seminars, workshops) or can be used for teaching purposes and understand that all data will be presented anonymously	Yes	No
I agree that data will only be used for this doctoral thesis project, although the data may also be audited for quality control purposes	Yes	No
I understand that all data will be stored safely on a password protected computer (electronic data), or locked away securely (hard copies of data) for 10 years before being destroyed	Yes	No
I understand that I can withdraw my data from the project up to point of analysis without having to give an explanation	Yes	No
I hereby give consent to take part in this study	Yes	No

Name Participant (print) Date..... Signature.....

Name Participant (print) Date..... Signature.....

Note: one copy of the consent form to be retained by researcher and one copy provided to participant.

Appendix H. Participant Debrief Sheet

DEBRIEF SHEET FOR PARTICIPANTS

IRAS ID: 338379



Title of study

What are the experiences of clinicians working with adults with learning disabilities who have experienced sexual vulnerability?

Thank you for taking part in this study. The information you have provided today will be analysed and written up as part of the researcher's doctorate thesis submission to the university. It is also the aim to submit the report for publication in peer reviewed journals, which would make the results publicly available.

What should I do if I feel distressed by anything we have discussed?

If you feel comfortable to, please raise any concerns or questions with the researcher, who will endeavour to answer or resolve any problems in the first instance. It is not expected or intended that you should feel distressed by any of the topics raised, however should this occur, you can also seek support from the following organisations:

Staff support and counselling service – North Staffs Combined:

0300 124 0104

staffsupportandcounsellingservice@combined.nhs.uk

Staff Psychological wellbeing hub – North Staffs Combined:

0300 303 5406

twb.staffwellbeinghub@nhs.net

Staff Psychological wellbeing hub - MPFT

07890 066445

stwstaffwellbeing@mpft.nhs.uk

What should I do if I want to withdraw my data?

You are able to withdraw your data, should you wish to, up to two weeks (14 days) after the date of your interview. After this point analysis will have begun and it will no longer be possible to separate your data from other participants. Please contact the researcher using the details below if you have any concerns.

F026011j@student.staffs.ac.uk
Georgina.fox@combined.nhs.uk

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Co-Chair of the University of Staffordshire Ethics Committee for further advice and information:

Professor Sarah Jane Jones
sarahjane.jones@staffs.ac.uk

Appendix I. Independent Peer Review Approval Letter – University of Staffordshire



INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	Georgina Fox
Title of Study	What are the experiences of clinicians working with adults who have a learning disability and have experienced sexual vulnerability?
Status of approval:	Approved

Thank you for your submission to the Independent Peer Review (IPR) Panel. Your application is now approved.

Action now required:

You must now apply to the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without Health Research Authority (HRA) and/or REC approval, and relevant site-specific approvals. Please note that the University Sponsor contact to be named on the form is Prof Sarahjane Jones.

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received HRA and/or REC approval, and participating Trusts/organisations have confirmed their capacity and capability to support your study, you can commence your research. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved application.

When your study is complete, please send an end of study report to Dr Edward Tolhurst: e.tolhurst@staffs.ac.uk. A template can be found on the ethics Blackboard site.

Comments for your consideration: *The University Ethics contact stated in the supporting documents can be changed to: Prof Sarahjane Jones, Co-Chair:*
sarahjane.jones@staffs.ac.uk

A handwritten signature in black ink, appearing to read 'E Tolhurst'.

Signed: Dr Edward Tolhurst
 University IPR coordinator

Date: 10th June 2024

Appendix J. Letter of Ethical Approval from Health Research Authority



Miss Georgina Fox
Trainee Clinical Psychologist
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Trentham
ST4 8HH

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

08 January 2025

Dear Miss Fox

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title:	What are the experiences of clinicians working with adults who have a learning disability and have experienced sexual vulnerability?
IRAS project ID:	338379
REC reference:	24/HRA/4550
Sponsor	Staffordshire University

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The "[After HRA Approval – guidance for sponsors and investigators](#)" document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 338379. Please quote this on all correspondence.

Yours sincerely,

Mathew Barnes
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Dr Sarahjane Jones*

Appendix K. Confirmation of Capacity and Capability from both Midlands Partnership Foundation Trust (MPFT) and North Staffordshire Combined Healthcare Trust (NSCHT)

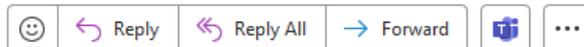
RE: IRAS 338379 – Confirmation of Capacity and Capability at MPFT



Christopher Flanagan (RRE) MPFT

To Georgina Fox (RLY) NSCHT

Cc Ruth Richards (RRE) MPFT; Brendan Donoghue (RRE) MPFT



Thu 20/02/2025 11:15



Dear Georgina,

RE: IRAS 338379 – Confirmation of Capacity and Capability at MPFT

Full Study Title: What are the experiences of clinicians working with adults who have a learning disability and have experienced sexual vulnerability?

On behalf of Ruth Lambley-Burke (Director of R&I), this email confirms that Midlands Partnership University NHS Foundation Trust has the capacity and capability to deliver the above referenced study; please find the agreed Organisation Information Document/Clinical Trial Agreement attached as confirmation.

Midlands Partnership University NHS Foundation Trust agrees to start this study from today.

If you wish to discuss further, please do not hesitate to contact me; good luck with your study.

Many thanks,
Chris

Chris Flanagan

Research Support Administrator

Branch Chair – UNISON South Staffs & Shropshire Healthcare Branch (12278)

Pronouns: he/him #pushforpronouns

IRAS ID. 338379 Student Research Project – Trust Authorisation of Research – North Staffordshire Combi...



LouiseC Alston (RLY) NSCHT

To Georgina Fox (RLY) NSCHT

Cc Research & Development



Wed 19/02/2025 11:14

You forwarded this message on 19/02/2025 13:28.

OID v1.1 14.11.2024 NSCHT Site SRGF_Fully executed copy.pdf
267 KB

Dear Georgina

Trust Authorisation of Research at North Staffordshire Combined Healthcare NHS Trust

Short Title:	Clinician experience - working with sexually vulnerable adults with LD
IRAS ID.:	338379
R&D ID.:	CHC0265/RS
Principal Investigator:	CI is PI - Georgina Fox

This email confirms that North Staffordshire Combined Healthcare NHS Trust has granted Trust Authorisation, and can deliver the above referenced study. Please find attached our agreed Organisation Information Document as confirmation. We agree for you to start this study from the date of this email communication.

Please take time to read the conditions of Trust Authorisation below. You will need this email as proof of Trust Authorisation.

Trust Authorisation has been granted on the basis described in the HRA approval application. The documents received and to be used at site are:

Document	Version	Date
Protocol	1.1	14/11/2024
Participant Information Sheet	1.2	17/12/2024
Participant Consent Form	1.1	14/11/2024
Participant Interview Schedule	1.1	14/11/2024
Participant Debrief Sheet	1.1	14/11/2024
Risk Assessment	1.0	14/10/2023
OID	1.1	14/11/2024
SoE	1.0	04/10/2024

Trust Authorisation is granted on the understanding that the study is conducted in accordance with the [UK Policy Framework for Health and Social Care Research](#), [ICH GCP](#) (where applicable), and NHS Trust policies and procedures. Trust Authorisation is only granted for the research activities which have received approval from all applicable regulatory bodies.

Please contact the [R&D Office](#) should you require any further information.

CONDITIONS OF TRUST AUTHORISATION

Please read the following conditions in order for your Trust Authorisation to conduct research to be valid:

- ✓ Please submit the following to the Trust's [R&D Office](#):
 - All amendments submitted to the HRA (please refer to the [HRA guidance on amendments](#))
 - Recruitment figures on a monthly basis (at end of study for non-portfolio research)
 - New researcher details (prior to them commencing on the research study) (please refer to the [HRA guidance on HR arrangements for researchers](#))
 - Changes to the status of the research study
 - A copy of reported urgent safety measures (USM), adverse events (AE) and serious adverse events (SAE) (please refer to the [HRA guidance on safety reporting](#))
 - A final report (or summary report) (please refer to the [HRA guidance and publication and dissemination of findings](#))
 - A copy of all progress reports as submitted to the regulatory body(ies) (please refer to the [HRA guidance on progress reports](#))
 - A copy of the end of study declaration as submitted to the regulatory body(ies) ([please refer to the HRA guidance on ending your study](#))
 - Details of any study publication(s)
- ✓ Please ensure to acknowledge the Trust in final reports, presentations or publications
- ✓ Please note that the Trust shares research findings internally (please contact the [R&D Office](#) for further information)
- ✓ Please ensure to complete and return in a timely manner any monitoring or audit forms sent by the R&D Office (research is subject to monitoring by the R&D Office)

Kind regards,

Louise Alston

Research Portfolio Manager

North Staffordshire Combined Healthcare NHS Trust

Research and Development Department

Appendix L. Screenshot of NVIVO coding – multi coloured codes align with highlighted text.

The screenshot displays the NVIVO interface with a text document on the left and a 'CODE STRIPES' panel on the right. The text document contains several paragraphs with yellow highlights. The code stripes panel shows a list of codes, each with a colored dot corresponding to the highlights in the text. A callout box in the bottom right corner lists the codes for the highlighted text.

Participant 1 9:09

It's really hard. It's really hard because we're trying to be least restrictive and our care, I mean me as a nurse especially you know, in LD, but all of LD care is so person centred, so whether they need the education in Group or one to one format, whether they need the bild assessment broken up over 10 sessions or just done in two, you know it's so specific to what they need and not everyone is is this, and obviously as soon as people mention sex and relationships and learning disabilities there is a huge stigma.

So we're trying to advocate for the clients that not everyone is sexually vulnerable, but equally recognising where there are areas. So you know the bild report is so good because of the layout where you can actually say what they were able to do and that's that actually what you thought as well. And like the armadillo such a good tool because you can say to somebody what they think.

You can do your own personal experience of that client. Then you ask their carers or family as well, and that's where I think our tools are really useful because we're not then just deeming everyone with an LD sexually vulnerable and they can't manage their own lives and they can't have relationships ever and sex should never happen and children should never happen because actually there are quite a lot of our clients want children and they want relationships.

But you know, we get a lot of people that come in with restrictions that work like, you know.

When we do our duty assessments, for example, one of the physical health questions is around contraception for women and you've got a lot of people say, oh, well, they're on it because, you know, and we have to go, well, why, you know, is it because you don't want them to have kids because have you asked them about that?

And we have had cases where we've had clients that say, I do want kids. I was just told to take this. My mum told me.

So weighing that in is really hard

CODE STRIPES

- not labelling everyone with an LD vulnerable
- courts asking staff to vet sexual partners
- domestic abuse
- consent is complex
- internet safety is a big part of vulnerability
- no one talks about sexual health in LD population
- consideration of religious views
- should be an enforced area of professional knowledge
- how to make a sexual relationship safe
- understanding of sex and relationships
- education around relationships and sex
- role of advocates
- so much coercion over the internet
- MDT working
- child's law
- perpetrator yet vulnerable
- easily coerced
- TZ plans
- giving SUs choice around education
- easier for clinicians if SUs don't want to use the internet
- challenging when courts become involved
- working with SUs support staff
- different components of vulnerability
- perpetrator from abuse history
- providing more education for other teams
- I have to do something about it
- vulnerability due to impulsivity not lack of capacity
- lack of education for clinicians
- lack of professional knowledge
- disagreement over SUs understanding
- right to privacy for SUs within sexual relationships
- positive risk taking
- she can't have a baby
- court enforced treatment
- BILD assessment
- pornography is creating vulnerability
- barriers between LD and MHS services
- old fashioned view people with LD shouldn't have kids
- least restrictive practices
- positive outcome from RAG education
- discussing topics can be uncomfortable
- everyone's really worried
- clinician learning from previous experience
- desire to live independently
- importance of support
- advice from other agencies such as police
- history of trauma
- incorrect use of MCA
- taboo to talk about sex and relationships
- risks of not talking about issues with SUs
- cuckooing
- normalising uncomfortable topics
- Stigma of Sex and LD
- SU struggled to implement learning
- MA 27/02
- Coding Density
- not just deem everyone with an LD sexually vulnerable
- wanting kids

Codes for this extract include:

- Least restrictive practices
- Stigma of sex and LD
- Advocate for SU's but recognise vulnerability
- BILD assessment
- Not just deem everyone with an LD sexually vulnerable
- Wanting kids

Appendix M. Codes organised on excel spreadsheet to start to form themes

Code	Theme
hard to convince others to let pwld make their own decisions around sex and relationships	PWLDS RIGHTS/ ADVOCACY
getting other people to a particular viewpoint is challenging	
everyone's really worried	
come a long way but still a long way to go	
commissioners and care teams anxious around pwld engaging in consensual sexual relationship	
changing peoples beliefs is difficult	
british culture of a stiff upper lip	
abstinence and supression disempowers pwld	
worried about risk but not about that individuals holistic needs	
you cant restrict people or stop them going out	
why shouldnt someone with an LD have a healthy sexual relationship	PERPETRATOR FROM VULNERABILITY
wanting to make sure pwld are treated fairly	
want to improve quality of life for pwld	
supporting pwld in this area is a priviledge	
significant intrusion of peoples rights	
sexual needs are human rights	
Sex and relationships is part of SUs overall life	
role of advocates	
restricting pwld right to sex doesnt feel fair	
right to privacy for SUs within sexual relationships	
pwld struggle to advocate for themselves	BALANCE
interesting that I have talked about peoples rights	
involving the SU in conversations about them	
I have to do something about it	
human right to a family life	
how to keep people safe without treading on their rights	
great work by supported loving	
felt protective of SU in police interview process	
empowering pwld and advocating for them	
determined to do something about it	
determined to fight for pwld rights battle	PWLD WANTS
biggest part of our role is advocating	
basic human right to be in a loving relationship	
at the core of human being to have somebody special	
advocate for pwld	
advocate for SUs but recognise vulnerability	
a positive voice for people who arent listened to	

File Home Insert Page Layout Formulas Data Review View Automate Help

Clipboard Font Alignment Number Styles Cells Editing Sensitivity Add-ins Excel Labs

K93 : X ✓ fx safeguarded and enriched the lives of many pwld

	F	G	H	I	J	K	L
1							
2		CAPACITY		EDUCATION		INTERNET	
3	arents	a lot of the work involves assessing and understanding capacity		bad decisions even after education		a 21st century vulnerability	
4		a risk that professionals use the MCA to control pwld decisions		concerns that educational work may be triggering for trauma history		a delay in access for the LD population social media	
5		abuse of the MCA		court requested education work		adult talking to 15 year old girls and parent intervenes	
6		assumed lack of capacity around sex		education around relationships and sex		AI boyfriend	
7		dangers of incorrect use of MCA		education cant take place until after court		AI pornography	
8	ing opportunity	educating to improve and assess capacity		education for pwld lacks nuance		being exploited for things sent online	
9	nily	incorrect use of MCA		education has to lack ambiguity to protect pwld		caught by paedophile hunters	
10		joint capacity assessment with social care very valuable		education needs to be repeated and individualised		challenge that less restrictions on the internet poses	
11		MCA useful when people understand it		giving SUs choice around education		clients who have been catfished	
12		multi disciplinary capacity assessments		lack of education for clinicians		concepts around sharing photos online being permamant are abstack	
13	process	not using the MCA correctly and fairly		lack of education means pwld cant spot red flags		difficulties of anonymous online perpetrators when supporting SUs	
14		people are not believing of capacity even after assessment		lack of ongoing education is problematic		easier for clinicians if SUs dont want to use the internet	
15		poor service of external capacity assessments		lack of professional education		education should include risks of social media	
16	to remove the child	pwld lacking capacity or knowledge		maintenance of education is key		explaining that people can hide their identity online	
17		questioning capacity when professionals are morally uncomfotable with decisions		need for more education in the police force		exploitation could be face to face or online	
18	kids	the assumption that pwld lack capacity		not seeing an improvement in education for younger pwld		exploited online to send indecent images	
19		the bar for having capacity is very low		nowhere for pwld without diagnosis to access sex education		facebook and snapchat are prominent	
20		timing of capacity assesments		positive example of education work with SU		facebook dangers paedophile hunters	
21		vulnerability due to impulsivity not lack of capacity		positive outcome from RAG education		fresh challenges of social media	
22		vulnerability relates to capacity and understanding		professionals need education not just SUs		impact of pornography on perceptions of sex	
23		shouldnt be preventing people from making unwise decisions		provided education around relationships		increase in referrals around social media	
24	keep their baby	legal frameworks		providing more education for other teams		influence of social media and internet	
25				psychoeducation and capacity work		influence of the internet creates expectations	
26				pwld dont have the same access to education		Internet safety is a big part of vulnerability	
27				pwld lack education around contraception		LD population always behind social media	
28				pwld lack of education and awareness		made more complicated by social media	
29				repeating education and using different formats		online exploitation	
30		MORAL OR PERSONAL RELIGIOUS VIEWS		risk and vulnerability occurring to lack of education		paedophile hunting groups	
31	sexual health	clinician morally objecting to SU choices stops work progressing		SU had very limited education		people hiding their identity online is a difficult concept to understand	
32		christian establishment not allowing sex		SU report lack of education on sexual wellbeing since leaving school		pornography is creating vulnerability	
33		impact of personal or religious views		successful outcome of relationship education group		pwld being vulnerable to people online	
34		the catholic faith challenges		support staff not utilising ongoing education		pwld need to be able to access social media in a safe way	
35		consideration of religious views		trying to provide education around exploitative situation		pwld targeted by vigilante groups	
36	if expression	conflict of religious catholic views with work		vulnerability might not have occurred if education had been delivered sooner		pwld vulnerable to online grooming	
37	much pwld should know	old fashioned values		vulnerability of pwld requires education to be clear		risk of potential offending due to online communications	
38	is perceived by professionals	PWLD DON'T HAVE SEX		would be helpful for education to focus on vulnerability		sending images online results from grooming	
39	sexual	assumption that pwld arent interested in sex		young people who come through for capacity ax basic knowledge of sex isnt there		so much coercion over the internet	
40		assumption that pwld dont have sex					

Ready Accessibility: Good to go

Display Settings

Appendix N. Table of supporting quotes

Theme/Sub theme	Quote
Lack of education for professionals	<i>“I’m just thinking, like, you know, I was never taught at Uni about the sexual vulnerability and exploitation...at Uni, I was not taught around people with an LD and their sexual vulnerability or relationships and sex.” – Participant 1</i>
The Internet	<p><i>“So yeah, that’s another kind of vulnerability in terms of relationships. That’s a new thing. But yeah, I mean that’s the whole other complexity. Is that people pretending to be somebody they’re not and then inviting people into relationships online and then possibly inviting people to meet and them not then being who they say they are. So yeah, another level of layer of complexity, I think in terms of negotiating relationships.” – Participant 7</i></p> <p><i>“So during my career I have worked pre Internet and post Internet. So some people’s vulnerability online has been marked so people have been vulnerable to grooming, just as they might be in in the real world, grooming online. And that’s been very tricky for some people and managing that’s been very tricky.” – Participant 10</i></p>
Professionals advocating for SU’s rights	<p><i>“So that, all those experiences for me way back in the 80s made me absolutely determined that I was going to advocate for people with a learning disability for their right to have a sexual relationship because I just felt it was just unbearable. Completely unfair. But throughout it I’ve been battling, battling, battling.” – Participant 2</i></p> <p><i>“And then, you know, everyone’s then wanting to kind of co-write risk assessments around particular acts or have meetings about it because they’re worried about the risk. But they weren’t worried about other points where it was just about that person being a holistic individual that included having sexual needs.” – Participant 3</i></p>
Protection or Peoples rights?	<i>“I’ve worked with a few people that I’ve had to recommend positive risk taking because they... I guess it’s making sure that we’re still acting in a least restrictive way and sometimes we have to, you know, we cannot wrap everybody in bubble wrap.” – Participant 1</i>
Risk focused mindsets: negative attitudes	<p><i>“All the general things that teenagers do would be seen in very much different light and do generate referrals to ourselves when people exhibit behaviour that their brothers and sisters would have exhibited without them batting an eyelid, and all of that contributes to their sexual vulnerability.” – Participant 5</i></p> <p><i>“Obviously as soon as people mention sex and relationships and learning disabilities there is a huge stigma....so we get a lot of carers that come in and they make really, really big deals out of the topic of sex, usually around some sort of exploitation, whether they are the victim or the perpetrator, the client that they support. And actually, they’re very much of the opinion of, like, I can’t talk about this even in front of them...I guess we’ve had a lot</i></p>

	<p><i>of carers and I've observed them where they bring clients in and when they come out of the group and the clients say I learned about sex today, or I learned about sexual health, and I know that I need to shower every day now and the carer says No, no, no. Don't talk about that. We don't. We don't talk about that" – Participant 1</i></p>
<p>People with learning disabilities as parents</p>	<p><i>"I think you know relationships are supported until they become sexual, and then there's, oh, my God, she's going to have a baby." – Participant 7</i></p> <p><i>"So for me it's about sort of people go into absolute panic because what will happen if they don't keep that person safe? Will they get blamed? What will happen if that person gets pregnant? Will they get blamed? What will happen if you know? I don't know and they get an STD or you know anything?" – Participant 11</i></p>
<p>Crazy schemes that start to seem rational</p>	<p><i>"How did you do with her risk assessment and all? All this sort of..do you do a risk assessment when you have sex? No, you don't do it." – Participant 2</i></p> <p><i>"How do they continue their lives, but also if people have been controlled in a relationship and then after that relationship, professionals control them? Are we just passing the abuse over to sort of sanctioned, more formalised form of control that isn't helpful?" – Participant 3</i></p>
<p>Professional reluctance</p>	<p><i>"There wasn't any more that could be done, but it seemed very clear that what they wanted was someone else to come and carry out those recommendations, which would include just having a conversation with him because they just weren't, weren't willing to really. It wasn't that they didn't know what the situation was. They could have written a book on it". – Participant 3</i></p>
<p>Finding allies in other services</p>	<p><i>"But then in another instance I work with an MDT and where the children, the child has been taken away. And this has been an amazing experience. It I feel like it's one of the best experiences in my career that I've had, so children's services worked together with adult services, social services, police and the LD team, advocacy. Everybody's been involved and it's been very, very good. And even though the outcome isn't perhaps what the parent would have wanted, it is the best outcome that could have been done for everybody in a positive way with some positive outcomes for the parent as well as a result." – Participant 11</i></p> <p><i>"Where I work now, there are a few people who used to work on that ward so I think that probably influences this, but I think that there are quite a few people who are quite sort of I don't, I don't know, progressive or forward thinking or you know, comfortable with the sort of ideas I've been talking about - that it is OK for human beings to want normal human relationships with other human beings, even if they've got a learning disability. So it's not like I'm, I don't know, shouting at the wall or anything like that. There's other people who share those views and those values." – Participant 9</i></p>

Appendix O. A table to show which participants discussed each theme

Theme	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11
Ignorance is not bliss: Lack of education	X	X	X	X	X	X	X		X	X	X
The internet: Fresh challenges in sexual vulnerability	X	X	X	X	X	X	X	X	X	X	X
Protection or people's rights: What is the bottom line?	X	X	X		X	X	X	X	X	X	X
Risk focused mindsets: Negative attitudes toward sexuality and relationships	X	X	X	X	X	X	X	X	X	X	X
Polarity of multiagency working	X	X	X		X	X	X	X	X	X	X

Appendix P. Reflexive Journal extracts

Interview ~~1~~

Nothing changing for people with an LD?
p's reporting same difficulties now
as back in the 80's - peoples attitudes.
P feels frustrated and so do I.
Ideas of specific people advocating
for people with an LD - always
fighting to try to make things
better. Shouldn't have to be a fight.

coding

So many codes and all feel too
important to cut out. overarching
ideas of advocacy have come through
from everyone so feels important
to prioritise that as an idea.