

Empowering LGBT+ people with intellectual disabilities to live socially inclusive lives: Debating rights, responsibility, and risk

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Abstract

Feelings of marginalisation impact the lives of LGBT+ people in a fundamental way, but for those who have an intellectual disability, and are gay, there is a heightened sense of alienation. This article examines the unique oppression faced by these individuals in a heteronormative and ableist world, where a long history of extreme control of sexual intimacy has resulted in harsh forms of social exclusion. Although moves have been made to empower service users who are intellectually disabled and identify as LGBT+ to participate fully in life, there is also a need to assess the relationship between rights, responsibility, and risk. This article further explores whether by drawing upon government social policy, barriers are being dismantled through the development of innovative local strategies that aim to deliver non-discriminatory person-centred services.

Keywords

Intellectual disabilities / LGBT+ / empowerment / voice / wellbeing

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Introduction

A good deal has been made about the advances in recent decades concerning equality for people with intellectual disabilities, however in terms of sexual identity, it continues to be taken for granted they are either asexual or heterosexual, but seldom seen as lesbian, gay, bisexual, or transgender (Noonan and Gomez 2011; Wilson et al. 2018). Scholars draw attention to the importance of recognising the challenges faced by LGBT+ intellectually disabled people who have to negotiate, on a daily basis, a heteronormative world with its restricted ideas on disability and sexuality (Abbott 2013; Hodges and Parkes 2005; Wilson 2006). Yet sexual orientation is a fundamental characteristic of being human, demonstrating how people relate to one another—what relationships are fostered, how love and affection are established, and the ways in which individuals experience their lives. Nevertheless, even with advancements such as person-centred planning, and personalised care, there remains a complicated relationship between individual rights, supported action, and risk. The chances of same-sex intimacy for adults with intellectual disabilities is regularly frowned on by families, hindered by care staff, and decisions are made using policies focused on eliminating risk (Wilson and Frawley 2016; Wilson and Plummer 2014). This is despite the fact as Appel (2010) points out, hindering sexual intimacy is of itself a violation of a human right (see Equality Act 2010; Human Rights Act 1998). Denying individuals with intellectual disabilities the opportunity to learn about their sexuality, and develop social relationships with others, is a denial of their right to self-realisation (Swango-Wilson 2008). Even so, considerable numbers of support staff feel uncomfortable when confronted by a service user wishing to discuss same-sex attraction. Prejudice against LGBT+ individuals is motivated by a range of factors, but personal conviction emerges as a recurring theme. People of faith consider homosexuality a ‘sin’ believing gay people have chosen a sinful lifestyle. It is a way of living which goes against their convictions and one not to be encouraged. A support worker of faith claims:

People are not born homosexual or lesbian, it’s their CHOICE! The word of God, the Holy Bible states this is SIN! (Old & New Testament). So does the Jewish Torah & the Islamic Qur’an! (Somerville 2015, 18. Capitalisation in original).

Other reasons staff are reluctant to support people with intellectual disabilities identifying as LGBT+ is the fear they might violate their duty of care, should they be seen to encourage same-sex intimacy. As a consequence they express concern their conduct may be viewed as irresponsible and lead to an investigation (Leven 2021). Furthermore, doubts about the legitimacy of consent communicated by each person is highlighted as a further issue, along with a lack of training to facilitate LGBT+ service users (Abbott and Burns 2007; Abbott and Howarth 2007; Swango-Wilson 2008).

Set against an historical background of segregation and control, this article demonstrates that even though progress has been made for heterosexual adults with intellectual disabilities in terms of sex and relationships, the same claim cannot be applied to non-heterosexual intellectually disabled people. Accordingly, relations deemed inappropriate are suppressed through codes of conduct that maintain everyone is, or should be, heterosexual (Marchia and Sommer 2019; Wilson and Plummer 2014). Against this backdrop, the article

raises a number of fundamental yet important questions relevant to social policy and professional practice by considering the implications for people with an intellectual disability who are non-heterosexual. It reviews the literature drawing on sources of qualitative data which have sought to give ‘voice’ to these individuals using their personal accounts. The accounts are of interest because they reveal the complex ways in which discrimination in social care operates to re-enforce prejudice and exclusion (Concannon 2006; Leven 2021). The narratives emphasise how heteronormative ‘norms’ have thus far limited inclusive services for intellectually disabled gay service users. Consequently, heteronormativity as a social construct is examined, and within this theoretical framework the ways in which power relations are maintained in care services, is investigated. The narratives of service users propose that in order to productively respond to their wants and needs, existing government policies must be translated into workable local strategies. Strong feelings of powerlessness are revealed but the accounts also offer hope by illuminating positive ways in which such experiences can inform the future development of care provision. The conclusion presents an opportunity to consider fresh ways in which agencies, commissioners, and professionals, can empower their clients. It reflects on current thinking to recommend areas where further research could inform social policy and advance professional practice.

Controlling sexual intimacy: lessons from the past

Sex is an innate part of life, yet for adults with intellectual disabilities throughout much of history, it has been a segment consistently denied to them (Noonan and Gomez 2011). In the past, social acceptance of what was proper and ‘normal’ behaviour, resulted in oppression towards those displaying sexual affection. The powerlessness that resulted from such control has been a key feature enabling the exploitation and sexual abuse of people with intellectual disabilities (Noonan and Gomez 2011) with examples continuing to surface from time to time in the media. But before discussing present day attitudes towards intellectually disabled people and sexuality, it is useful to shed light on the topic by locating it within a historical context. The core of the past narrative for this group is one depicting them as ‘innocent children’ incapable of individual choice and responsibility (Concannon 2005). It was due to early discourses examining the concept of free will and original sin, in the writings of St Augustine (bn.354 – d.430) and his work *Anti-Pelagian*, that the notion of the ‘idiot’ as childlike—‘*holy innocents*’—was first introduced (Allan 2012). (*The word ‘idiot’ is used in its historical context along with similar such terms*). By using religiosity, Augustine argued that, because children cannot ‘reason,’ it is not possible for them to be responsible for their ‘sins.’ He claimed, ‘infants could never commit an offence ... [since they have] great weakness of mind and body [and] their great ignorance of things [means] the complete absence ... of all perception’ (Warfield 1956, 27–8). In other words men and women with intellectual disabilities lacked capacity to make meaningful choices, and applied to relationships, this maintained they could not understand the consequences of sexual intimacy (Concannon 2005). Augustine’s philosophy began a longstanding association between the notion of adults with intellectual disabilities, and children lacking acuity. So ingrained did this powerful image of the helpless child become that for some it endures to the present day. By the mid 19th Century a growing dissatisfaction had arisen about the degeneration of society resulting in a demand for segregation of ‘subnormals.’

They were to be detained in asylums which Goffman (1961) famously referred to as ‘total institutions.’ Structures of confinement that functioned as dumping-grounds for undesirables, where men and women were separated for fear of intimacy and procreation (Foucault 2001, 1961; Scull 1979). The work of the British medical researchers George Shuttleworth and William Potts at the beginning of the 20th Century, had a significant influence in propagating the argument for partition. Shuttleworth and Potts proposed restrictions between the sexes was necessary because:

though children in mind, they are often men and women in wickedness and vice; and it may be necessary to place them under restraint ... There is a tendency to low and depraved habits, to brutish sensual enjoyment [with] an absolute disregard for right behaviour (Shuttleworth and Potts 1910, 114).

The controlling regimes inside asylums reflected a growing moral panic governing the outside world (see Royal Commission 1908). Over time the solution to eliminating the ‘problem,’ set in motion a dark response, culminating in an embracing of eugenics and Darwinian Biology. It was social engineering by means of forced sterilisation to eradicate people with intellectual disabilities, under Nazi rule, during the second world war, where the most extensive expression of this practice was realised.

In the UK, control and restraint continued to dominate institutional care by the time Pauline Morris published her ground breaking work, ‘Put Away’ in 1969. Her study described hospitals as Dickensian and grotesque, with working practices revolving around authoritarianism. Fundamental to many codes of practice was the parent-child model signifying the enduring influence of Augustine’s *holy innocents*, and was the relationship employed by most staff (Smith 1994). It was not until the introduction of the Normalisation Principle that social and political attitudes towards safeguarding the rights of people with intellectual disabilities experienced a transformation (Concannon 2005). The pioneer, Bengt Nirje, declared policies founded on Normalisation had been designed to enable citizens with intellectual disabilities to live as near normal patterns of daily life as possible (Perrin 1999). But critics remained unconvinced, arguing it was an unattainable ideology for all except the most articulate and capable individuals (for background context see Culham and Nind 2003; Wolfensberger 1980). In spite of criticism, the foundations were laid for ordinary living seeking to ‘make the quality of life the same for disabled people as for non-disabled, based on notions of equality, quality of life and quality of services’ (Alaszewski and Roughton 1990, 22). As the advent of care in the community dawned from the late 1980s onwards, attempts were made to radically change the relationship between staff and service users to one that was optimistic and equitable. However, critics viewed this as misguided and ‘based on the unreal idea of staff as friends of users and equal colleagues’ (Concannon 2005, 39). They claimed professionals were becoming irresponsible by blurring the boundaries and glossing over the need for limitations, that had been introduced to ensure protections. With the development of care packages, and the policy of individual assessment, the plan was for choice and control to pass to the service user. In reality overall control remained in the hands of social workers—renamed care managers in the 1989 White Paper, *Caring for People* (see Griffiths 1988). The challenge for social policy was to create methods through which individuals could articulate their wants and choices, and

have them respected and met (Abbott and Burns 2007; Stainton 1994). Included was supporting the development of personal relationships. Nevertheless, although these moves saw a growing encouragement for heterosexual relationships, and in some cases led to marriage and children, the question arises: did such innovatory developments have a positive impact on support for same-sex relationships, or did the paternalistic philosophy of Augustine translate into a contemporary form of homophobia?

Identity, disability, and powerlessness

Notwithstanding innovatory moves to improve the lives of intellectually disabled people, the disadvantages faced by those who identify as LGBT+ has been referred to as a cohort of powerlessness (Wilson et al. 2018). A similar argument can be found in the model of intersectionality pioneered by Crenshaw (1989) which suggests ways a person's social and political identity can fuse to create a new form of oppression. Applied to LGBT+ people with an intellectual disability, the theory sees them marginalised because of their disability, and ostracised farther from mainstream society due to their sexual orientation, or gender expression. Powerlessness can lead to family and professional relationships becoming problematic owing to restrictions imposed on a desire for same-sex activity. Yet the layers of discrimination and homophobia can extend further to include rejection from fellow service users; on the part of organisations who fail to introduce supportive policies; and from within the gay community itself who may perceive intellectually disabled people negatively (Abbott and Howarth 2003; Stauffer-Kruse 2007). Significant numbers of adults with intellectual disabilities live either in a residential facility, supported living, or the family home. Such forms of communal living lack privacy. Residential accommodation is not only a home, but a place of work for staff, where approaches towards expressions of homosexual intimacy can mean they are regulated (Aylott 1999; Noonan and Gomez 2011). Withers et al. (2001) came across one such example whereby male participants in their study voiced concerns that staff would not tolerate them bringing male partners home. As a result sexual activity occurred in public spaces, such as toilets, where access to condoms and negotiations around safe-sex was seldom possible. The researchers also stated parents of two of the men approached them to express apprehension about their sons coming into contact with potential sex partners by attending the sessions. They needed to be reassured that the group had a genuine focus on mental and physical wellbeing. The powerlessness these gay men experience offers an insight into the subtle ways in which control continues to operate in the care system. Agencies can be guilty of constructing barriers against LGBT+ clients through an absence of policies to facilitate them. Barriers deriving from a top down authoritarian management structure, where decisions determine intentionally or inadvertently, to prohibit the rights of non-heterosexual intellectually disabled service users to express themselves sexually. Noonan and Gomez (2011) assert having a policy of privacy in residential care, by providing a separate bedroom, where inquisitive young adults can explore their bodies, is a simple answer to countering this. Educating that masturbation and sexual fantasy is a normal and healthy part of human growth (Tarnai 2006) and that it is acceptable to experiment in the privacy and safety of their room, is another way. However, gay men with intellectual disabilities living independently who can bring men home, are equally at risk of exploitation (Withers et al. 2001). While professionals must recognise and

respond with protective measures, for the client, getting help can proven to be difficult to negotiate. In order to effectively empower gay service users, the organisation must demonstrate a commitment to confronting homophobia through person-centred planning and the review process (Stauffer-Kruse 2007). Yet examples of poor practice are easy to locate. Richard, an 'out' gay man with intellectual disabilities is one such case. Now in his late twenties, he attended special schools as a child and afterwards went into residential care. His account demonstrates the obstacles faced when he began to talk to staff about the feelings he was having towards other men.

Unfortunately, in special schools you never had any sexual relationship training or any sex education, it just didn't happen. So in the time I was going through it, it was a bit like actually, "What are these feelings? What is happening to me? Why do I fancy this person?" And you don't understand the reasons why, because you start thinking is it just a learning difficulty, or do I have something else wrong with me? (SCIE 2021).

Feelings of powerlessness which have been a key feature in the past, continue to make individuals like Richard vulnerable. Hindrances such as failing to provide comprehensive sex education in the transition from childhood to adulthood is absent, and is of particular concern when the person is alone in the community (Noonan and Gomez 2011). Richard's move to independence brought with it a new sense of freedom, but when he turned to staff for help on 'coming out,' the type of support he needed was more challenging to get than expected. He explained:

I wanted to have a relationship, and when you live independently, you have what they call Person Centred Review, so you have a monthly review, or yearly review. And for about three years all they wanted to talk about was how am I doing with spending? What am I like with doing my laundry, cooking and washing? And actually all very important things to talk about, but I wanted to talk about having a relationship. And every single time it was brought up, it always seems to be "Well, we can talk about that a bit later on" but we never actually got to a point of talking about it, it always sort of got swept under a carpet. What I decided to do was to have a review, who were people [*sic*] I wanted to invite, so I could say to them, "Look, this is who I am, and this is the support I need" (SCIE 2021).

Education promotes the ability to make good choices around sexual activity and enhances capacity based on an understanding of safety and wellbeing. Imparting knowledge not only contributes to reducing vulnerability, but also to the reduction of inappropriate sexual expression (Swango-Wilson 2008). Education can be a powerful weapon against exploitation in that the person is equipped with the language needed to defend themselves and inform others of potential abuse (Noonan and Gomez 2011). Nevertheless, although the guidance in care assessments and the review process seeks to proactively support service users in all aspects of their lives, little evidence exists to suggest overall, local services are making enough effort to meet the basics for people like Richard. A social worker admits:

There is a shocking lack of importance placed on awareness of issues surrounding sexual orientation. Racial issues and those from ethnic minorities are seen as important; indeed information detailing these issues are required as part of the assessment process. However, sexual orientation is often ignored or sidelined as irrelevant to a community care assessment, which I feel results in a lack of knowledge about that person (Somerville 2015, 24).

Similarly, the limited involvement of LGBT+ people with intellectual disabilities in empirical research means their specific care needs and wellbeing, and how they differ from heterosexual individuals with intellectual disabilities, remains chiefly undetermined. This void has consequences for the successful development of local health and social care policies. Frustrated with his sexuality not being taken seriously and needing support, Richard decided to confront the system by taking out a formal complaint. Remembering the courage it required, he recalled:

I got the confidence to actually say to somebody, “Look, this is who I am. You’re being paid to give me the care that I need, and this is part of the care that I need. I need someone for support to be the person who I am.”

As a result his support transformed.

My support became the best support you could imagine, so I think if I hadn’t done ... hadn’t put that complaint in, then the support would never actually have really changed very much (SCIE 2021).

Shaun discussed the barriers he faced when he came out as bisexual. He has short-term memory problems and dyslexia. Throughout his years attending special school, Shaun says he received no sex education to help him understand his bisexuality. Looking back he said:

I thought I was going mad, I thought there was something wrong with me. I didn’t know what bisexual meant. Special needs schools didn’t do proper sex education for people with learning disabilities. They think people like us don’t have sex. [Sex education mainly focused on] making babies rather than explaining terms like gay, bisexual, trans and non-binary. Coming out when you’re 38 is a big thing to do. It’s life-changing; a huge weight had been lifted (Ebrahim and Hunte 2021).

Nowadays Shaun lives with his wife and children. He received an MBE for his dedication to helping people with intellectual disabilities in the UK and abroad. Shaun said, ‘I feel proud to be a role model for people with a learning disability to help them to understand about their sexuality’ (Ebrahim and Hunte 2021).

Promoting self-worth through positive representation

These experiences draw attention to the importance of encouraging non-heterosexual service users to develop confidence as a way of increasing self-worth, fostering a sense of empowerment, and enabling ‘voice.’ However, before staff can support LGBT+ clients, they must first recognise their own prejudice in a world that imposes heteronormativity. Marchia and Sommer (2019) propose the social order is organised around codes of conduct that deem everyone should be heterosexual. Scholars likewise agree adding there are dominant ‘norms’ of behaviour in relation to disability and sexuality; norms that inevitably demand conformity to heterosexuality (Abbott 2013; Hodges and Parkes 2005; Wilson 2006). Imposing heteronormativity can intensify feelings of segregation and inequality in a group of people who are already one of the most prominently marginalised and socially excluded (Wilson et al. 2018). Regardless of sexual identity the important matter is being able to choose whom to have a relationship with, bearing in mind that to obstruct the choice of a partner based on sexual orientation is a breach of a human right (Appel 2010). Of equal importance is how best to quantify an individual’s capacity to make the choice (Murphy and O’Callaghan 2004). The following case illustrates tensions that can arise.

[A] young man’s mother was not comfortable with her son’s relationship and argued that he was not capable of providing valid consent, and that he was not homosexual. The other side of the argument was that, after careful observation, there was no coercion, there was no (actual) sexual activity between the two, and female clients were available but the son chose the male bed partner (Wilson et al. 2018, 190).

This example raises questions about capacity and the right of each person to make a choice about forming an intimate relationship. Although he was an adult, this mother saw her ‘child’ as incapable of giving consent. Provider organisations tend to be more concerned with liability and protecting themselves when confronted with issues of capacity and consent by family members, than they do with enhancing the right to sexual expression. This is particularly the case where the person has limited communication, or is cognitively impaired (Lyden 2007; Murphy and O’Callaghan 2004). What the example also underlines is the importance of delivery of specialised training. In keeping with the principles of the Care Act (2014) and those of the Mental Capacity Act (2005) training can ensure social workers empower their clients to be at the centre of their care plan, reflecting choice and needs (Concannon 2005; DOH 2005; DOH 2014). Notably, the focus of the Mental Capacity Act (2005) is on—as far as possible without endangering the client—providing liberty to make mistakes in the same way as everyone else does. The legislation provides a context within which professionals can have a rational dialog relating to sexual identity, gender and sexual relationships. Empowering a person who may be considered vulnerable might be difficult for staff, but this should not impede the person’s right to decide about engaging in a sexual relationship (Bates 2018; Maguire et al. 2019).

Staff can facilitate their clients using a range of activities such as group sessions that promote ‘voice.’ Learning from each another in a safe and confidential environment (Elderton

and Jones 2011). Life stories are useful as a tool to assess a person's needs and wants, while also offering an insight into their history and helps shed light on how and why they make the decisions they do (Concannon 2005). Shared narratives can have a twofold benefit in that the individual is an expert in their own experience, their story can inform staff training, as well as fellow group members. Exchanging experiences about sex in a group is a more relaxed way of exploring sexual orientation and gender identity (Robinson et al. 2020). Groups provide a forum through which sexuality can be discussed as part of ordinary life, and where information and guidance on sexual practice is made available. Knowledge of the health consequences of certain types of sexual activity, as well as activity which might constitute a criminal act, and how to avoid them, can be shared. Participants are able to speak about exploitation and abuse, while correspondingly being informed about tactics someone might use to take advantage of them (Tarnai 2006). In addition, ensuring images of sexual diversity including; photographs, posters, and books portraying positive representations of LGBT+ individuals and couples, are placed around day and residential settings, can heighten feelings of self-worth and confidence. Targeted education, accessible information and support, representation of diversity and advocacy, are all required to progress positive changes to improve self-esteem (McClelland et al. 2012; Wilson and Frawley 2016). Health and social care staff should be committed to keep informed about the unique needs of intellectually disabled clients who are LGBT+ in order to create change that supports wellbeing, counteracts heterosexism, ableism and oppression (Thompson et al. 2001). In contrast, the adverse outcomes associated with sexuality and marginalisation can leave individuals at risk of STIs, HIV, and other issues such as psychological damage or physical attack (McClelland et al. 2012).

Nevertheless, surveys exploring the lives of the LGBT+ population, including people with an intellectual disability, continue to paint a bleak picture of prejudice and discrimination. In 2017, the government launched a national survey in which it set out to investigate the main areas where inequality exists for LGBT+ citizens those of personal safety, education, the workplace and healthcare (GEO 2018a). Arising from the findings, the government published the LGBT Action Plan the following year (GEO 2018b). As a key part of the survey, participants were probed about their involvement with health services, social care, and gender identity clinics. Contributors were asked if they had disclosed their sexuality or gender identity to professionals and as a result, believed their disclosure had affected the delivery of care. Many offered examples of discriminatory practice such as alleging staff used inappropriate questions based on curiosity rather than necessity. While others claimed their specific needs were ignored (p.165). The findings highlighted that at least 38 per cent had a negative experience which they attributed to their gender identity, and 51 per cent who tried to access mental health services, said they were kept waiting too long. Additionally, 80 per cent of trans people who tried to engage with gender identity clinics were left feeling upset. There is a perception among the general LGBT+ populace that health inequalities are the consequence of prejudice on the part of health professionals—notably relating to gender identity—and are liable for causing higher rates of mental distress (Robinson et al. 2020). These barriers mean non-heterosexual people with intellectual disabilities need additional support. Furthermore, the Action Plan suggests there is a pathologisation of transgender people, where the person's mental health difficulties are ascribed to their identity. Ray is a case in point—a 21-year old trans man with

communication problems who also struggles with audio and visual processing. For Ray, negotiating trans health services has been overwhelming, whereby the main difficulty has been:

processing information especially when it comes to gender identity clinics, which are a whole minefield. They have a checklist of things you need to be able to explain and I have difficulty expressing myself properly. There are a lot of invasive questions about your sex life. That makes me uncomfortable. And when I'm uncomfortable it's even harder to express myself ... Trans people are always *infantilised to some degree and so are people with learning disabilities*, so it becomes really challenging (Ebrahim and Hunte 2021. Emphasis added).

The Action Plan proposed a set of objectives to improve health and social care support to all LGBT citizens. This included people with intellectual disabilities where it resolved to:

review, collate and disseminate existing best practice guidance and advice regarding LGBT issues and learning disability; and ... ensure that training requirements for support staff and advocates who work with people with learning disabilities includes advice regarding LGBT people (GEO 2018b, 10).

From asylums to safeguarding: the changing face of control

Yet, the historic maltreatment of people with intellectual disabilities in asylums, documented in the work of Goffman (1961), Foucault (1961, 2001) and Pauline Morris (1969) has been the foundation on which discriminatory practices towards non-heterosexual intellectual disabled individuals, has been shaped. Until relevantly recently, anti-libidinal medication was used by staff to control sexual expressions in people with intellectual disabilities, rather than teaching boundaries. Support staff failed to respect the self-determination of the individual denying them the right to engage in meaningful relationships (Leven 2021; Robinson et al. 2020). In the present day, some agencies persist in stigmatising homosexuality and same-sex intimacy, regarding the subject as interdicted (Bates 2018; Maguire et al. 2019). This is mirrored in the lack of training that educates on the inclusivity of LGBT+ citizens. Even when courses are provided, critical areas of significance about the rights of LGBT+ people have been neglected. For example, only 30 per cent of staff who contributed to research conducted by Stonewall, said they were informed about the legal protections for LGBT+ clients (Somerville 2015). While some training sessions included material on the use of language and practices that related to the LGBT+ community, 25 per cent of *all* care staff alleged their employer did not offer any equality and diversity guidance. This figure increased to 34 percent in the independent sector. Reflecting on the training delivered, a service manager concluded it was, 'very basic and does not cover how to work with people from a diverse range of backgrounds.' A nurse said, 'training is invariably online and pretty rubbish to be honest.' While another stated, 'I fail to see the need for this type of training' (Somerville 2015, 24, 26). When probed about training on policy, staff reported that discussions tended to be around policies dealing with internal matters of the agency, such as staff bullying, rather than broader themes linked to social policy and inequality.

A dilemma faced by many staff is in reaching a balance between protecting their clients, and empowering the development of their sexual identity. Coupled with a lack of training and an over zealous desire to rigidly follow safeguarding practices, support staff have been culpable of restricting sexual relationships between service users (Bates 2018; Cambridge 2013; Harflett and Turner 2016; Maguire et al. 2019). Safeguarding procedures are important for protecting the wellbeing of service users, as well as the staff who care for them, yet some decisions made in the interests of safety, deny personal choice and autonomy. Having concern for the welfare of people with intellectual disabilities requires not only having a duty to protect them, but also respecting their preferences and valuing their right to a particular lifestyle (DOH 2009; O'Brien 1998; Tindall 2015). Nevertheless, for some staff, accountability is about doing the 'right thing' that will attract the least amount of criticism should something go amiss. As Tindall (2015) notes:

the lives of many people with learning disabilities are unduly restricted because the people they rely on, in order to live an ordinary life, are fearful of having to go through the process of justification if something negative happens.

Despite this a main component of the Care Act (2014) emphasises the importance of having the voices of service users heard and respected. It is within this framework that the safety needs of LGBT+ people with intellectual disabilities must be steadfastly located. The majority of safeguarding protections relate to explaining how harm occurred, and ensuring the possibility of it happening again in the same manner is avoided. While these are essential processes, at the same time they are imprudent because they result in preventing clients from having access to aspects of life that are important to them, and beneficial to their physical and mental health (DOH 2014; Tindall 2015). Being alert to abuse, and taking action when it occurs, should never be used to validate needless restrictive decisions that are then passed off as protective measures. Intensifying regulations around safeguarding which often negatively impacts people with intellectual disabilities, but rarely involves them in a consultation process, is not the answer (Concannon 2005, 2006; Tindall 2015). Rather it lies in positioning support firmly in the context of encouraging people with intellectual disabilities who identify as LGBT+ to foster meaningful companionships, and loving relationships with others.

Conclusion

Sexuality is a multidimensional paradigm that contributes to a person's sense of self-worth and incorporates identity, sex, gender and intimacy (Bates 2018; Maguire et al. 2019). Achieving self-actualisation and fulfilment can be realised through the loving companionship that a relationship provides. Feelings of belonging which intimacy can offer is an essential part of human growth (Robinson et al. 2020). While it is acknowledged that discrimination and social exclusion are key factors in the lives of the general LGBT+ community, providing health and social care to non-heterosexual adults with intellectual disabilities, brings with it an added need to balance rights, responsibility, and risk. This article argues that LGBT+ people with intellectual disabilities, like the rest of society, are sexual beings who have a right to express themselves through same-sex loving relationships. The study combines the literature on

sexuality, social exclusion, and intellectual disability to give ‘voice’ to the experiences of LGBT+ intellectually disabled people with the aim of informing social policy, improving professional practice and to recommend better outcomes for service delivery. Even though examples of St Augustine’s philosophy that infantilises adults with intellectual disabilities continue to surface, since the introduction of the Normalisation Principles, policy development has made impressive strides in terms of empowering people with intellectual disabilities to broaden healthy lifestyles, take more control of their lives, and procure their place as equal citizens.

Belonging to a community can reduce marginalisation, increase happiness, and dismantle barriers resulting in improvements to physical and mental health. Weeks et al. (2001) describes the importance of ‘families of choice’ emphasising the bonds and friendship they create through shared experiences of discrimination and powerlessness. But it continues to be the case that for LGBT+ intellectually disabled individuals, accessing these communities is not an easy task, due to the lack of appropriate support. The barriers which they encounter include safeguarding procedures aimed at protecting them from abuse. As a means of countering this, training that includes the theory of intersectionality, will help support staff to understand the multiple layers of discrimination, and highlight the importance of accessing communities to support identity and individualism. Policy-makers, commissioners, and service providers must acknowledge the importance of these communities when designing local strategies. In addition, as part of innovatory local policies, provider agencies need to encourage their staff towards positive risk-taking (Robinson et al. 2020). Introducing mentoring programmes which draw on members of the gay community without intellectual disabilities, who are willing to support service users to access ‘gay spaces,’ is one way of achieving this. LGBT+ intellectually disabled people could engage with interest groups, social events, and outings to gay pubs and clubs. Nonetheless, the key to the full social inclusion of LGBT+ citizens with intellectual disabilities lies in providers equipping their staff with appropriate training to support the sexual identity and gender expression of their clients. This study has evidenced the lack of awareness about sexuality among many social care staff and clinicians. It recommends that health and social care providers, involved in supporting people with intellectual disabilities, must implement compulsory LGBT+ equality and diversity training for all staff. The training should be completed by employees on a regular basis, and sessions should be group based as opposed to online, covering topics such as: language, diversity, homophobia, biphobia, transphobia, and health inequalities. Training policies must be designed at a local level that include the experiences and thoughts of, not only the service user but also draws on members of the gay community, involved in the mentoring programmes. This will allow for first hand experiences to be shared and moreover it will enable staff to empathise. A part of the training should allow staff time to examine their own negative beliefs and prejudices about gay people. Provider organisations need to communicate clearly in the training strategy and subsequent group based sessions that homophobic, biphobic and transphobic abuse or bullying is unacceptable. Literature placed in prominent parts of day centres, residential accommodation and supported living should be there to encourage the reporting of bullying or abuse. The complaints procedure should be up-to-date and it must be made clear that complaints about homophobia and transphobia will be taken seriously. Alongside routine training, monitoring of sexuality and gender identity needs to be implemented to improve health and social care outcomes. The

information gathered from monitoring can be used to inform and revise policy annually. Commissioning, partnership and consultation boards must allow for the inclusion of service users with intellectual disabilities who are LGBT+ to accurately reflect the full and diverse range of clients, that services endeavour to support. Finally, this study recommends the next stage in advancing the rights and protections for non-heterosexual citizens with intellectual disabilities is to create within local environments, pioneering educational programmes, community awareness, and health promotion plans that will generate empirical data offering fresh perspectives to inform the development of local strategies.

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Liam Concannon began his career in the UK as a student Registered Nurse for the Mentally Subnormal (RNMS) back in 1980 in one of Birmingham's major hospitals for people with intellectual disabilities. After the first year, and disillusioned with the whole process of institutionalisation, he left nursing. Later he returned to working with adults with intellectual disabilities, spending over 20 years in a variety of provisions within London social services, targeted at supporting adults with intellectual disabilities. He worked in day centres, residential care homes, outreach and independent living schemes, and finally commissioning. Liam received his PhD from the Department of Social Policy, London School of Economics & Political Science in 2003 for his thesis exploring the consultation process administered by local authorities in London that sought to include the views and wishes of service users in the planning of their own care. This was later published as a book by Routledge. Liam went on to teach modules on social policy and the planning of services to adults with intellectual disabilities. These days he is an independent research scholar with an interest in society and its relationship to non-normative sexualities. His work explores ways in which organizations and policy initiatives seek to develop and maintain the inclusion of LGBT+ people as full-citizens. Dr Concannon has published comparative studies assessing the outcome of policy and practice for the LGBT+ populace in the UK, USA, and Ireland.