



## DOCTOR OF CLINICAL PSYCHOLOGY (DCLINPSY)

### Doctorate in Clinical Psychology: Main Research Portfolio

**1) Journeys Through Inpatient Services in the UK: Experiences of People with an Intellectual Disability and Those That Care for Them: A Qualitative Systematic Review and Narrative Synthesis; 2) Inclusivity within the Profession of Clinical Psychology: An Exploration of Contextual Markers in Trainee and Qualified Clinical Psychologists; 3) Coming Out Stories as Told by People with an Intellectual Disability: An Interpretive Phenomenological Analysis.**

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# Research Portfolio Submitted in Part Fulfilment of the requirements for the Degree of Doctorate in Clinical Psychology

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## Main Portfolio:

**Literature Review:** Journeys Through Inpatient Services in the UK: Experiences of People with an Intellectual Disability and Those That Care for Them: A Qualitative Systematic Review and Narrative Synthesis

**Service-Related Project:** Inclusivity within the Profession of Clinical Psychology: An Exploration of Contextual Markers in Trainee and Qualified Clinical Psychologists

**Main Research Project:** Coming Out Stories as Told by People with an Intellectual Disability: An Interpretive Phenomenological Analysis

Volume 1

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Doctorate in Clinical Psychology

University of Bath

Department of Psychology

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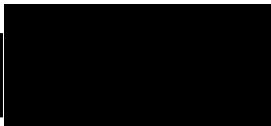
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## Abstracts

### **Literature Review: Journeys Through Inpatient Services in the UK: Experiences of People with an Intellectual Disability and Those That Care for Them: A Qualitative Systematic Review and Narrative Synthesis**

Inpatient treatment for people with intellectual disabilities has gained significant attention during recent years in the UK. Transitions into and out of inpatient settings may present particular challenges for people with intellectual disabilities and those that care for them. This review aimed to understand the stories and illuminate the voices of the people at the centre of this debate. A systematic search of the qualitative literature into the inpatient transition experiences of people with intellectual disabilities, family carers, and staff identified 14 papers. A narrative synthesis of the results revealed two overarching themes: the psychological impact of transitions and things that helped or hindered this process. The psychological impact related to distress, loss, and responsibility, but also to the positive aspects of transitions. Helpers or hinderers of this process related to support, barriers, joint working, and other contextual factors. Study quality, clinical implications, limitations, and recommendations for future research are discussed.

*Keywords: Intellectual disability, learning disability, inpatient, carers, transitions*

### **Service-Related Project: Inclusivity within the Profession of Clinical Psychology: An Exploration of Contextual Markers in Trainee and Qualified Clinical Psychologists**

#### **Objective**

It is thought that current admissions processes to the Doctorate in Clinical Psychology courses in the UK are failing to consider contextual information when selecting candidates, potentially disadvantaging candidates who have experienced deprivation. The aim of this project was to explore the contextual markers of current and past Trainee Clinical Psychologists at the University of Bath in order to provide insight into how admissions processes may or may not have disadvantaged groups and how this can be improved.

## **Methods**

This study used a quantitative questionnaire to explore the contextual markers of 81 current and past Trainee Clinical Psychologists at the University of Bath. 48 participants answered an open-ended question on the impact of contextual markers on their journey to becoming a clinical psychologist. 27 responses were used in the content analysis.

## **Results**

Results showed that 69% of participants identified at least one marker of deprivation, 46% reported at least two, 30% reported at least three, 15% reported at least four, 9% reported at least five, and 2% reported six markers of deprivation. 31% of participants reported no markers of deprivation. The content analysis revealed that many participants viewed their contextual factors as posing a challenge relating to resources, identity, cultural narratives, mental health difficulties, and accessibility. Participants also acknowledged the positive impact of their contextual factors which related to support and cultural narratives.

## **Conclusion**

People who have experienced deprivation are/have trained at the University of Bath but may feel conflicted about their identities and unable to express difference. People who have experienced certain markers of deprivation may be underrepresented. Recommendations and limitations are discussed.

*Key words: Clinical psychology, training, diversity, inclusivity, socioeconomic status*

## **Main Research Project: Coming Out Stories as Told by People with an Intellectual Disability: An Interpretive Phenomenological Analysis**

People with intellectual disabilities who identify as LGBTQ+ desire to be in loving and intimate relationships, but their needs often go unmet. There is limited research on how this group have navigated 'coming out'. This study aimed to understand how five people with intellectual disabilities experienced coming out using interpretive phenomenological analysis. Three group experiential themes with six subthemes were identified: a dual identity (who am I and who can I be? Double discrimination, the power of a community), a double-edged sword: the fallout of coming out, and the coming out journey (the impact of the system, the role of a catalyst, an unfinished journey). Findings suggest that people with intellectual disabilities who identify as LGBTQ+ experience difficulties and positives associated with belonging to two

marginalised groups and coming out, which is an ongoing process. Clinical implications and directions for future research are discussed.

*Key words: intellectual disability, learning disability, LGBT+, coming out*



**Journeys Through Inpatient Services in the UK: Experiences of People with an Intellectual Disability and Those That Care for Them: A Qualitative Systematic Review and Narrative Synthesis**

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**Literature Review**

August 2024

**Supervisor:** Dr Cathy Randle-Phillips

**Word count:** 7250 (excluding abstract, tables and references)

The target journal for my Literature Review was Journal of Intellectual Disabilities.

The guidance on journal formatting requirements is here:

<https://journals.sagepub.com/aims-scope/ILD>.

This journal was chosen as it publishes a wide range of research related to improving services and enhancing quality of life for people with intellectual disabilities.

## Introduction

It is well known that people with intellectual disabilities (PWID) have been treated very poorly in the UK, with institutionalisation being common during the first half of the 20<sup>th</sup> century (Goodley, 2000). The deinstitutionalisation movement during the 1980s led to a reduction in the number of long stay beds from 64000 in 1970 to approximately 4000 by 2012 (Royal College of Psychiatrists, 2013). Despite this progress concerns have remained, with a BBC Panorama documentary exposing the abhorrent abuse of PWID in an assessment and treatment unit (ATU) near Bristol (Winterbourne View: BBC, 2011). The Department of Health's (DOH, 2012) response to this was the Transforming Care (TC) programme, which aimed to improve the lives of PWID by closing inpatient hospitals, increasing community support, and repatriating people from out of area placements. TC aimed to reduce inpatient beds by 35-50% by 2019.

Evaluations of the success of the TC programme have varied, with reduction rates ranging from 5.6% (Taylor, 2021) to between 21-24% (Langdon et al., 2023). In 2019 a BBC Panorama documentary exposed the abuse of PWID in Whorlton Hall, another ATU in County Durham (BBC, 2019), demonstrating further systemic failures for PWID. Despite differences in figures, it is generally agreed that TC significantly missed its targets, which is thought to be due to inappropriate funding and a lack of community infrastructure (NHS Digital, 2018), which is supported by Langdon et al.'s (2023) findings that numbers of community nurses and nursing support has significantly reduced in recent years. The TC programme was superseded by the NHS Long Term Plan (NHS, 2019) which states the government's plan to extend its targets of reducing inpatient beds for PWID by 2023/24, although Mencap has used current data to estimate that these targets will not be reached until 2030 (Mencap, 2024).

Although inpatient units for PWID have quite rightly been heavily scrutinised, when done well, inpatient treatment can be helpful for PWID. A recent systematic review by Melvin et al. (2022) found that inpatient care for PWID is associated with improvements in mental health, behaviour, social functioning, and risk, with admission to specialist services potentially resulting in better outcomes. Following their review of models of inpatient care for PWID, Burrows et al. (2023) suggested that inpatient care is still required and proposed the development of inpatient services as an alternative to forced closure.

## **Attachment and People with Intellectual Disabilities**

Attachment theory (Bowlby, 1973, Ainsworth & Bowlby, 1991) proposes that good emotional care during childhood results in secure attachments, which provide the foundations for wellbeing later in life. Insecure attachment is thought to be a contributing factor in mental health difficulties (Mikulincer & Shaver, 2012). Research suggests that PWID are more likely to develop insecure attachments than people without ID (Hamadi & Fletcher, 2021). This may be due to differences in the parent-child relationship such as difficulties in communication and attunement, parental stress, and emotional availability (Howe, 2006). The importance of attachment relationships for PWID has gradually gained more attention, with The British Psychological Society (BPS, 2017) producing guidelines on incorporating attachment theory into clinical practice when working with PWID. Some services have used attachment theory to develop a model of care, which was found to be feasible in a female medium secure unit (Barber et al., 2006), and some authors have proposed that attachment theory is a useful framework to inform the design and delivery of mental health services (Bucci et al., 2014).

Considering this, transitions in and out of inpatient services may be a particularly important time for PWID and those that care for them. Despite this, a literature search found no available evidence exploring the association between transition experience and later outcomes. However, research from the non-ID literature suggests that a lack of or discontinuity in care after discharge is associated with poor outcomes such as readmission, medication adherence, and suicide (Tönnies et al., 2023), and transition interventions involving carers may increase positive outcomes (Petkari et al., 2020).

Some PWID have experienced admission as a lack of control (Longo & Scior, 2004) and being admitted and discharged seems to impact PWID's sense of identity (Head et al., 2018; Tearle, 2022). Caregivers can also experience this as a difficult time, with some parents reporting conflicting emotions (James, 2016), and staff reporting feeling the pressures of TC (Hudson et al., 2021).

Previous studies have focused on discharge (e.g., Head et al., 2018, Tearle, 2022) or compared specialist vs generic settings (e.g., Longo & Scior, 2004). Some studies have focused on the experience of family carers (e.g., James, 2016), and some on staff experiences (e.g., Manahandar-Richardson et al., 2023), sometimes within the context of discharge programmes (e.g., Clifford et al., 2018). To the authors

knowledge, there has not yet been a review that has brought together this research to tell a story about the experiences of staff, families and PWID themselves.

### **Current Review**

The aim of this study is to systematically review and synthesise qualitative evidence in order to understand how PWID and those that support them have experienced transitions in and out of inpatient settings. This will illuminate the voices of the people at the centre of the debate around inpatient care for PWID, providing insight into how services can support PWID and their families better, as well as the staff that support them. This study also aims to assess the quality of the current evidence and provide suggestions for future research.

### **Methods**

This review is reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines (PRISMA; Page et al., 2021, Appendix B). A protocol for this study was registered with PROSPERO (CRD42023447508). However, changes made throughout the process are yet to be updated on the PROSPERO registration.

### **Search Strategy**

A specialist librarian was consulted to provide guidance on search strategies and relevant databases. Searches were conducted using PsycINFO (APA PsychNet), Web of Science Core Collection (Web of Science), Scopus, Ethos (grey literature), and Google Scholar (grey literature) in August 2023 and again in March 2024 to check for recently published papers. Ethos was unable to be re-searched in March 2024 due to a cyber-attack. It was decided to include unpublished theses due to the limited research in the area. Search terms were developed by the lead researcher and their supervisor and can be found in Table 1 (for full search strategy see Appendix C). Searches were run on title, abstract and keywords fields, and additional filters were applied where available (e.g., UK only).

**Table 1***List of search terms*

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<b>Intellectual disability</b>	Intellectual disab*, Learning disab*, Learning diff*, Cognitive disab*, Cognitive diff*
<b>Inpatient</b>	Inpatient, Ward*, Locked, Secure, Forensic, Unit*, Hospital*
<b>Transition</b>	Transition*, Admission*, Admit*, Discharge*, Leave, Leaving, Move, Moving, Change*, Detain*, Progress*, Journey*, Transform*
<b>Method</b>	Qualitative, Interpretive phenomenological analysis, Thematic analysis, Grounded theory, Content analysis, Discourse analysis, Narrative analysis, Interview*, Focus group*

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**Eligibility Criteria**

Inclusion and exclusion criteria can be found in Table 2. This review focused on qualitative data as this allowed for synthesis of rich lived experiences. Only studies conducted in the UK were included as the research question focused on understanding experiences of people within the context of inpatient transitions in the UK (e.g. scandals and political agendas).

**Table 2***Inclusion and exclusion criteria*

	<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Participants	<ul style="list-style-type: none"> <li>• Adults (18+) with an intellectual disability who have experience of inpatient settings.</li> <li>• Professionals who have experience of supporting people with an intellectual disability in inpatient settings.</li> <li>• Family carers of people with intellectual disabilities who have experience of inpatient settings.</li> </ul>	<ul style="list-style-type: none"> <li>• Studies also containing participants without an intellectual disability, where the views of people with an intellectual disability were not easily identifiable.</li> </ul>
Setting Design	<ul style="list-style-type: none"> <li>• UK</li> <li>• Qualitative methodology.</li> <li>• Mixed methods (where the qualitative component was formally analysed).</li> </ul>	<ul style="list-style-type: none"> <li>• Studies conducted outside UK</li> <li>• The quantitative component of mixed methods studies.</li> <li>• Quantitative methodology only.</li> </ul>
Focus	<ul style="list-style-type: none"> <li>• Participants experiences of transitions into or out of inpatient settings.</li> <li>• Participants experiences of supporting people with intellectual disabilities into or out of inpatient settings.</li> </ul>	<ul style="list-style-type: none"> <li>• Transitions only briefly mentioned.</li> <li>• Primary focus is evaluating a service.</li> </ul>
Published	<ul style="list-style-type: none"> <li>• Peer reviewed journals.</li> <li>• Unpublished theses.</li> </ul>	

**Study Selection and Data Extraction**

Covidence data management software was used to screen the results from the database searches. Title and abstract screening was completed by the lead researcher, with a second rater independently screening 50%, resulting in an agreement rate of 91%. Authors were contacted where full texts were not available. If authors did not reply or did not have a copy the paper was excluded. Full texts were reviewed by the lead researcher, with a second rater independently screening 50%, resulting in an agreement rate of 90%. The two screeners met to resolve disagreements, with final decisions agreed by both parties.

The first step of data extraction involved extracting study characteristics and key findings (presented in Table 3). This data was extracted by the lead researcher and a second rater, with details checked for accuracy. The second step involved reviewing papers for relevant qualitative data on transitions and exporting the data into a table in Word. Where the focus of the paper was on experience of transitions, this usually involved extracting the whole results section. Where the focus was on another topic, results were reviewed carefully to extract only the data relevant to experience of transitions. This was done by the lead researcher.

### **Quality Appraisal**

The Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2018) was used to appraise the quality of included studies. The CASP checklist is commonly used for quality appraisal in qualitative syntheses in health and social care research (Hannes & Macaitis, 2012), is endorsed by Cochrane (Noyes et al., 2018), and is recommended for novice qualitative researchers (Hannes & Bennett, 2017). The CASP checklist is not a standardised measure and a scoring system is not advised (CASP, 2018). It was not used to determine inclusion of studies in the synthesis, but to assess the quality of the literature and to make recommendations for future research. Quality appraisal was conducted by the main researcher, with 4 papers (28.5%) independently reviewed by a second rater, resulting in an agreement rate of 90%. Disagreements were resolved through discussion.

### **Data Synthesis**

Due to the heterogeneity of study designs and scope of the project, narrative synthesis was used to synthesise the results, following Popay et al.'s (2006) framework. Meta-ethnography was considered, but due to time constraints and usability of some papers, narrative synthesis was chosen instead. This approach allowed for the results to be synthesised in order to 'tell a story' that reflects the current evidence (Popay et al., 2006). Data were organised into three categories: PWID experiences, family experiences, and staff experiences. The data were then examined line by line to identify important concepts. Next, the narratives were analysed for conceptual overlaps between studies and arranged into themes (Popay et al., 2006), which was done for each participant group. Participant group themes were then analysed together to identify overarching themes. As it is important to consider influences or biases that the review team may hold in qualitative synthesis

(Flemming & Noyes, 2021), a reflexive diary was used, a second rater was used at all stages, and themes were discussed and evolved between the lead researcher and their supervisor.

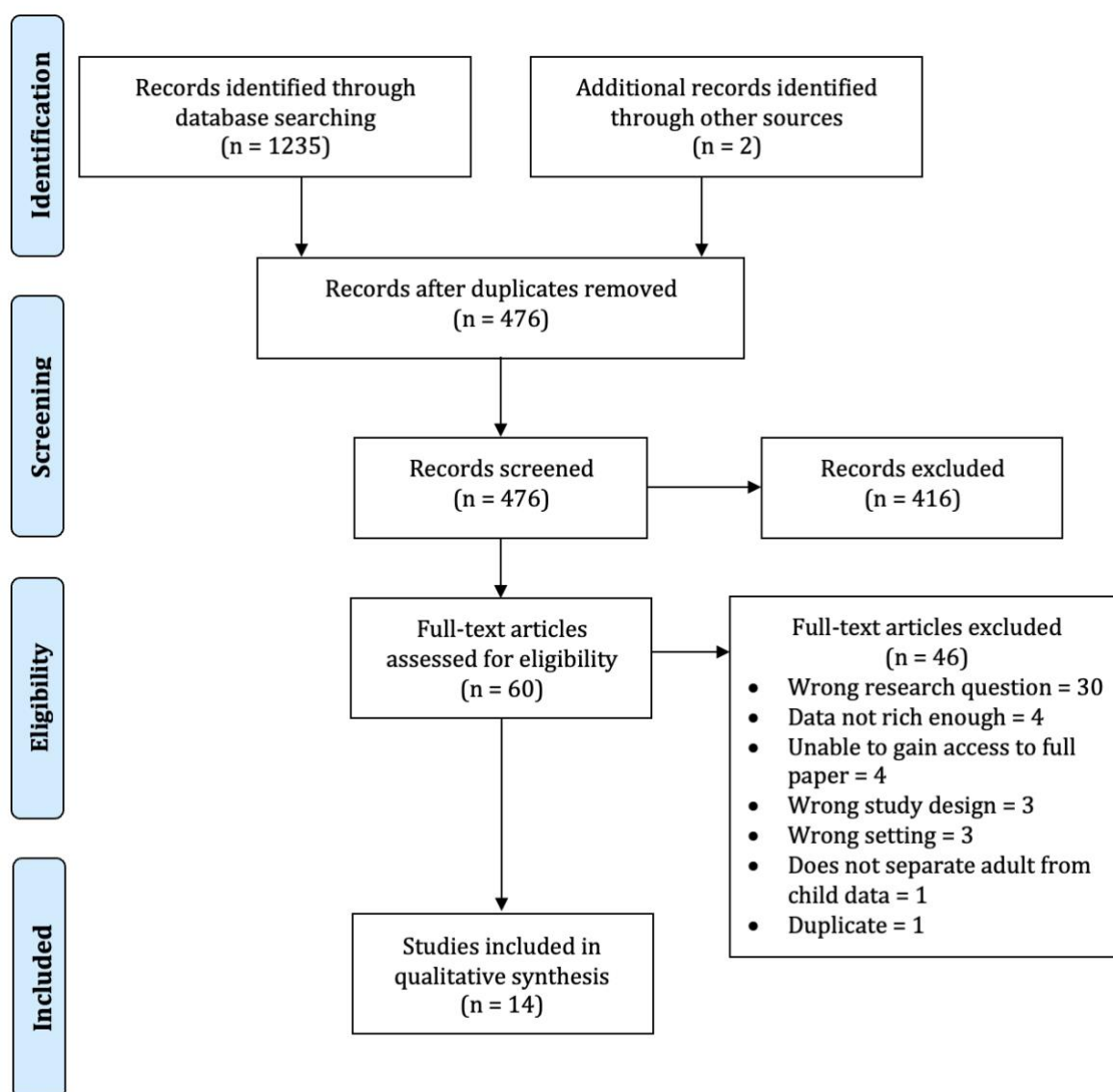
## Results

### Identification of Studies

The full search and screening process is presented in Figure 1. A total of 14 papers were identified to be included in the synthesis.

**Figure 1**

*PRISMA flowchart (Moher et al., 2009)*





## **Study Characteristics**

Included studies were published between 2001 and 2023 and were conducted in England (n=8), Wales (n=2), Scotland (n=1), and UK (non-specified, n=3). Some studies explicitly explored transitions (n=6), some of which focused on experiences of discharge programmes (n=4), with the remaining studies exploring transitions as part of a wider research question (n=8). Inpatient settings included specialist services for PWID, forensic services, and mainstream inpatient services. Interviews were the most common method of data collection (n=14), with observation (n=2), focus groups (n=1) and document analysis (n=1) used also. Studies employed various qualitative analysis methods including interpretive phenomenological analysis, grounded theory, thematic analysis, and ethnographic approaches. The analysis method was not clear in two studies (Fish & Lobley, 2001; Fish & Morgan, 2019). 12 studies were published in peer-reviewed journals and two were unpublished theses.

Data from 107 people with intellectual disabilities and 124 carers (family and staff) were included in studies. Four studies included PWID only, four included staff only, three included PWID, family and staff, two included family only, and one included PWID and staff. Although not all papers reported detailed demographic data, participants ages ranged from 18-72 years and where reported, most were White British (n = 31). Where PWID were included, most were categorised as mild-moderate, with some data from PWID who were considered to have a severe intellectual disability.

**Table 3***Study characteristics*

No.	Authors	Aim	Method: approach & analysis	Method: data collection	Setting	Participants	Participant characteristics	Key findings & themes
1	Longo and Scior (2004)	To explore PWID and carers' views on in-patient psychiatric treatment across generic and specialised treatment settings	Qualitative, Interpretive Phenomenological Analysis	Semi-structured interviews	7 general psychiatric wards, 3 ATUs, North & East London	PWID, family carers, staff.	29 PWID; 14 admitted to generic ward, 15 to ATU. Mild or moderate ID.  20 carers; 10 supported in generic ward, 10 in ATU. Demographics not available.	PWID key themes = lack of control and information, support from staff (or lack of). Carer's key themes = concerns about SUs vulnerability, negative staff attitudes and opportunities for involvement. Specialised settings were experienced more positively than generic settings.

2	Fish and Morgan (2019)	To explore the meaning of recovery/moving on through services for women with ID	Qualitative and observational. Analysis method not clear	Semi-structured interviews and observations	3 wards for women in NHS ID secure unit in England	PWID and staff	10 staff (2 male, 8 female). 7 nursing staff, 2 support workers, 1 clinical psychologist.  16 PWID (all female). All White British, aged 18-60.	Staff conceptions of moving on include behavioural change and utilising coping strategies. PWID discussed taking back responsibility, success in arranged relationships, acceptance of regime and resistance to progression
3	Hudson, House, Robson and Rayner-Smith (2021)	To explore nursing staff experiences of Transforming Care (TC) programme within forensic services	Qualitative - Multi-perspectival Interpretive Phenomenological Analysis	Semi-structured interviews	NHS MH trust that provided forensic ID care (inpatient and community), England	Staff	9 nurses. 4 forensic inpatient ID nurses (1 male, 3 female). 5 community forensic ID nurses (3 male, 2 female)	Inpatient staff experienced TC as a threat, which led to consistency of perspective and practice. Community staff felt TC presented opportunity and was a worthwhile challenge. Both groups frustrated by inadequate community infrastructure and felt needs of forensic population needed more consideration.
4	Donner, Mutter and Scior (2010)	Examine how PWID, their carers and service providers perceive mainstream inpatient mental health services	Qualitative - Interpretive Phenomenological Analysis	Semi-structured Interviews & focus group	5 NHS mainstream acute MH wards, England	PWID, family carers, staff	9 service users (6 male, 5 female), 7 White British, 4 'BME', ages 30-55 years	Positive aspects = provision of respite, good basic care. Outweighed by perception of admission as disempowering and lacking flexible treatment options. Major problems = accessing help and staff

							9 carers, 4 community nurses.	neglecting specific needs of PWID
							Focus group: 7 service providers, 6 nurses & 1 Occupational Therapist	
5	James (2016)	To explore the experiences of family carers of PWID requiring admission to in-patient care	Qualitative - Interpretive Phenomenological Analysis	Semi-structured interviews	3 NHS ATUs in Wales	Family carers	6 family carers- 3 mothers & 3 fathers of adult offspring	Five themes. Caring resulted in higher levels of anxiety, stress and uncertainty. Affected their view of self, identity, value and careers. Admission of relatives was a time of increased vulnerability and delicateness for their sense of self-identity.
6	Manandhar-Richardson, Woodrow and Cooper-Taylor (2023)	To understand the experiences of staff who support PWID who are 'at risk of admission'	Qualitative - Thematic Analysis	Semi-structured interviews	Community ID team, NHS Northwest of England	Staff	8 Participants: 5 males, 3 females. 3 managers, 2 service leads, 1 PBS/training lead, 1 senior support worker, 1 team leader	Three main themes relating to support systems, training and supervision, and change.
7	Parlais (2009)	To identify particular barriers that arose in one specific discharge program in context	Qualitative-Grounded Theory	Structured interviews	An institution for people with intellectual	Staff	28: 3 managers, 10 social workers, 6 nurses, 4 psychologists, 3 psychiatrists, 1	Main obstacle = lack of coherent approach, failure to discharge according to staff plan or SU needs, lack of holistic support for staffs, ambiguous model of

		of deinstitutionalisation			disabilities, Scotland		occupational therapist and 1 physiotherapist	management and lack of interest in joint working.
8	Owen, Hubert and Hollins (2008)	To understand how women with severe intellectual disabilities experience transition from a locked ward into their new homes	Qualitative- Ethnographic methods	Participant observation, interviews, document analysis	NHS locked long stay hospital, group home, community homes	PWID	11 women (aged 29-72). All ID, mostly severe ID. Some co-morbid ASC and mental health problems. All described as having 'challenging behaviour'	The move was mostly negative for all women. Not involved in the process, lack of information transferred to new homes, insufficiently supported. Those who moved to communities had more opportunities to make choices, learn new skills and explore new activities
9	Williamson and Meddings (2018)	To explore experience of family members of individuals with ID regarding their involvement with one Assessment and Treatment Unit (ATU)	Qualitative - Thematic Analysis	Semi- structured interviews	ATU in NHS trust, England	Family carers	4: 3 mothers and 1 father. Aged between 40-54 years. Parents to adult offspring.	Four master themes: Admission as traumatic, a relief, or both, negotiating a new role, valued features of the unit and negative experiences
10	Head, Ellis- Caird, Rhodes and Parkinson (2018)	To explore how people with learning disabilities experience moving as part of transforming care	Qualitative - Social Constructionist Grounded Theory	1:1 Semi- structured Interviews with SUs, dyadic internalised other interviews with SU and	Community, local MDT Transforming Care team, England	PWID and carers (interviewed as PWID)	11 PWID, mild- moderate ID. Additional diagnoses of mental health difficulties and/or challenging behaviour. 9 KSPs including parents,	People reported that their relationships with other people, including friends, family and staff, played a significant role in how they experienced the move. Moving was also an opportunity for people to shift their ideas about who they were as a person

				Key Support Person (KSP)			social worker, support worker, nurse, manager.	
11	Clifford, Standen and Jones (2018)	To gain the views and perspectives of community staff on barriers and facilitators to supporting adults moving into community services as part of TC agenda	Qualitative - Thematic Analysis	Semi-structured Interviews	Community - care providers linked with NHS trust, England	Staff	13: 6 Support staff, 3 team leaders, 1 deputy manager, 3 managers.	Participants identified difficulties balancing people's rights, safety and quality of life needs, and felt the system's expectations of them are hard to deliver within current infrastructure. MDT expertise valued but not when perceived as blaming. Felt specialist health input was withdrawn too soon.
12	Tearle (2022)	To explore experiences of men with ID who transitioned from secure care to semi-independent community living	Qualitative - Interpretive Phenomenological Analysis	Semi-structured telephone interviews	Semi-independent community services, England	PWID	8 men, all mild ID, aged 28 - 60 years. All White British. Some additional diagnoses of ASC and EUPD	Three themes: A chance to turn my story around, feeling torn apart, and the cost of trying to please others. Suggests the transitional experience is in crisis, and highlight the need for more direct and indirect psychologically informed compassion-focused support
13	Hill (2012)	To explore PWID experiences of specialist inpatient assessment and treatment units from multiple perspectives.	Qualitative - Grounded Theory	Semi-structured interviews	3 specialist inpatient ATUs within one Health Board in South Wales	PWID. family carers, staff	3 PWID (2 female, 1 male) all mild LD with comorbid diagnoses e.g. ASC, PD, epilepsy. 20s, 30s, 40s 3 family carers - 2 mothers and 1 sister.	Five core concepts constructed. PWID experiences can be understood in relation to procedural aspects of 'the course of admission', psychological processes 'sense of self and connectedness', 'sense of agency', 'creating safety and protection' which contribute to

							3 staff - 1 nurse, 2 HCA, 2 female 1 male	construction of 'understanding and meaning'
14	Fish and Lobley (2001)	Evaluating a new community forensic learning disability service in relation to quality of life	Mixed methods. Qualitative analysis not clear	Unstructured interviews, observation, questionnaire	NHS Trust - Institutional setting unit & Community based apartments	PWID	20 service users. No demographics reported.	Strengths identified = more frequent family and community contact, quality of house facilities, staff and atmosphere. Weaknesses = restrictions on free time, lack of contact with people at previous institution and a limited range of activities.

**Key:** PWID = People with intellectual disabilities. ATU = Assessment and Treatment Unit. MDT = Multi-disciplinary Team. ASC = Autism Spectrum Condition. EUPD = Emotionally Unstable Personality Disorder

## Quality Appraisal

Studies were assessed for quality using the CASP and results are displayed in Table 4 (see Appendix A for CASP questions). A challenge in using the CASP was the lack of guidance regarding the use of the ‘no’ and ‘can’t tell’ categories. As in Long et al.’s study (2020), the ‘can’t tell’ category was used when information was included but not thorough enough to assess (e.g., mentioning ethical approval but little to no information on how ethics were implemented). An additional challenge was the diversity in journals and presentation of papers, meaning it was more difficult to assess papers where they appeared to be determined by strict word limits.

**Table 4**

*CASP qualitative appraisal tool results*

Paper No.	Citation	CASP item									
		1	2	3	4	5	6	7	8	9	10
1	Longo and Scior (2004)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
2	Fish and Morgan (2019)	Y	Y	Y	?	Y	N	Y	?	Y	Y
3	Hudson et al. (2021)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
4	Donner et al. (2010)	Y	Y	Y	Y	Y	N	?	Y	Y	Y
5	James (2016)	Y	Y	Y	Y	Y	?	?	Y	Y	Y
6	Manandhar-Richardson et al (2023)	Y	Y	Y	Y	Y	N	N	N	Y	Y
7	Parlais (2009)	Y	Y	Y	Y	Y	N	?	Y	Y	Y
8	Owen et al. (2008)	Y	Y	Y	Y	Y	N	Y	N	?	Y
9	Williamson and Meddings (2018)	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
10	Head et al. (2018)	Y	Y	Y	Y	Y	?	?	Y	Y	Y
11	Clifford et al. (2018)	Y	Y	Y	Y	Y	?	?	Y	Y	Y
12	Tearle (2022)	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
13	Hill (2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
14	Fish and Lobley (2001)	Y	Y	Y	Y	Y	N	N	N	N	Y

**Key:** Y = yes, N = no, ? = can’t tell



Quality of studies was generally mixed, with the highest quality papers tending to be more recent studies, which is likely to be due the effort to increase the methodological rigour of qualitative studies over recent years. Unpublished theses also scored well, which is likely to be due to high word count allowances.

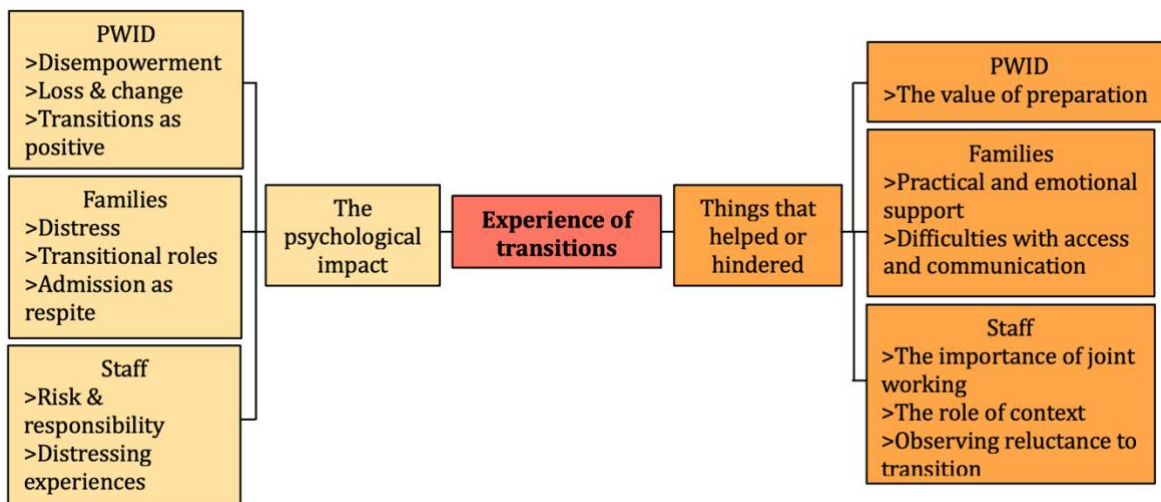
The most poorly scored item was the consideration of the researcher’s position in relation to the participants, research question, and interpretation, which is surprising given that most qualitative methodologies encourage or require reflecting on the self as a researcher. Another poorly scored item was ethical considerations, with studies scoring poorly ranging from no mention of ethics at all to one sentence confirming ethical approval by a committee. This is concerning given that many of the studies included data from PWID, who are a vulnerable group where enhanced ethical considerations are often required.

### Synthesis

Two broad themes were identified that organised PWID, families, and staff experiences of transitions: ‘The psychological impact’ and ‘Things that helped or hindered’ (Figure 2).

**Figure 2**

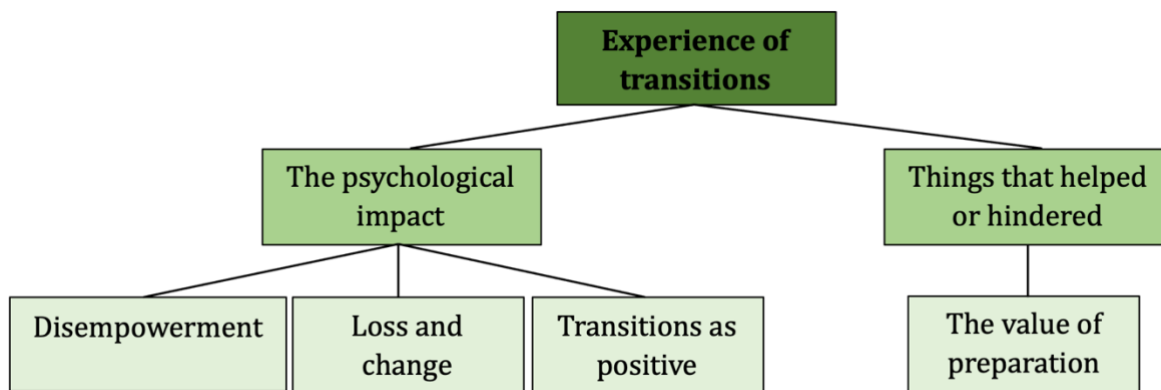
*A visual representation of collated themes*



## People with Intellectual Disabilities

**Figure 3**

*Themes for people with intellectual disabilities*



### ***Disempowerment***

Participants experienced transitions to and from inpatient units as disempowering, which was related to a lack of information, control, and choice (Longo & Scior, 2004; Donner et al, 2010; Owen et al, 2008; Hill, 2012). Some participants did not understand where they were transitioning to and reported that decisions were made without their involvement; “It’s too late now. They have decided.” (Longo & Scior, 2004, p. 214), with some not even being aware why they were being admitted (Donner et al, 2010). Owen et al. (2010) observed that women with severe ID in their study were given very little information about their new homes, had little preparation, and were not involved in important aspects of moving, which was distressing for the women. Some participants lacked information on when or where they would be discharged to due to a lack of housing (Hill, 2012).

Admission was viewed by some as punishment (Hill, 2012; Head et al., 2018) and others felt admission was traumatic, unsettling, and scary (Hill, 2012). Further reflecting disempowerment, some participants described enforced compliance and perceived this to be a central aspect of progress (Donner et al., 2010), and others felt admission represented a loss of freedom and autonomy (Hill et al., 2012).

### ***Loss and change***

Many participants experienced loss as a result of transitions (Owen et al., 2010; Tearle, 2022; Hill, 2012; Fish & Loblely, 2001; Head et al., 2018). This referred to the loss of meaningful relationships with other service users (Head et al., 2018) often with people they have lived with for a long time (Owen et al., 2010), which was experienced as distressing; “It was God awful...when we had to say bye” (Tearle,

2022, p. 88) and meant settling in to new homes could be difficult (Fish & Lobley, 2001).

Sadness related to the loss of relationships with staff also felt important. This seemed particularly pertinent to some participants who viewed staff as family or friends (Head et al., 2018) which left them feeling lonely upon discharge and was experienced as abandonment for some participants (Tearle, 2022). As well as missing staff from a social perspective, participants spoke of the loss of familiarity and safety associated with these relationships (Head et al., 2018), and was thought to contribute to insecurity and distress displayed by women in Owen et al.'s (2010) study. Loss of relationships was discussed mostly in relation to discharge, but loss of important relationships was also experienced due to admission (Hill, 2012).

Some participants reflected on using their behaviour to communicate their distress about a transition (Head et al., 2018) and bring about change, for example "playing up" to be moved back to a preferred setting or be acknowledged (Fish & Morgan, 2019; Tearle, 2022). This could be understood by staff as 'attention seeking' (Owen et al., 2010)

### ***Transitions as a positive***

Although many difficulties were identified, participants also highlighted positives associated with transitions. Admission was experienced as providing respite for some participants, as the proximity of staff seemed to provide a supportive function and perhaps felt safer (Donner et al., 2010), or provided respite from their usual living environment, particularly if they were admitted to a specialist ID setting (Longo & Scior, 2004).

Discharge meant increased autonomy, less surveillance, increased freedom to develop new skills (Tearle, 2022) and engage in enjoyable activities (Fish & Lobley, 2001). This was regarded as progress by participants, who felt pleased not to be treated "like a kid" as they were as an inpatient (Head et al., 2018). This was observed to be a drastic improvement for some, with Owen et al (2010) reporting that one woman transformed from being "locked into a baby role" to an adult who could engage freely with the world.

Discharge also provided opportunities for participants to build new identities and to shift problem-saturated stories told about them (Head et al., 2018), although admission seemed to have a lasting impact on forensic participants' identities (Tearle, 2022). Part of transforming identities appeared to be related to a desire and

opportunities for connection with new, positive communities and to live safer lives; “My life was with lots of not nice people...now I can make new friends” (Tearle, 2022, p. 86). Although participants reported making new friends, this was often limited to other service users, staff, or family (Head et al., 2018).

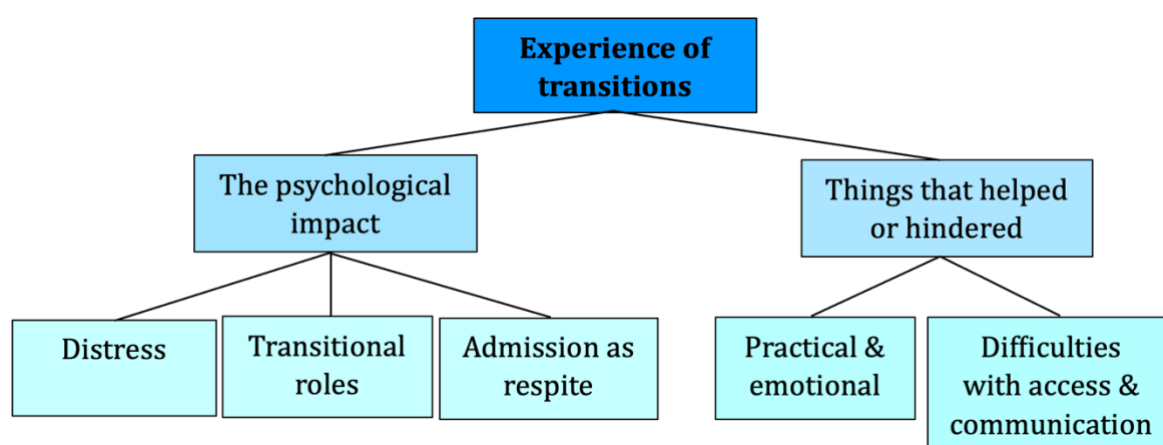
### ***The value of preparation***

Some participants identified important steps that had been taken to support them during their transitions. An induction and orientation to the inpatient unit was felt to be helpful for increasing understanding and therefore reducing anxiety and distress associated with admission (Hill, 2012). Visiting new placements, familiarity with the unit, or community staff doing shifts in inpatient units prior to transitions seemed to help people feel at ease; “...it was a bit scary...that made me feel a bit easier because I knew somebody already here.” (Head et al., 2018, p. 67).

### **Families**

**Figure 3**

*Family themes*



### ***Distress***

Many participants described the events leading up to admission of their relative as traumatic or deeply distressing (Williamson & Meddings, 2018; James, 2016; Longo & Scior, 2004; Donner et al., 2010; Hill, 2012). This was due to the chaos and crisis surrounding admission (Hill, 2012; Longo & Scior, 2004), with the instability of their relative seeming to result in a physical and psychological exhaustion; “...getting exhausted and fragile and unable to function.” (Williamson & Meddings, 2018, p. 235). Some participants likened their experience of the admission of their relative to a death; “It’s worse than losing someone when they pass away”, which represents the grief and loss felt (James, 2016, p. 48).

Leaving their relative in an environment which they felt was unpleasant was distressing for some (Donner et al., 2010), and a lack of control, feelings of failure, and anxiety about the care of their relative had a psychological impact; “I got to have counselling myself” (James, 2016, p. 47). Participants reflected on the protective mechanisms they used to cope with this, such as normalising admission or avoiding visits (James, 2016).

Some participants reflected on experiencing strong emotions due to feeling powerless, which could result in conflict with staff: “...I could feel my bloody hackles going up” (James, 2016, p. 47). However, some participants actively tried to avoid conflict with staff as they felt this risked further exclusion: “...I just said okay I’ll abide by the rules”, and complied with their role within the perceived hierarchical system (James, 2016, p. 43).

### ***Transitional roles***

Participants identified that their relatives’ admission meant a change in role for them, which was complex and involved a range of emotions (Williamson & Meddings, 2018; James, 2016; Longo & Scior, 2004). Parents felt uncertain about their involvement in their relatives’ care and were concerned about losing their parental roles, with some feeling like they could not retain this (Longo & Scior, 2004). Parents in James’ (2016) study described feeling disempowered by their relative’s admission due to feeling excluded from decision making or overpowered when they were included. They also felt devalued as parents: “We’re not important, we’re only the parents” (James, 2016, p. 42), which some participants felt meant their opinions were not listened to or appreciated, particularly after the admission had taken place (James, 2016).

Although there was distress associated with navigating a changing role, some participants acknowledged that their relative’s admission meant they were able to resume their role as parents rather than advocates or full-time carers: “I’ve gone from being a carer, always on the look out, to being a mum.” (Williamson & Meddings, 2018, p. 236). Some parents expressed wanting to transition back into a parental role but guilt and worry about their relative seemed to maintain a sense of needing to be heavily involved in their care (Williamson & Meddings, 2018).

### ***Admission as respite***

Despite the many difficulties associated with transitions, carers also described the admission of their relative as a relief or respite (Longo & Scior, 2004; Donner et al., 2010; Williamson & Meddings, 2018; James, 2016). For some, relief was felt after trying to access help for a long time: “I was pushing and pushing for him to come here for months before he actually got here ... it was actually quite a weight lifted off my shoulders...” (Williamson & Meddings, 2018, p. 236). This was not an uncomplicated feeling, with parents describing the mix of emotions they felt during admission: “So we was happy but sad like you know.” (James, 2016, p. 48).

### ***Practical and emotional support***

Many participants reflected on factors that made their experience of transitions easier. Practical considerations were felt to reduce anxiety and facilitate a smoother transition, such as viewing the inpatient unit prior to admission: “having a look round helped me see that Adam would be ok with a stay on here and it’s not what you imagine...” (Williamson & Meddings, 2018, p. 236), having an accessible point of contact (James, 2016), and information about treatment (Longo & Scior, 2004). Effective joint working between community teams and inpatient units was identified as having a positive impact on care (Williamson & Meddings, 2018). Being linked with other services was felt to positively impact the discharge process (Donner et al., 2010), and discharge could be experienced positively if arrangements were felt to be satisfactory (Longo & Scior, 2004).

Participants also recognised the impact of interpersonal factors, such as compassionate, friendly, and caring staff (Williamson & Meddings, 2018; Longo & Scior, 2004), as well as feeling listened to and respected (James, 2016). For example, staff supporting parents’ transitional roles was felt to be freeing and empowering: “his key nurse said to me, ‘The team’s just got a bit bigger. You’re still part of the team and an important part, but just because you’re not there doesn’t mean that Richard’s not getting care.’” (Williamson & Meddings, 2018, p. 236). Staff openness and honesty was valued by parents as it provided them with security and reassurance regarding their inclusion in their relative’s care (James, 2016; Williamson & Meddings, 2018).

### ***Difficulties with access and communication***

Some family carers found help difficult to access which meant they felt forced to take action: “It was awful trying to get him in there. In the end, I decided to let him run wild, so that he could get an admission.” (Longo & Scior, 2004, p. 216). Some resorted to contacting the police or threatening to abandon the individual (Donner et al., 2010).

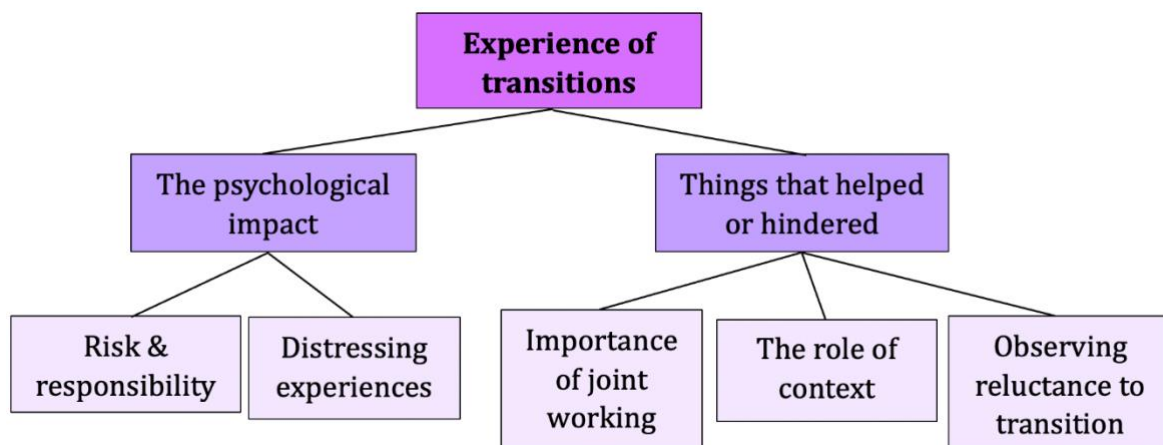
Poor communication was felt to be a cause of frustration for carers, which either related to miscommunication about length of stay, or to insensitive information sharing: “there needs to be more sensitivity perhaps about when is discharge introduced to the family ... It was far too early for me, I was in complete shock from the admission.” (Williamson & Meddings, 2018, p. 237). Uncertainty about the aim of the admission resulted in a mismatch of expectations for some parents, which could be distressing (Williamson & Meddings, 2018), and some carers felt a lack of information excluded them (Longo & Scior, 2004; Donner et al., 2010).

Although for some discharge could feel too soon (James, 2016) and without adequate assessment (Donner et al., 2010), for others discharge of their relative felt delayed, which raised concerns about their relative becoming too comfortable and institutionalised (Hill, 2012).

### **Staff**

**Figure 4**

*Staff themes*



### ***Risk and responsibility***

Some studies focused solely or partly on understanding staff experience of supporting PWID in the context of programmes such as Transforming Care or deinstitutionalisation. Staff identified that discharges often felt rushed and lacked planning: “...let's move them out because they're suitable, even if they're not quite ready” (Hudson et al., 2021, p. 1070) which made them feel anxious and uneasy (Clifford et al., 2018). Many felt this was due to targets, finances, and politics being prioritised rather than person-centred care (Clifford et al., 2018; Parlais, 2009; Hudson et al., 2021), which some identified as the cause of failed transitions (Clifford et al., 2018; Parlais, 2009).

For staff in forensic settings, rushed discharge and lack of planning was felt to present an additional risk: “...why would you in a sense, usher somebody out of the door that is, still poses a big risk to the public?” (Hudson et al., 2021, p. 1070), which staff felt demonstrated a lack of understanding of the specific needs in forensic intellectual disability settings by the TC agenda. This resulted in staff feeling pressured due to a responsibility to protect the public (Hudson et al., 2021). Responsibility was also considered in Fish and Morgan’s (2019) study, as participants felt the team were responsible for supporting women to make progress, which could present as a dilemma when positive relationships and safety could also mean reluctance for some women to move on.

Staff in Clifford et al.’s (2018) felt TC could offer PWID freedom and choice but wondered if this could be overwhelming for some individuals. Although they wanted to empower PWID and support positive risk-taking, they expressed concern about being blamed if the outcome was negative; “I don’t wanna risk it because I might be risking my job...” and acknowledged the impact of wider societal judgement (Clifford et al., 2018, p. 1212).

### ***Distressing experiences***

Some participants reported that supporting a PWID during a crisis admission was traumatic due to witnessing self-harm and suicide attempts, stating that trauma-informed supervision was helpful for coping with this (Manhandar-Richardson et al., 2023). Some participants recognised the emotional impact of admission for the people they support, identifying that familiarity with the inpatient setting and an orientation to the environment can support PWID to settle in: “...we’ll talk to them,



we'll show them where they're going to be staying, we'll introduce them, we'll try and put them at ease and make them as welcome as possible..." (Hill, 2012, p. 62).

### ***Importance of joint working***

Some participants reported that a lack of joint working between services led to shortcomings during transitions: "There was no sense of working together. Even when we did go on the ward they were not interested in what we had to say." (Donner et al., 2010, p. 220), with Parlais (2009) commenting that participants did not seem interested in joint-working until they were forced to by the Scottish government. Confusion regarding roles and responsibilities was felt to be a barrier to joint-working (Parlais, 2009), which was related to assessments, support, and care planning, and was complicated by a lack of liaison (Donner et al., 2010).

Some participants reported a sense of conflict between teams, for example "battles" between mental and physical health services (Manandhar-Richardson et al., 2023), with a sense that PWID 'belonged' to a specific team (Donner et al., 2010). Specialist ID staff expressed concern about mainstream staffs' understanding of ID and felt frustrated that difficulties were over-attributed to an individual's intellectual disability (Donner et al., 2010).

Where joint working did happen, it was felt to be very positive: "...the crisis team agreed she could ring them at all hours. And they liaised with us. That worked really well, joined up service." (Donner et al., 2010, p. 220; Manandhar-Richardson et al., 2023) and resulted in joint decision-making (Parlais, 2009).

Views regarding the support of other staff was mixed, with managers generally appreciating the support of a multi-disciplinary team (MDT) during transitions, but less senior staff feeling that the MDT's decision making could be theory rather than practice driven (Clifford et al., 2018). Participants in Manandhar-Richardson et al.'s (2023) study experienced social workers, intensive teams, and emergency services as either supportive or hindering of transitions which seemed to be related to resources and perceived helpfulness.

In terms of family members, some participants reported that family input is highly valued, whereas others felt navigating family input could be difficult as it was felt to make things worse (Manhandar-Richardson, 2023).

### ***The role of context***

Delayed discharge was experienced as a problem by some staff, which was attributed to lack of funding: "...the first group of people went out, got high quality services and the money ran out." (Parlais, 2009, p. 204), lack of community infrastructure (Parlais, 2009; Hudson et al., 2021), and bureaucracy: "I've been in meetings where three months later I'm sat in the same meeting again and there's no further progress." (Hudson et al., 2021, p. 1070). Participants in Parlais' (2009) study reported that specific policies, an increase in stakeholders, and joint approaches between services resulted in more successful discharges.

Hudson et al., (2021) reported that views on TC seemed to be related to the context staff worked in. Community nurses accepted TC as a challenge and saw it as an evolution of their role and practice, which empowered them and enabled joint working. Inpatient nurses felt threatened by TC but believed that it was transient, meaning inpatient services would be needed again in time (Hudson et al., 2021).

### ***Observing reluctance to transition***

Many participants shared their experience of observing reluctance in PWID to leave hospital due to a loss of attachments (Hudson et al., 2021; Fish & Morgan, 2019; Hill, 2012), and safety and belonging (Hudson et al., 2021; Fish & Morgan, 2019), which could be a barrier to discharge (Hudson et al., 2021). Some participants felt that an extended period in an inpatient setting meant people become too settled (Hill, 2012) and could result in anxiety and fear about the outside world: "The whole of society has changed in 10 years. So the expectations of what you're going to. How they're going to be supported. It's not there anymore." (Hudson et al., 2021, p. 1072). Some participants felt that anxiety about discharge could lead to self-sabotage: "...when they do come to move onto the next stage, that they will do something to destroy it...". (Fish & Morgan, 2019, p. 937), and that discharge can be experienced as rejection, complicated by the awareness that this can mean going back to a place where trauma was experienced (Fish & Morgan, 2019).

## Discussion

This is the first systematic review that has synthesised experiences of inpatient transitions from three perspectives: PWID, family carers, and staff. Despite diverse research questions and different participant groups, the review identified two overarching themes related to the psychological impact of transitions and things that helped or hindered this process. Themes within this spanned admission and discharge and related to positive and negative experiences. All three groups reflected on the emotional impact of inpatient admissions which could be experienced as distressing. For PWID and families, this often related to a sense of loss, disempowerment, and a lack of control. Staff reflected on the additional emotional impact of managing risk and responsibility, which was often discussed within the context of discharge programmes such as TC. Families and staff both reflected on the psychological impact of witnessing the person they cared for in acute distress.

Transitions could bring up conflicting emotions in PWID and families, as although they clearly had difficult experiences, they both acknowledged that admission could feel like respite. For families, this generally related to respite from their intense and demanding role as carers and family members and a sense of relief that their relative was getting support. This is in keeping with research from carers of adults without ID (Clibbens et al., 2018), although this is potentially likely to be more complex for family carers of PWID, considering their enhanced care needs and increased dependency. For PWID, respite seemed to relate to a break from a challenging situation, with 24/7 support providing a sense of safety and containment.

It was clear from families and staff that joint working could either help or hinder transitions. Families reflected on the lack of joint working between themselves and services, and (usually) community and inpatient services, which resulted in them feeling excluded and frustrated. Staff felt a lack of joint working created barriers to accessing services and successful discharge, and reflected that roles and responsibilities could be unclear, often resulting in conflict between teams. A lack of collaboration also relates to PWID's experience, as they described feeling 'done to' rather than 'done with', with some identifying that admission resulted in a lack of autonomy. Research suggests that non-ID adults also feel their autonomy was violated during inpatient admission (Katsakou & Priebe, 2007), although they also felt like active participants in their care, which was not a finding in this review. Poor communication between people and/or services was experienced by all three groups, which could result in confusion about the reason and aims for admission or discharge.

Caregivers highlighted the positive impact of successful joint working on practical and psychological outcomes.

Findings regarding joint working and staff experiences of discharge programmes are particularly relevant considering the implementation of integrated care systems (ICSs) in England in 2022, which aim to bring together NHS organisations, local authorities, and other health and care organisations to create partnerships and improve peoples' lives. If ICSs are to be successful for PWID, the results of this study suggest that clear roles and responsibilities need to be established, communication should be respectful, clear, and sensitive, and collaboration between PWID, caregivers, and services should be prioritised. Additionally, staff highlighted issues with funding, a lack of community infrastructure, and an over-focus on meeting targets and deadlines, suggesting that considerable development and investment is imperative for ensuring that ICSs and the NHS long term plan fulfil their targets to improve the care of PWID.

Loss was another theme that transcended the three groups. For PWID this was mostly related to a loss of meaningful relationships during transitions, which is not surprising given the smaller social networks of PWID (Lippold & Burns, 2009) and their tendency to view staff as friends (Pockney, 2006). Families reflected on losing their sense of identity as a carer, which was either due to feeling they lacked a role after admission or their parental role feeling enmeshed with an advocacy role. For some, admission was likened to the death of their family member. Staff did not reflect on their own sense of loss but acknowledged the impact of loss on the people they support. This tended to be related to an observation that PWID can be reluctant to move on from inpatient stays due to fear associated with losing relationships and a familiar environment.

Attachment theory (Bowlby, 1973; Ainsworth & Bowlby, 1991) can provide insight to these results. Some PWID saw discharge as an abandonment, which may reflect their internal working models (Bowlby, 1973) about relationships and the world, which is not surprising given that PWID are more likely to experience adversity (Reiter et al., 2007; Vervoort-Schel et al., 2018). Anticipating a loss of attachments could explain the observation by staff and self-reflection by PWID that they may use behaviour to communicate their distress and 'sabotage' progress. This is supported by research which found that more secure attachments with staff was associated with less challenging behaviour in young people with ID (De Schipper & Schuengel, 2010). Owen et al.'s (2008) observation that staff anxiety increased

PWID's anxiety during transitions may reflect a sense of relational insecurity, which is in keeping with research which found that people with severe ID identified relationships and a secure base as important features of inpatient care (Claire Lloyd et al., 2013).

As well as highlighting difficulties, participants identified positives associated with transitions. This was mainly identified by PWID and generally related to the opportunities they had after discharge, mostly from forensic services. Although not explicitly discussed in original papers, it may be that PWID go through a process whereby they initially experience difficulties after discharge, then over time discover new opportunities, meaning parts of the transition may have different feelings attached to them. It seems PWID were able to integrate into their communities, but this was limited to the people they were living with, staff, and family members. This is in keeping with research that found that following discharge as part of TC, PWID were successfully settled into the community but lacked opportunities for informal relationships and meaningful occupation (Niven et al., 2020).

### **Clinical Implications**

All three groups identified factors that improved their experience of transitions or made it more difficult, which have important implications for clinical practice. PWID and their carers should be adequately prepared for transitions, for example by visiting a new environment, meeting new staff, having an induction, and being involved in decision making. PWID should be provided with individualised, accessible information regarding transitions to ensure they understand the purpose of the transition.

Discharge planning should be thorough and collaborative, and if re-admission is required PWID should be admitted to the same setting if possible. Carers should have access to an accessible point of contact, should be provided with regular updates, and should receive support by staff or be signposted to services which can offer this. Effective joint working was highlighted by all groups and should be prioritised by services.

From an attachment perspective, as a loss of relationships (temporary or permanent) is inevitable during transitions, transitional objects (Winnicott, 1951) may provide comfort, soothing, and containment for PWID during these times. These may be objects the individual already has or could include the creation of new transitional objects (e.g., photos of positive memories with staff/peers). PWID should

be supported to maintain relationships with their peers, families, and staff (if appropriate).

These results could be used to inform a training session for staff supporting PWID to understand how PWID and those that care for them may experience transitions in and out of inpatient settings. This would increase their awareness and support application of the above recommendations.

### **Limitations of Papers and Future Research Directions**

Many papers in this review demonstrated a lack of consideration of the researchers' relationship with their participants, which is an important factor in increasing the credibility and readers' understanding of the work (Dodgson, 2019). Although it is acknowledged that journal word limits can restrict space for discussion, it is the researchers' responsibility to be clear and concise about their position (Dodgson, 2019) and is an important consideration for future research. Some papers failed to demonstrate consideration of ethical processes, which are particularly important for vulnerable groups (Iacono, 2006) and future research should be sure to explicitly discuss this.

Some papers did not report sufficient demographic information, and where reported demonstrated a lack of diversity, particularly in ethnicity and level of intellectual disability. PWID with ethnic minoritised identities face health inequalities (Robertson et al., 2019), including in mental health care (Umpleby et al., 2023). A study by Chinn et al. (2010) found that PWID in inpatient settings felt there were limited opportunities to develop and practice their cultural and religious identities, with families of PWID in inpatient services also raising concerns that cultural needs are not being met (Bonell et al., 2011).

People with severe intellectual disabilities are drastically under-represented in research (Vereenoghe et al., 2018). Limited research suggests transitions may be a more complex and relational process for people with severe intellectual disabilities (Jacobs et al., 2021), and this group and their parents seem to have highly interdependent needs during transitional periods (Jacobs et al., 2018).

Considering the potentially unique experiences of these subgroups, future research should seek to explore the experiences of these populations and those that support them to ensure they are better represented in the literature. Researchers should be sure to report demographic information to allow readers to interpret results within context.

The synthesis revealed that managing responsibility, risk, and distressing experiences can be difficult for staff. As staff wellbeing is identified as a priority in the NHS Long Term Plan, future research could further explore first person experiences of supporting PWID when they are most distressed, to allow us to better understand what support staff need to enable them to cope with the emotional impact of this.

This review has highlighted the value of investigating first person experiences, and as only 14 papers were identified, it is clear that there is more work to do to ensure that the voices of PWID and those that support them are at the centre of practice and policy.

### **Limitations of Current Review**

This review included studies that were conducted in the UK only due to the current socio-political context around inpatient care for PWID/autism, for example the recent proposal to remove intellectual disability and autism as conditions from the Mental Health Act (1983). Therefore, results should be considered within this context and future research could explore experiences of transitions in different cultures with different healthcare and legal systems.

Although this review synthesised evidence spanning experiences of admission and discharge for all three groups, the amount of data available was variable within each group. For example, there was more evidence relating to staff experience of supporting discharge than admission, which is not surprising given the aim of four studies was to explore staff experiences of discharge programmes. For families, there was more evidence for experience of admission than discharge. This may reflect an absence of studies on discharge experiences or may indicate that admission is a more salient time for families, potentially due to heightened emotions during this time. The evidence was more balanced for PWID, although many of the discharge experiences were in the context of transition from forensic services. Further research is needed to explore whether transitions from secure or non-secure services are unique experiences that elicit specific support needs.

The review was conducted by one core researcher, who is a White-British female without an intellectual disability, with no lived experience of being admitted to an inpatient setting. The researcher and her supervisor have experience of working in an inpatient unit for PWID/autism which is likely to have impacted the design of the study and synthesis of data, so results should be considered with this in mind (Popay et al., 2006). Attempts were made to reduce bias by employing a second

screeener at various points throughout the review, and themes were discussed in research supervision, although involvement of another core researcher or team may have allowed for multiple perspectives.

The review synthesised qualitative information only as it was felt this method lends itself best to understanding lived experience, however this means information may have been missed. Future research could include quantitative data which may further enhance our understanding within this area.

## **Conclusion**

This review systematically reviewed and synthesised qualitative data from 14 UK papers, bringing together inpatient transition experiences of PWID and those that support them. Results highlight the psychological impact of transitions into and out of inpatient settings and factors that help or hinder this process, which have important implications for future research and clinical practice.



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# **Inclusivity within the Profession of Clinical Psychology: An Exploration of Contextual Markers in Trainee and Qualified Clinical Psychologists**

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The target journal for my Main Research Project was Training in Education in Professional Psychology. The guidance on journal formatting requirements is here:

<https://www.apa.org/pubs/journals/tep>.

This journal was chosen as it publishes research related to advancing professional psychology education, including papers related to inclusion, diversity, and equity in relation to training.

## Introduction

Clinical Psychologists in the NHS work with people with a wide range of psychological difficulties and aim to reduce psychological distress. A diverse clinical psychology profession is essential for ensuring that clients have access to therapists and services that reflect their identities and cultures (Turpin & Coleman, 2010). Paying particular attention to socioeconomic status (SES), Appio (2013) found that clients reported feeling disconnected from and misunderstood by their therapist if they appeared inauthentic and did not attend to class issues. Trott and Reeves (2018) reported that some lower SES clients would not disclose the same information to a middle-class therapist as they would a working-class therapist and felt like they might be judged on aspects of their lives.

On a wider systems level, it is important that people from diverse backgrounds are represented within management and leadership roles in clinical psychology. This will help to ensure that a variety of cultural knowledge and experiences are brought into service design, delivery, and organisational policies. For these reasons, it is important that the clinical psychology profession does not disadvantage aspiring clinical psychologists based on contextual factors and that any individual has equal opportunity to pursue a career in clinical psychology.

Although there have been efforts to increase diversity and inclusivity within the clinical psychology profession, UK trainees are not representative of the diverse populations that they serve (Turpin & Coleman, 2010). In 2021, 24% of clinical psychology applicants lived in a Quantile 5 area (highest participation rate in higher education) when they were 17, compared to 9% of applicants who lived in a Quantile 1 area (lowest participation rate in higher education) (Leeds Clearing House, 2021). 29% of successful candidates came from a Quantile 5 area, whilst only 7% came from a Quantile 1 area. This suggests that individuals from lower socio-economic backgrounds are less likely to apply and be accepted onto clinical psychology training than individuals from more advantaged backgrounds. Disadvantage can be observed at multiple points in education. UCAS (2017) found that children who received free school meals, attended non-selective state schools, and lived in areas of high economic disadvantage were nearly 10 times less likely to attend higher tariff universities than the most advantaged. Murphy and Wyness (2020) found that high attaining, disadvantaged students are more likely to enrol in courses which they are overqualified for, due to being significantly more likely to receive pessimistic predicted grades.

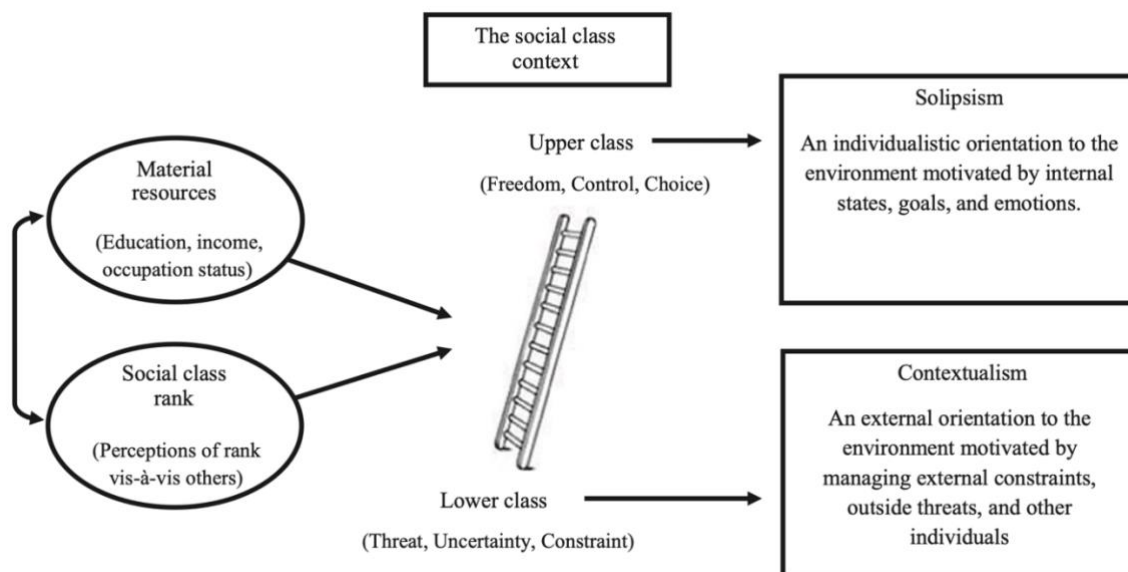


## The social class context

Kraus et al. (2012) propose that lower social rank and fewer resources lead to individuals from lower social classes disproportionately focusing on uncontrollable, external social forces (contextualist tendencies). Comparatively, they propose that higher social rank and plentiful resources results in individuals from higher classes focusing on personal goals, motivations, and emotions (solipsistic tendencies). Kraus et al. (Figure 1) suggest that this constrains the actions, pursuit of goals and therefore social outcomes of lower-class individuals. In support of this, Kraus et al. (2009) found that lower subjective social class participants reported lower perceived control than higher subjective social class participants. They were also more likely to attribute various phenomena (e.g., income quality or entry to medical school) to external factors in comparison to higher subjective social class participants.

**Figure 1**

*A model explaining how social class influences social cognition, proposed by Kraus et al., (2012)*



This model provides an interesting framework to understand the many barriers that individuals from a lower SES face when trying to enter typically middle-class professions such as clinical psychology.

As social class is not a protected characteristic under the Equality Act (2010), there is no obligation for employers to monitor the socioeconomic background/status of applicants and employees and SES can be difficult to measure. Contextual admissions have been suggested as a way of diversifying the DClInPsy training courses. Contextual recruitment processes involve using applicants' contextual

information (such as markers of deprivation) to identify applicants who have demonstrated the potential to succeed, even if their formal attainment is less than others (Boliver et al., 2015). It is thought that this would help selectors to identify candidates that have achieved in the context of difficulty, allowing them to compete with candidates who may have had access to more privileges.

Other typically middle-class professions have utilised contextual recruitment to increase the diversity within their workforce. Law firms have reported that a contextual recruitment process has resulted in 28% of legal trainees now coming from a disadvantaged background, compared to less than 20% before it was introduced (Montacute & Maton, 2020).

Contextual admissions are early in the development process and there is currently no guidance on how contextual information should be used. It appears that individual DClInPsy courses are using (or not using) contextual information in different ways as part of the admissions process. Social class can be defined in many ways and its relationship to disadvantage is complex. This may help to explain why diversifying the profession in terms of social class has been instigated at a slower rate compared to other protected characteristics. Of course, SES intersects with many of the other Social GRRRAACCEEESSS (Burnham, 2018) and diversifying the profession across all the social grades is hugely important. However, this study will focus on markers of deprivation within the DClInPsy as this was requested by stakeholders.

### **Consultancy process**

The trainee clinical psychologist met with two members of the Admissions Working Group (both Clinical Psychologists/Senior Lecturers) to develop the aims and objectives of the project. The Admissions Working Group is made up of different stakeholders from the Admissions Committee at the University of Bath (UoB). The Doctorate in Clinical Psychology department at the University of Bath were planning on implementing a contextual admissions process for the next intake of trainees. The department did not have access to any data on the markers of deprivation that current or past trainees have experienced. Therefore, the main aim of this project was to gather data on this topic to provide insight into how current admissions processes may or may not have disadvantaged certain groups and how this can be improved.

## **Methods**

### **Ethical Approval**

This study received ethical approval from the University of Bath Ethics Committee (PREC code: 21-020; see Appendix G).

### **Participants**

Participants were current Trainee Clinical Psychologists at the University of Bath (years 1, 2 and 3) and qualified Clinical Psychologists who had trained at the University of Bath since the programme began in 2011. The total possible number of participants was 159.

### **Questionnaire**

The questionnaire in this study was based on one developed by The Selection Sub-group of The Group of Trainers in Clinical Psychology. It was designed to be used by Leeds Clearing House to collect contextual admissions information from clinical psychology applicants. The questionnaire contains ten questions relating to markers of deprivation, including experience of being a young carer, receiving income support and being estranged from family (see Appendix H). An open-ended question was added to the end of the questionnaire to allow participants to express their views on the impact of contextual factors on training to be a clinical psychologist.

### **People with Personal Experience (PPE) involvement**

A Person with Personal Experience (PPE) of using mental health services and a key stakeholder (UoB DCLinPsy trainee) were consulted to provide their opinions on the design of the study and the content of the questionnaire. Both individuals considered the questionnaire to be clear and sensitive, and felt it would be helpful for informing the move towards contextual admissions at UoB. Following this consultation, the wording of one question was changed from 'Did you receive free school meals during your school years?' to 'Were you eligible for free school meals during your school years?'. This was based on a reflection that some families may have been eligible for free school meals but may not have claimed them.

### **Procedure**

An invitation to partake in the study was circulated to current trainees via cohort email addresses and to previous trainees via an alumni email list in April 2021.

The email contained a short description of the study and a link to the Qualtrics survey. If participants followed the link, they were presented with an information sheet and consent form. Participants were informed that the questionnaire was anonymous and were provided with 'prefer not to say' options for every question. Participants were given an option to withdraw from the study at any point up until the final submission of the questionnaire. If participants consented, they were presented with the survey followed by a debrief form and thanked for their time. The questionnaire took around 10 minutes to complete. Data were collected from mid-April 2021 to the end of May 2021. As the study was limited to current and past University of Bath trainees, identifying information related to personal characteristics such as gender, ethnicity, and age were not collected.

### **Analysis**

Quantitative data were exported into Excel and analysed descriptively (frequencies and percentages, see Table 1). Qualitative data were analysed using content analysis, following the steps outlined by Elo and Kyngäs (2008). An inductive approach was used, as recommended by Lauri and Kyngäs (2005) due to little prior investigation into this topic. In this study, content analysis was used to allow for exploration of commonality of experience, by quantifying qualitative responses to an open-ended question regarding the impact of contextual factors.

## **Results**

### **Descriptive statistics**

A total of 81 trainee or qualified psychologists participated, equating to a 51% response rate. Frequencies and percentages of responses to each question are presented in Table 1. The most frequently reported marker of deprivation was first generation to go to university, followed by receiving a bursary during an undergraduate degree, then receipt of income support. No participants identified as a refugee, although two people selected "prefer not to say". The second least frequent marker was being looked after by a local authority.

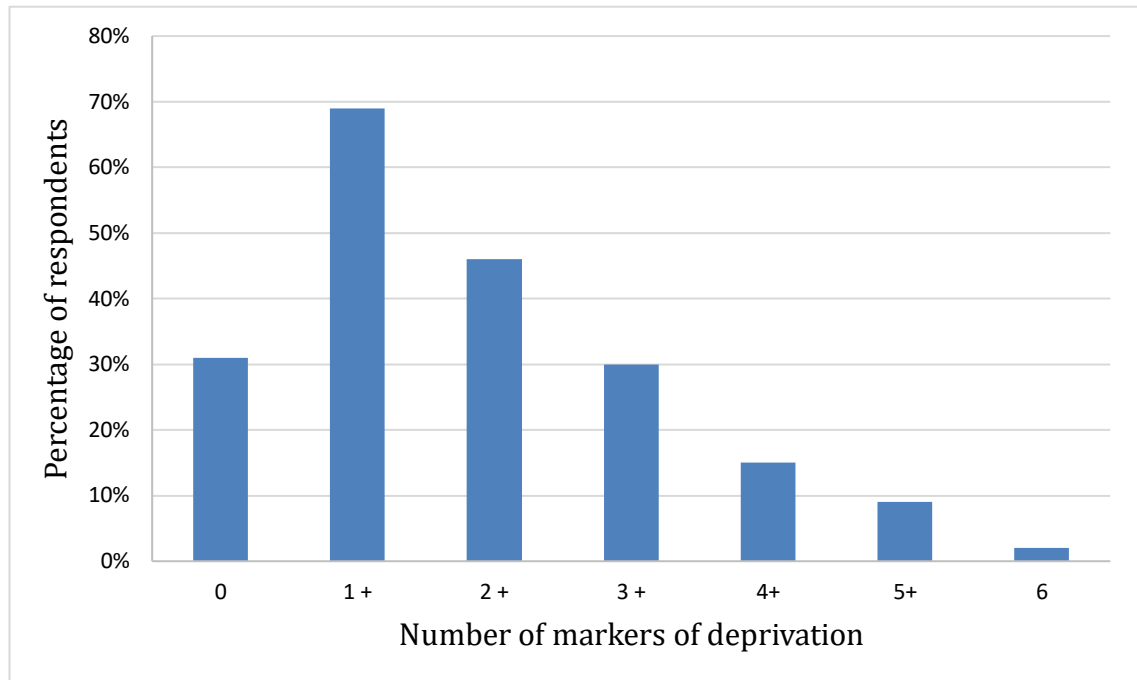
**Table 1***Frequencies and percentages of responses*

<b>Question</b>	<b>Responses (n)</b>	<b>Yes</b>	<b>No</b>	<b>Prefer not to say</b>	<b>Not applicable</b>
First generation university	81	37 (45.7%)	44 (54.3%)	0 (0%)	0 (0%)
Free school meals	81	16 (19.75%)	61 (75.3%)	3 (3.7%)	1 (1.25%)
Income support	81	23 (28.4%)	56 (69.1%)	1 (1.25%)	1 (1.25%)
Looked after by local authority	81	5 (6.2%)	76 (93.8%)	0 (0%)	0 (0%)
Estranged from family	81	6 (7.4%)	75 (92.6%)	0 (0%)	0 (0%)
Young carer	81	6 (7.4%)	71 (87.7%)	4 (4.9%)	0 (0%)
Refugee	81	0 (0%)	79 (97.5%)	2 (2.5%)	0 (0%)
UG offer based on adjusted results	81	6 (7.4%)	75 (92.6%)	0 (0%)	0 (0%)
Bursary in UG degree	81	33 (40.7%)	47 (58%)	1 (1.25%)	0 (0%)
Financial support for post-grad education	81	11 (13.6%)	66 (81.5%)	4 (4.9%)	0 (0%)

Key: UG = undergraduate

**Figure 2**

*Percentage of respondents who reported markers of deprivation*



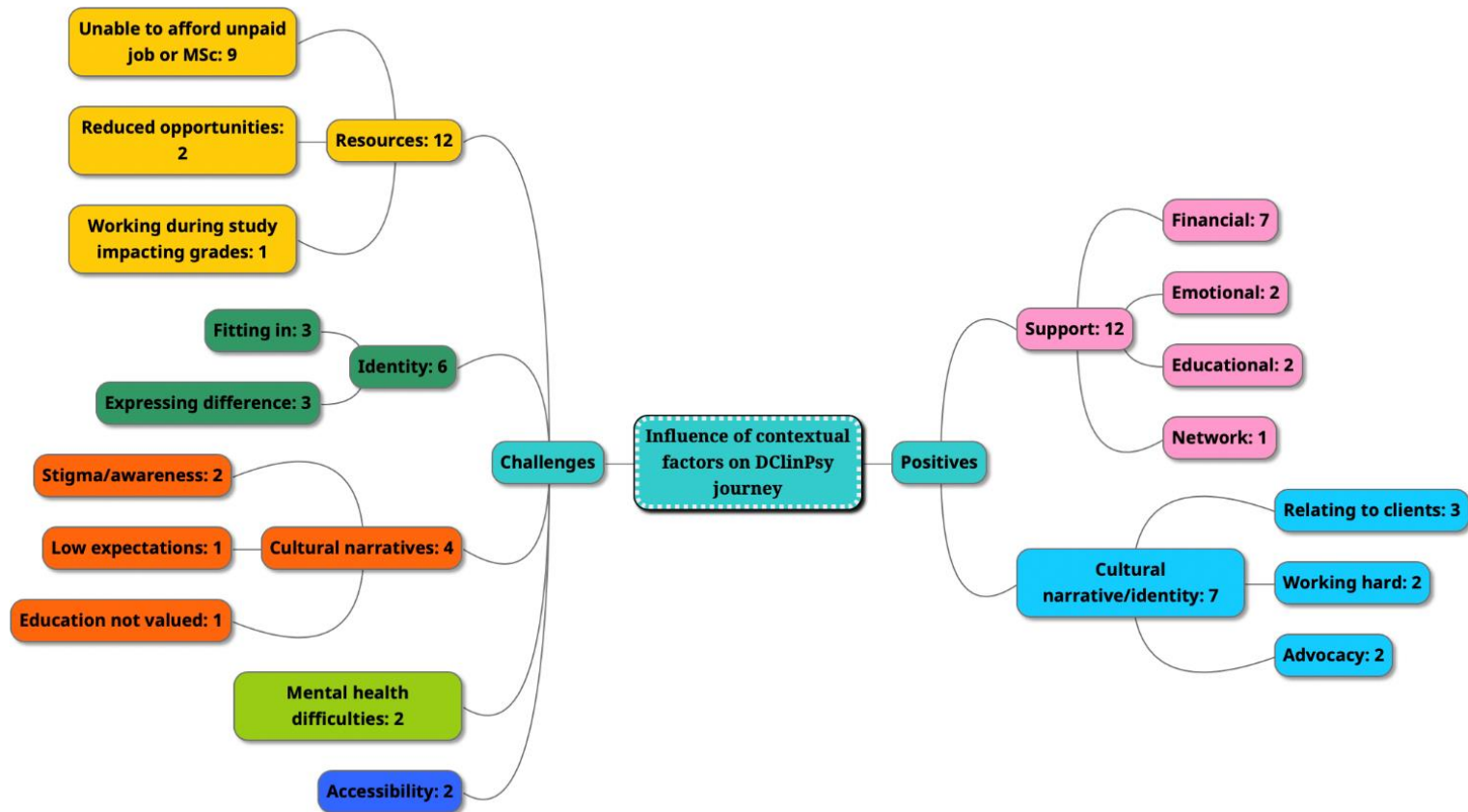
As seen in Figure 2, 31% of participants reported no markers of deprivation, 69% reported at least one marker of deprivation, 46% reported at least two, 30% reported at least three, 15% reported at least four, 9% reported at least five, and 2% reported six markers of deprivation.

### **Content Analysis**

Forty-five participants answered the open-ended question, and 27 were included in the analysis due to some responses being more generic in nature (e.g., commenting on the importance of diversity within clinical psychology). The qualitative question was analysed using content analysis to allow for examination of relationships between responses and trends within the data. The primary researcher completed the initial analysis of the entirety of the data by identifying subcategories and grouping them into categories. The primary and secondary researchers then met to review the categories and subcategories, which led to identification of two main themes (Challenges and Positives). Figure 3 displays the themes, categories, and sub-categories that were identified.

**Figure 3**

*A content analysis map displaying themes, categories, and sub-categories*



## **Challenges**

The results from the open-ended question show that 74% of participants identified a challenge associated with their contextual factors on their DCLinPsy journey.

### ***Resources***

The most common challenge was related to resources, with 44% of participants reporting that a lack of resources impacted them negatively. For example, 33% of participants acknowledged the impact of being unable to afford voluntary work or a Masters degree; "Being from low income working class background meant I couldn't take up unpaid opportunities to gain experience which others could."

### ***Identity***

Twenty-two percent of participants mentioned a challenge relating to their class identity, such as struggling to "fit in" with colleagues; "I feel aware of being from a working-class background with associated struggles and being around mainly middle class people. It can feel hard to fit in.", or with feeling able to express difference; "I think there needs to be less judgement within the training system and more openness to people's diverse experiences despite potentially appearing to fit the mould of 'white middle class female'." One participant reflected on the lack of discussion of contextual factors; "It was interesting completing this research and being prompted to reflect on these factors. I've had brilliant supervision throughout the DCLinPsy both from my personal tutor and on placement but this has never come up, even though I would say both of the factors above have been incredibly influential on me throughout training."

### ***Cultural narratives***

Fifteen percent of participants identified challenges associated with the cultural narrative of their background, including the awareness of clinical psychology as a career and how mental health difficulties are perceived; "Mental health stigma and general awareness of wellbeing services in the culture and community - this impacts on aspirations and motivation for the career. Similarly having role models who you can relate to (racially but other social graces) is important for shaping beliefs about what 'type' of person suits the career, or rather fits the 'mould' of a



psychologist and who is more likely to be successful (gaining experience, get onto training etc).”

### ***Mental health difficulties***

Seven percent of participants reflected on their experience of mental health difficulties and how this impacted on their journey; “I've had lived experience of mental health problems - primarily depression and anxiety, which resulted in some challenges during my final year of my undergrad.”

### ***Accessibility***

Seven percent of participants identified accessibility issues as a challenge; “I have epilepsy and don't drive. This can make getting an appropriate assistant post difficult, as many of these will need you to travel in the community.”

### **Positives**

As well as challenges, over half of participants acknowledged how contextual factors had positively influenced their journey to becoming a clinical psychologist (52%).

### ***Support***

Nearly half (44%) of participants identified the impact of their privilege and power on their journey to becoming a clinical psychologist. Some acknowledged the financial support they had received; “My parents helped me financially to attend university to complete my undergraduate and whilst doing my masters. Having stability and safety at home during my childhood enabled me to attend private school and not have worries about finances, meals, safety or looking after others.” With others identifying the positive impact of emotional support; “I've also relied on their [parents] support when I've worked in stressful and upsetting environments prior to the course. I think I might have burnout and not been able to work without their support. This would have prevented me from studying on the course too.”

### ***Cultural narrative/identity***

For 26% of participants, their cultural identity had positively impacted their journey to and experience of being a psychologist. Some discussed their ability to relate to clients who faced similar challenges to them; “I think my experiences have

benefitted me in that they help me to relate to people in vulnerable of powerless circumstances”, as well as highlighting the importance of advocacy in their work; “...a positive is that it does make me very conscious of the need to appropriately support people who suffer with the impact of socioeconomic and class disadvantages.” Others reflected that their experience of growing up in a working-class family had a positive impact on their work ethic and ability to cope with the DClInPsy course demands; “...I was exposed to lots of examples of people striving against the odds to achieve great things and there was a narrative of grafting and that 'nothing good comes easy’”.

Some participants answers were not included in the content analysis as they referenced more general opinions about diversity and inclusivity within the profession. Many respondents expressed their dissatisfaction with the current recruitment process, highlighting how current routes disadvantage large groups of people (such as honorary contracts, low paid, fixed term contracts etc.).

### **Discussion**

The aim of this research was to collect data on the contextual markers of current and past UoB DClInPsy trainees to enable exploration of the diversity (or lack of) within current/past cohorts. The Admissions Working Group were interested in collecting this information so that they could use this to inform the development of contextual admissions processes for future cohorts. The findings from the quantitative questionnaire suggest that many current and past trainees have experienced deprivation, with nearly 70% reporting at least one marker of deprivation. The level of deprivation experienced varied greatly depending on the marker, with over 45% of participants identifying as first-generation university students, compared to no participants identifying as a refugee. Nearly one third of the sample identified three or more markers of deprivation.

Although some diversity was observed within the sample, particularly in relation to some markers of deprivation, other markers were not present or were present in very few respondents. It is important that the course continues to develop ways in which to encourage recruitment of less represented populations, such as refugees or people who are care experienced. The results of this study suggest that there is a discussion to be had around the individual contextual markers and how they relate to disadvantage. For example, do refugees and first-generation university students (who have not sought refuge) face the same barriers to education, to the same extent?

The content analysis revealed that many participants identified a challenge associated with their contextual factors, most commonly a lack of resources impacting on their journey pre-training. Another interesting category that was recognised as a challenge when training/qualified was identity. Participants spoke of identity in relation to fitting in with perceived middle-class colleagues and feeling safe to express difference. Research from other professions has found that lower SES individuals in typically middle-class professions can experience difficulty in navigating their work-life environments (Marks et al., 2005). This can result in a low sense of belonging, feeling disconnected, conflict, and a feeling of being unable to be their authentic selves in their work and home-life roles.

Although the original focus of this research derived from the Bath course's desire to increase diversity and inclusion through the selection process, the results from the content analysis suggest that there is more to be done to support and encourage inclusivity *during training* also. If trainees are trying to hide or modify their identities, this not only potentially inhibits some communities from engaging with or relating to their therapist, it also prevents aspiring clinical psychologists from seeing themselves in the Bath DClIn cohorts and may deter them from applying. The lack of conversation around difference may also be perpetuating the "white middle-class female" narrative that surrounds clinical psychology, which could help to explain the potentially higher rates of deprivation than expected within this sample.

The results from the content analysis can be understood in the context of Kraus et al.'s (2012) model of the social class context. Some participants spoke of their perception of their rank in comparison to more privileged colleagues (e.g., not feeling deserving enough of the career, lack of relatable role models). Multiple obstacles related to resources were also identified, as well as uncertainty about job security and constraints due to accessibility and/or mental health difficulties. These things together represent a multitude of barriers to accessing a career in clinical psychology. Also in keeping with the model, some participants acknowledged the privilege of accessing material resources, resulting in the freedom and choice to undertake unpaid jobs or expensive Masters degrees.

### **Recommendations for Stakeholders**

The course should continue their development of contextual admissions to increase access by disadvantaged groups to the clinical psychology profession, paying particular attention to potential candidates who do not seem to be currently

represented within cohorts. Although there is currently no guidance on how contextual information should be used as part of the admissions process, it is recommended that the course continues to develop its own processes so as not to delay the potential for diversification of the UoB DClinPsy cohorts.

The results from this study suggest that there are/have been trainees with markers of deprivation on the course. However, the content analysis suggests that some people do not feel safe to discuss aspects of their Social Graces (Burnham, 2018) or feel they must change parts of themselves to fit in. The course should consider how it can create psychological safety when discussing both visible and invisible difference; it could be helpful to think about how staff members, who are perceived as holding power, could take responsibility for this initially. This could be done by integrating reflection and discussion around invisible differences into supervision, teaching, and reflective practice, so that it becomes part of standard practice.

It is important that the course consider how they can communicate that they not only accept but actively encourage people from diverse backgrounds to apply. This should include liaising with the Trainee Led Inclusivity Group (TLIG) to share ideas about both increasing access and supporting trainees. On a wider systemic level, the course could think about how it can support increasing access to the clinical psychology profession from earlier on in the process, for example at GCSE and A-level.

### **Feedback of findings and recommendations**

The initial results were fed back to the admissions committee before the write up of this study so they could inform how the preliminary contextual data were used. More detailed results were then fed back, and the course have stated that they are responding to the challenges identified in this project by continuing to monitor and audit contextual factors as part of the yearly audit process to compare rates of successful and non-successful candidates across the items. They are continuing to develop shortlisting processes to reflect how different degrees of disadvantage within contextual factors might be recognised and accounted for, rather than assuming there is equal disadvantage attributable to each item.

The course is considering ways to further encourage early interest in the profession through school careers liaison opportunities and ensuring that contextual factors are included in conversations and planning in relation to this, and as part of

wider diversity initiatives. They are liaising with relevant trainee and staff forums to disseminate results and to raise the issue of how trainees are supported to feel safe to discuss their more 'invisible' social graces, particularly within teaching and placements.

### **Limitations**

Due to opportunity sampling, the questionnaire results are open to response bias. It is possible that individuals who have experienced markers of deprivation were more likely to participate in the study, meaning the results cannot be interpreted as fully representative of current and past cohorts. As this study was exploratory, conclusions around representativeness were not drawn. However, it would be interesting to collect data on the markers of deprivation of successful candidates in future cohorts, which would allow for measurement of the impact of contextual recruitment. As the study was explorative, there is no comparison data. This means that although subjectively it appears as though people from diverse SES backgrounds are/have trained at Bath, it is difficult to know how this compares to other DClInPsy and postdoctoral courses. Finally, this study has allowed for exploration of the contextual information of individuals who have gained a place at Bath. We do not have any information on the individuals who applied but did not get in. It is possible that the University of Bath is rejecting individuals with many markers of deprivation, or with specific markers of deprivation. The introduction of this contextual information questionnaire to the DClInPsy application form will allow for further examination of the social and economic backgrounds of all applicants, rather than just the successful ones.

### **Conclusion**

This project sought to explore the contextual markers of current and past Bath DClIn trainees. The results suggest that people with experience of deprivation have or are currently training at Bath, although it is difficult to know proportions due to the potential of a response bias. Trainees reported facing many challenges associated with their contextual factors but also acknowledged the positive impact of their contextual factors. Recommendations have been made to the Bath DClInPsy course and they are in the process of implementing these.

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**Coming Out Stories as Told by People with an Intellectual Disability: An  
Interpretive Phenomenological Analysis**

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**Main Research Project**

August 2024

**Supervisor:** Dr Cathy Randle-Phillips

**Word count:** 8349 (excluding abstract, tables and references)

The target journal for my Main Research Project was the Journal of Intellectual Disabilities. The guidance on journal formatting requirements is here:

<https://journals.sagepub.com/aims-scope/ILD>.

This journal was chosen as it publishes a wide range of research related to improving services for people with intellectual disabilities. It has a larger word limit than many other journals which makes it suitable for qualitative research.



## **Introduction**

Sexuality is an integral part of what makes us human and is a fundamental human right for all ages, sexual orientations, genders, and levels of cognitive ability (Ailey et al., 2003). The opportunity to have control over one's life and make decisions, as well as building relationships, is central in developing a healthy sexual identity (Ailey et al., 2003). Historically, people with intellectual disabilities (PWID) were denied access to sex and relationships and were often subjected to abhorrent practices such as forced sterilization and segregated institutions. Although there has been progress in the treatment of PWID, caregivers, services, and wider society may hold paradoxical views about the sexuality of this population (Dotson et al., 2003). PWID can be seen as asexual, hypersexual, or victims, which impacts opportunities for the development of a sexual identity (Winges-Yanez, 2014).

A recent systematic review by Correa et al. (2022) found 'moderate' to 'positive' attitudes towards PWID's sexuality, with most positive attitudes found in community samples, followed by staff, then family. Although this seems positive, it is concerning that the people who hold most power over PWID have less positive attitudes. There was a preference for platonic and friendship relationships, and less positive attitudes towards sexual intercourse, one-night stands, and sexual behaviour caregivers considered to be risky, perhaps due to the conflict between a protective and facilitative role experienced by carers (Rushbrooke et al., 2014b). This suggests that although PWID are increasingly being seen as sexual beings, opportunity for expressing their sexuality remains limited. A review of staff views by Charitou et al. (2020) highlighted many barriers to enabling PWID to fulfil their sexual and relationship needs, including a lack of policy and training, fear of accountability, and role uncertainty. Multiple studies have found that PWID see themselves as sexual beings and have a desire for sexual and intimate relationships (e.g., Rushbrooke et al., 2014a; Correa et al., 2022), meaning there is a disparity between PWID's rights and desires and the attitudes and behaviours of those that surround them.

## **Intersectionality**

Interestingly, although unsurprisingly, the review by Correa et al., (2022) revealed that very few studies discussed attitudes to LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) identities, and when they did attitudes towards same-sex relationships were less positive. This is keeping with research that found that 41% of staff would support a PWID to develop a same-sex relationship, compared to 76% for a heterosexual relationship (Clarke & Finnegan, 2005). We

know that PWID experience violence, abuse, and harassment (Sin et al., 2010), as do people who identify as LGBTQ+ (Bachmann & Gooch, 2017), meaning that PWID who identify as LGBTQ+ face increased discrimination and a multitude of barriers due to their intersecting identities (Wilson et al., 2018).

Belonging to two marginalised groups creates specific challenges for this group. Abbot and Burns (2007) found that PWID who identify as lesbian, gay, or bisexual (LGB) experience similar barriers to LGB people without an intellectual disability but face additional barriers that related to reliance on others. Abbot and Burns (2007) also interviewed staff that support PWID, finding that staff reported lacking confidence in supporting LGB people, stating that a lack of training impacted their ability to engage in work around sexuality and relationships. Staff also reported feeling concerned about “backlash” from parents and carers if they were to engage in this work, suggesting the views of the system are prioritised over client needs or desires.

Reflecting this lack of support, Stoffelen et al. (2018) found that lesbian and bisexual women with an intellectual disability felt they were left to explore their sexuality without support or guidance and found it difficult to talk to others about their sexuality. In keeping with Correa et al’s (2022) research, Dinwoodie et al. (2016) found that PWID who identify as LGBTQ+ felt others problematised intellectual disabilities and sexuality, had experienced abuse and discrimination, and had to navigate acceptance from others. A review by Ramasamy et al., (2021) found that PWID who identify as LGBTQ+ lack opportunities to explore their identities and lack sexual agency (Milot et al., 2024).

Although discrimination against people who identify as LGBTQ+ continues to be a problem, recent years have seen an increase in awareness, acceptance, and the rights of this population. For example, same-sex marriage was legalised in England and Wales in 2014 and the World Health Organisation declassified transgender health issues as a mental illness in 2019 (Burton, 2020). As a minority within a minority, it is unclear what, if any, impact this has had on PWID who identify as LGBTQ+, with recent research suggesting little has changed (Milot et al., 2024).

‘Coming out’ can be defined as the process of an individual understanding, accepting, and sharing their non-heterosexual identity. Researchers from many social science disciplines have investigated this process, resulting in different models and conceptualisations (Alonzo & Buttitta, 2019). Eliason and Schope (2007) argue that linear stage models, although varying subtly, consist of similar themes involving;

feeling different, identity formation is developmental, the importance of disclosure, the need for a stage of pride, the need for identity integration. Coming out models are a controversial topic and have received extensive criticism for their assumption that LGBTQ+ people must disclose their identities to be well adjusted, their rigidity, and inconsideration of contextual factors (Klein et al., 2015). Regardless of different ideas, there seems to be an agreement that the process of coming out remains an important part of an individual's journey (Alonzo & Buttitta, 2019) that is impacted by the socio-cultural context (Klein et al., 2015; Toft, 2020).

People with intellectual disabilities are often left out of these studies and rarely considered in models. Toft (2020) explored young disabled LGBTQ+ people's experiences of coming out, which included young people with intellectual disabilities. Participants did not express that coming out was essential to them living authentically but did feel coming out enabled a sense of belonging within their communities. More studies can be found in the non-intellectual disability literature. Perrin-Wallqvist and Lindblom (2015) interviewed adolescents about their experience of coming out to their parents. They found that participants tended to go through a process involving feeling alienated, uneasy and fearful, self-acceptance, and feeling whole. Guittar (2013) interviewed 30 people about their experience of coming out and found that it meant different things to different people, although they agreed that coming out was a transformative process that influenced identity formation.

### **Social identity and people with intellectual disabilities**

People with intellectual disabilities are a stigmatised group, and belonging to this group can have negative implications for how PWID see themselves (Logeswaran et al., 2019). Beart et al. (2005) reviewed research on PWID's sense of identity and concluded that many PWID seem unaware of their label as someone with an intellectual disability, or do not feel it applies to them. The authors proposed an explanation that PWID desire to distance themselves from belonging to a stigmatised group or deny group membership as a defence mechanism.

An updated review by Longeswaran et al. (2019) found that PWID are generally aware of the label ascribed to them, but do not tend to see it as central to their identity. A review by Ali et al. (2012) indicated that awareness and consequent internalisation of the stigma associated with an intellectual disability label can have a negative impact on psychological wellbeing. Wilkinson et al. (2015) found that young adults with an intellectual disability were focused on achieving a 'normal' adult

identity, which included their sexual identity, suggesting that they were motivated to distance themselves from their intellectual disability identity.

However, Brandscombe et al. (1999) suggest that a sense of belonging in a marginalised group can lessen the impact of prejudice and discrimination. Evidence of this can be found in the LGBTQ+ literature, as greater LGBTQ+ integration (e.g., participating in LGBTQ+ social activities) is associated with fewer mental health symptoms (Rosario et al., 2011). This is likely, however, to be more difficult for PWID who identify as LGBTQ+ as they may not be welcomed by the ID community due to non-acceptance of sexual diversity (Burns & Davies, 2011), and may also be unaccepted in LGBTQ+ communities due to their ID (Stauffer-Kruse, 2007; Ramasamy et al., 2021).

### **IPA in intellectual disability research**

Interpretive Phenomenological Analysis (IPA) has become an increasingly popular method within the intellectual disability literature (Corby et al., 2015). IPA seeks to understand the lived experience of an individual, which involves interpretation by the researcher (Smith & Osborn, 2008). This approach is particularly useful where identity and making sense of the self are key issues (Smith, 2004). Concerns have been raised regarding the use of IPA in this field. This relates to the impression that PWID may not be able to provide a rich enough account of their experience or may be inarticulate (Rose et al., 2019). As qualitative studies involve detailed reflection and recounting of personal and sensitive topics, concerns regarding informed consent have also been raised (Iacano, 2006). However, Rose et al., (2019) reviewed IPA researched conducted with people with intellectual disabilities and concluded that IPA is an appropriate methodology to use with this population.

The voices of people with intellectual disabilities often go unheard, particularly in relation to topics that may be viewed as taboo or culturally sensitive. As an oppressed and disempowered group, it is imperative that the voices of PWID are at the centre of research, so we can understand their experiences, avoid making assumptions, and understand how to support them better.

The aim of the current study is to use IPA to explore how PWID who identify as LGBT+ make sense of their experience of the coming out process. This study seeks to add to the minimal research in this area and to help us understand how to better support PWID in the exploration and disclosure of their sexual identities. Considering

PWID who identify as LGBT+ hold two minoritised identities, it will be interesting to explore how participants in this study make sense of their identities and how this interacted with their coming out experience.

## Methods

### Participants

Participants were recruited through contacting third-sector or volunteer organisations that support PWID. These ranged from care providers to LGBTQ+ dating agencies for PWID. Five individuals participated in the study (demographics presented in Table 1) Specific ages are not reported to avoid potential identification of participants. All participants were residing in the UK.

**Table 1**

*Participant demographics*

<b>Name*</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Sexuality</b>	<b>Recruited from</b>
Ronnie	Male	Late 30s	WB*	Gay	Social media
David	Male	Late 30s	WB	Gay	Charity
Leanne	Female	Mid 30s	WB	Bisexual	Charity
Darren	Male	Late 30s	WB	Bisexual	Care provider
James	Male	Early 20s	WB	Gay	Dating agency

\*Name = pseudonym. WB = White British

### People with Personal Experience (PPE) involvement

An adult with an intellectual disability, who identified as a gay man, was consulted during the development of this project. He was supported by an Assistant Psychologist to review and comment on the recruitment poster, information sheet, draft interview schedule, and debrief form. A Microsoft Teams meetings was arranged for the PPE to feedback to the researcher. Following the PPE's recommendations, the Amazon voucher amount was increased from £15 to £20, and the researcher was sure to be explicit that participants did not have to answer a question if they felt uncomfortable. The term 'Queer' was highlighted as very upsetting for the PPE. He commented that he understood some people were reclaiming the term, but it was personally associated with very negative memories. Due to this, the word was

removed from the recruitment materials and the term 'LGBT+' was adopted. The PPE was paid £15 per hour.

## **Procedure**

The study received ethical approval from the University of Bath Ethics Committee (PREC code: 23035, Appendix K). The study was advertised by contacting agencies that support PWID and asking them to share with their network. On occasion, posters were printed and sent to organisations to display in their hubs or spaces. Social media was used initially, but the advert had to be removed due to the high frequency of disingenuous respondents which are a growing problem in qualitative research (Ridge et al., 2023). All participants were required to be 18 or over, identify as having an intellectual disability, identify as LGBT+, and have the capacity to consent to research (assessed by lead researcher, see Appendix L).

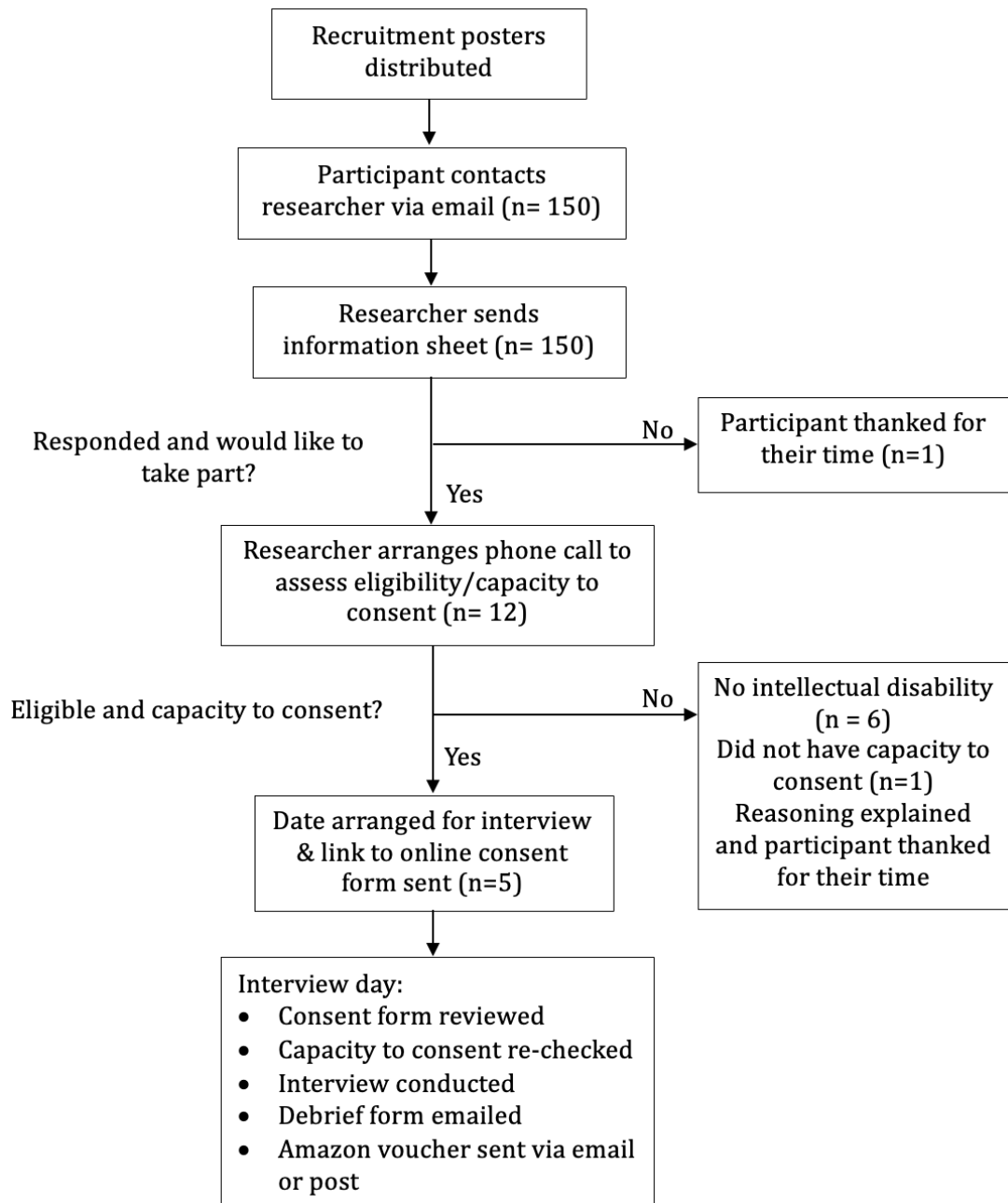
Potential participants contacted the researcher via email, and an easy read information sheet was sent in response. The researcher offered to support the participant in going through the information sheet if desired. Where potential participants were not eligible, this was due to confusion around the term 'learning disability' vs 'learning difficulty' (e.g., neurodiversity). The full recruitment process is presented in Figure 1, and the recruitment/study materials can be found in Appendices J-M. Participants could choose for the interview to be conducted at the University of Bath, via Microsoft Teams, or by telephone. All participants chose Microsoft Teams and interviews lasted between 40 and 70 minutes. All participants chose to be interviewed alone, without a support person.

Before the interviews began, the researcher attempted to build rapport with participants (e.g., asking questions about their day/hobbies) to help them feel at ease and empowered within the conversation. A semi-structured interview format was followed (Appendix O). The interviews were flexible to allow participants to have ownership over what is talked about, as recommended by Smith et al., (2021, p.3.) The interviews were recorded using the researcher's university Microsoft Teams account, with recordings saved to a secure folder. Once the interviews were finished, the researcher re-confirmed consent for data to be used and participants were informed that they had four weeks to withdraw from the study. Debrief forms were sent via email and participants were directed to their GP or the LGBT Foundation if they wanted support. A £20 Amazon voucher was sent via email or post. The interviews were transcribed verbatim by the lead researcher or a research apprentice

within the research team. Identifying information was changed or removed by the lead researcher. Transcripts were saved in a secure folder and the recordings were deleted.

**Figure 1**

*Recruitment flowchart*



## Analysis

Interpretive Phenomenological Analysis (IPA) was used in this study. This method was chosen as it aims to explore how participants make sense of their experiences and is not reliant on pre-existing theory (Smith et al., 2013). A significant component of IPA is the double hermeneutic, which can be described as a dual interpretation process involving the researcher attempting to make sense of the participant making sense of their experience (Smith & Osborn, 2008). To do this, the researcher must move between the emic (immersing themselves in the data and providing evidence of the participants meaning making) and the etic (examining and interpreting the data through a psychological lens, including the application of psychological concepts or theories) perspectives (Pietkiewicz & Smith, 2012). The etic perspective was primarily through the lens of the lead researcher, a Trainee Clinical Psychologist who identifies as cis female, heterosexual, without an intellectual disability. The lead researcher has several years' experience of working with individuals with an intellectual disability. As the analysis was likely to be influenced by these experiences (Smith et al., 2013), a reflective diary was utilised to promote reflexivity throughout the analysis process. Initial themes and ideas were shared within the research team and a cohort wide IPA supervision group to further enhance reflexivity.

Steps highlighted in Smith et al.'s book (2021) were followed. As the current project was in the early stages when changes to IPA terminology was made, the new terms were adopted. The first stage consisted of the researcher immersing themselves in the data, which involved reading and re-reading of an individual transcript to ensure the participant is the focus of the analysis (Smith et al., 2021, p. 78). The researcher then made exploratory notes in the right-hand side of the page, noting anything of interest, to facilitate engagement with the transcript.

Next, the researcher analysed the exploratory notes to construct concise summaries (experiential statements, Appendix Q), which were then cut up into separate pieces of paper and distributed in a random order on a large surface. Once experiential statements were displayed together, the researcher began to search for connections between them and map how they might fit together (Smith et al., 2021, p. 90). This was a dynamic process that involved grouping and re-grouping statements to explore different ways of representing the participants experience (see Appendix R for example). Clusters of experiential statements were then given a title, which in turn



became Personal Experiential Themes (PETs). These were written up in table format with corresponding quotes from the participant as supporting information.

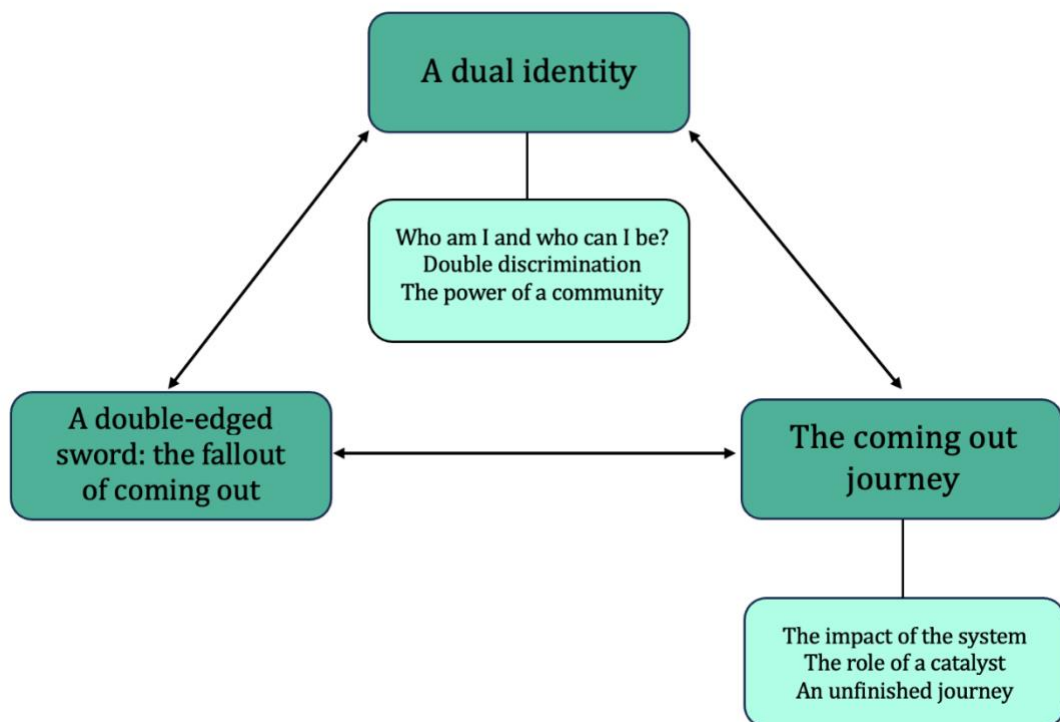
This process was then repeated for each transcript. Once individual transcripts had been analysed, the researcher searched for similarities and differences between individual PETs. This was done by cutting up individual PETs and displaying them in a random order on a large surface. The researcher frequently referred to a large table with collated PETs and experiential statements to allow the researcher to remain close to the participants account. From this, Group Experiential Themes (GETs) were developed, which aimed to capture both the shared and unique features of each participant's experience (Smith et al., 2021, p. 100). GETs were reviewed, discussed, and refined with the second researcher (the lead researcher's supervisor) to ensure the GETs were an accurate representation of participant experiences.

## Findings

All participants gave a rich and detailed account of their experience of coming out and things that had influenced this, such as the development of their sexual identity and what happened after they came out. Three Group Experiential Themes (GETs) and six subthemes were identified (Figure 2). Although each a distinct theme, there seemed to be bidirectional relationships between elements of the GETs, with each part of a participant's story impacting another. Participant representation within each theme can be found in Table 2.

**Figure 2**

*Visual representation of themes*



**Table 2***Participant representation within themes*

<i>Theme</i>	<i>Participants</i>				
	Ronnie	David	Leanne	Darren	James
<b>A dual identity</b>	+	+	+	+	+
<i>Who am I and who can I be?</i>	-	+	+	+	+
<i>Double discrimination</i>	+	-	+	+	+
<i>The power of a community</i>	+	+	+	+	-
<b>A double-edged sword; the fallout of coming out</b>	+	+	+	+	-
<b>The coming out journey</b>	+	+	+	+	+
<i>The impact of the system</i>	+	+	+	+	+
<i>The role of a catalyst</i>	+	+	-	+	+
<i>An unfinished journey</i>	-	+	+	+	+

Key: **Group Experiential Theme**, *Subtheme*. Participant represented within theme: +(yes)/-(no).

### **A dual identity**

All participants reflected on their experience of holding a dual identity to some extent; as people with an intellectual disability who identify as LGBT+, therefore belonging to two marginalised groups. There seemed to be a complex interplay between these identities, with participants acknowledging the difficulties as well as positives associated with this. This theme covered the whole of the coming out experience, from initial exploration of sexual identity to the search for relationships after coming out.

#### ***Who am I and who can I be?***

Many participants perceived their intellectual disability, and the perceptions held by others associated with this, as having had an impact on their sense of self. For some, this related to support required to explore their sexual identity and the nuances of vulnerability. Others referenced the harmful impact of stigmatised views often held by those around them and wider society.

“(…) people without a disability, seem to know who they are and be able to talk about it more.... I think a lot of people think that people with disabilities don't have our own voices. Like a lot of people have a stigma about disability.” (Leanne).

Leanne’s account suggested that the constant questioning and dismissal of her experiences as a PWID resulted in a fragmented sense of self. This extended to her sense of sexual identity and experience of coming out, as she repeatedly received the message that she did not know herself e.g. “(…) she just went as well, said, Ohh, that's not really you. That's just like, that's the drink talking.”, which resulted in an internal questioning of her identity and wondering about who she is allowed to be; “But it was, as if I had voices in my head saying to me. Ohh, you're not really bi. You're just saying that so just continue to tell people that you're straight.” Leanne attributed some of the confusion around her sexual identity to be a direct result of her intellectual disability, due to difficulties with understanding the boundaries of relationships.

Similarly, Darren seemed to attribute confusion around his sexuality partly to having an intellectual disability, meaning he felt support from others was central to his experience of coming out:

“See if I had not had a disability when I thought I was bi I might have been able to say, yes I am, I know I am. But I didn't know, I had to go to a group to find it out. I had to go to the group, which specialises in disabilities, to find out for certain, if I was bi.”

The sense of ‘who am I and who can I be?’ was related to participants’ views of themselves in comparison to people without an intellectual disability, which seemed to reflect a polarised view. For example, Darren and David felt that people without an intellectual disability were “more confident” (Darren), and “less nervous and shy” (David), which they felt meant they were surer of their sexuality and coming out would therefore be an easier process.

### ***Double discrimination***

This subtheme relates to participants’ experiences of being discriminated against as PWID, and how this intersects with being discriminated against as a person who identifies as LGBT+. Darren described feeling unliked by his family due to his disability and felt they would perceive his bisexuality as “another thing that’s wrong

with me". Darren's reference to his disability being visible suggests that he conceptualised his sexuality as an invisible identity. The researchers interpreted this to mean that Darren felt he had more control and power over disclosing his sexual identity, which he was choosing not to do in order to protect himself from further rejection.

Ronnie shared that his experiences of discrimination were made more difficult by practical barriers, such as reporting LGBT+ hate crimes to the police: "(...) That was very frustrating for me with someone with a disability...I'm like sorry I mean this and... my spelling's not that good. And then I get frustrated and anxious." Ronnie's account seems to reflect a sense of powerlessness, which left him feeling like a disregarded second-class citizen who had no faith in the police to protect him. Further feelings of disempowerment were evident in Ronnie's account of services responding to homophobic abuse he experienced at home ("...it was easier to move me on instead of dealing with the perpetrators."). The researchers interpreted this as Ronnie feeling like things were 'done to' him, which felt unjust but unchallengeable due to his status within society.

James spoke about sex and relationships feeling unachievable for PWID, e.g., "Good luck trying to get the basics, never mind relationships", and although he felt most barriers were due to restrictions placed on him due to his disabilities, it seemed there are added difficulties due to being a gay man:

"There's absolutely nothing [support to find relationships] I can say that with hand on my heart cause I've Googled. I've looked. I've gone to places. You struggle to even find somebody cause I've got to do it a certain way. I can't go on this. I can't go on that."

Although James did not describe overt discrimination, the lack of support or infrastructure for gay men with an intellectual disability, combined with the safeguards applied meant James felt like a deprioritised member of society with clear unmet needs.

### ***The power of a community***

Despite the difficulties of holding a dual identity, most participants expressed positives associated with this. Participants referred to the many benefits of support groups (online or in person) for PWID who identify as LGBT+. For some, being in a community supported them to explore their sexual identity and gave them the

confidence to come out. Leanne's account suggested her support group represented a safe and supportive environment which elicited her coming out:

"We were having a discussion about pride, and our leader said it was open mainly for people who felt that they needed to, like tell people who they were. But I then said to the leader, I think I might be bisexual. Could I please, like, join? And she said to me, 'well done for coming out like that it's a big step'."

For Leanne, coming out also appeared to be about seeking connection and acceptance within another marginalised community. It seemed Leanne felt more comfortable identifying as LGBT+ than she did as a PWID, possibly due to her first-hand experiences of discrimination and oppression associated with this label. David identified the support from his care provider as being integral to him coming out e.g., "I just realised that I wanted to come out to be honest, and I let know and she [support worker], she's been helping me with that." This was a powerful experience for David and meant he no longer felt he needed to "blend into the crowd", which suggests claiming his LGBT+ identity provided protection against negative and hurtful treatment by others.

Others found support groups later in their journey, and when they did so, described finding comfort and connection through their communities. For example, Ronnie spoke about being open and honest about his difficulties online, which usually results in him receiving comfort and encouragement from his peers. As well as connecting with people who he shares characteristics with, Ronnie spoke positively about "learning new things" about others with different identities in his support group. This seemed important to Ronnie and suggests he feels his support group is a safe and inclusive space.

### **A double-edged sword: the fallout of coming out**

This theme relates to participants acknowledgement of the complexity of coming out in relation to things that they gained and lost in the process. Nearly all participants spoke about the pain or distress associated with coming out, whilst also reflecting on the many things they had gained along the way. Ronnie spoke in detail about his experience of homophobic abuse, which impacted his relationships, others around him, and where he was able to live. Despite this, there was a sense that his experience of abuse contributed to self-acceptance and resilience that has served him

well in later life: “I think as I got into my late 20s, I couldn't give a crap what people think of me. I wouldn't say I'm thick skinned... I've had to adapt to be thick skinned you know?”

This suggests Ronnie does not view resilience as a permanent, inherent part of his personality, instead that it is a defensive response that he continues to deploy when he is threatened. Ronnie's experience of abuse and discrimination gave rise to his passion for advocacy, which seemed to give him a sense of purpose and protection. There was a sense that he was able to channel his negative experiences into advocating for other stigmatised groups, which he felt empowered by, highlighting that he feels this is his “mission”.

Some participants highlighted other people's reactions as a source of both pain and acceptance. Ronnie wondered whether his sexuality caused him to be rejected by some people in his family; but coming out seemed to strengthen relationships with others in his family. For Leanne, the process of coming out multiple times to multiple people was distressing and wished that people could “just tell” that she is bisexual. Distress seemed to be caused by a sense of not being believed, which had a powerful impact on her emotions and discouraged her from telling more people. Positive reactions, on the other hand, made Leanne feel seen and accepted. She felt as if a “weight had been lifted” off her shoulders, and that coming out meant she did not have to “hide away, like in the background”, which demonstrates the power of coming out if it is met with compassion and understanding. David also reflected on a sense of being different selves around different people, potentially carrying the burden of wondering who he is in each given context.

Despite participants sharing a sense-making experience with regards to the complexities of coming out, there was some divergence in how participants made sense of this overall and almost whether the process was ‘worth it’. For Ronnie, “going back in the closet” was never an option, suggesting that he would not be willing to sacrifice the things he has achieved for protection from abuse. But for Darren, although he seemed to highly value support from his group (“...they would accept it as normal. There wouldn't be any judgement there), overall, he felt regret at making the decision to come out due to feeling vulnerable and self-conscious around people who did not know: “(...) I just feel like people look at me differently.... It's like it's branded on my forehead.” (Darren). The language used by Darren in these quotes suggest he feels his sexuality is abnormal, something that needs to be accepted as normal rather than *being* normal. Although Darren was selective about who he came

out to, he felt this meant others could sense his bisexuality, almost as if coming out created a chink in his protective armour.

### **The coming out journey**

This theme relates to participants using the concept of a journey to make sense of their experience of coming out, which for many felt ongoing or unfinished. The actual act of 'coming out' (i.e. the disclosure to others) felt more important to some than others, but there was a collective importance placed on the processes that led up to the point of coming out.

**The impact of the system:** *"We didn't have the conversation about the bees and the bees and the birds and the bird."* Leanne

All participants identified various influences of the system around them on the development of their sexual identity, from individuals to wider societal or cultural norms. Many participants described a sense of feeling "odd", "different" or like something was "wrong" with them e.g., "So I knew there was something wrong but I wasn't quite sure what it was until about a couple of years ago" (Darren). Societal taboo, stigma, and a lack of visibility or representation of LGBT+ people were highlighted as significant influences on participants' sense of feeling different. Although all participants received some sex education, this was always heteronormative ("We just discussed sex education about the birds and the bees. We didn't have the conversation about the bees and the bees and the birds and the birds" Leanne), generally risk focussed (education on "stranger danger", putting a condom on) and seen as infantilising. A sense of feeling different led to participants trying to "fit in" or "blend in with the crowd" to avoid being "found out", as Ronnie explains: "I was bullied anyway. I thought, well, I can't really say anything to anyone. If I'll get picked and I'm gonna get picked on even more. So I didn't say anything."

Many participants spoke of their experience of being bullied before coming out (David, Leanne, Darren, and Ronnie), perhaps highlighting their vulnerability as PWID. Leanne's experience suggests she sees herself as abnormal and as a result has developed skills in presenting different versions of herself to fit in:

"(...) I always like masked myself so I've always hidden away from everybody and like just tried to be normal if you like. It's kinda like I've always had to do that with my life like. From having a disability."



Leanne became skilled in “fitting in” through looking to others around her to see what was expected of her, as well as seeking out heterosexual relationships as she perceived them as “easier” and more acceptable to others. As well as fearing rejection by peers, Darren described fearing rejection by his family, which in fact has informed his decision to never come out to them. Participants identified a lack of support as impacting the development of their sexual identities in many ways. James expressed anger at being robbed of explorative experiences by those around him, which seemed to delay self-acceptance of his sexuality and thus coming out. He spoke about the overt and covert messages he received from his education setting:

“They don't think people with disabilities should... be allowed to obviously date or have a relationships. That obviously would have knocked me back for a bit of time. (...) you couldn't hold hands with opposite sex, so you couldn't obviously do it with the same sex.” (James)

Some described exploring their sexual identity as a confusing, isolating process. Although some participants suppressed or ignored their feelings due to fear, others expressed wanting to find support but not knowing where to go (“I didn't know what to do, who to speak to” Ronnie) or that there was none (“...no books or anything in school or college” Leanne). Many participants felt that factors such as increased support, visibility of LGBT+ people, and better sex education could have made their journey easier in some way, as Ronnie explains:

“Talking about in schools and then maybe I might have come out when I was at school. I might not have done, but at least if they'd have spoke about it in school. I woulda knew...That it was normal instead of not normal.”

### ***The role of a catalyst***

Most participants identified a pivotal point in their journey that served as a catalyst for either the exploration of their identity or for coming out. These events seemed to influence participants experiences directly and indirectly. Both James and David reflected on the impact of the lockdowns during the Covid-19 pandemic. Although James first became aware of his sexual orientation during his teenage years, he disengaged with this until just before lockdown e.g., “And during covid, that's

when I really did realise, this is who I am and this is what I wanna be.” This period allowed James to reflect on how he was living, which he realised felt inauthentic and not aligned with his values. It seems disconnection from others prompted an introspective process that meant James came out of lockdown more accepting of himself and ready to share his sexual identity with some people.

Some participants understood sexual experiences to be catalysts in the development of their sexual identities. Ronnie recalled identifying as bisexual before he came out as gay, mainly because he felt this was more socially acceptable, but also because others had wondered how he knew he was gay if he had not had sexual experiences with a woman: “So I slept with a woman and it just didn't do nothing for me and. I just...That's when I knew I was gay.” For Ronnie, this sexual experience confirmed his sexuality, which also seemed to provide credibility to those around him.

Darren described a sexual experience with a male peer, which seemed to contain issues of consent and harassment, that he feels directly influenced his sexuality: “I think this guy may have changed me...Up until that time I've never been attracted to any guy...I think he changed my, changed it.” The researchers interpreted this to mean that Darren conceptualises his sexuality as something that could be awakened or switched, rather than something that is concrete and intrinsic.

### ***An unfinished journey***

Most participants spoke about the coming out journey as an unfinished one. For some, this was in relation to further exploration of their sexual identities and how they choose to express themselves. For example, Darren and David mentioned dressing up in “women's” clothes or wearing make-up. Both also seemed to view sexuality as fluid, with David viewing his future exploration of sexuality as an intrinsic, passive process: “I'm not quite sure yet. I'll just play it, just play it by ear. Just let nature take its course. Really.” Things felt more complicated for Darren, who conceptualised his attraction to men as a sexual, biological process, rather than an emotional one. Darren seemed to be continuing to make sense of his attraction to men and how he can integrate this with his life goal of being in a heterosexual relationship and conceiving biological children (“I can't get what I want from life going out with a man.”)

Two out of five participants saw themselves as completely ‘out’. David and Leanne were out to people they felt comfortable with, but not to others. Navigating

coming out to more people seemed to be part of the unfinished journey for them. Leanne expressed a desire to be able to live as her authentic self with everyone but did not feel ready yet. This seemed to be related to her experience of being repeatedly questioned and the impact this has had on her sense of self e.g., “I’m still trying to think to myself...is this really a phase or is this actually something?” and her exploration of this was ongoing: “I think once I found who I like, who I really am, and I’ve actually managed to believe it a lot more. I think it will be easier for me.”

Most participants described wanting relationships and sexual experiences and identified several barriers to accessing these. Some felt they lacked confidence, needed support that they had not received yet, or lacked opportunities. James felt many restrictions were placed on him and his use of words such as “allowed” suggests that despite being an adult, he feels he lacks autonomy to make his own decisions. He spoke about taking difficult steps towards negotiating more freedom with those around him: “I just need to build up the confidence to do it [have a conversation]. It’s not easy to do that.”

Leanne reflected on navigating relationships with women, which she finds confusing compared to men. This seemed to be related to the additional effort and discomfort in finding out if a woman is LGBT+, which she feels is “scary”. This experience was shared by Darren, who felt there are risks associated with approaching a heterosexual man, and seemed concerned with how this might be perceived by others.

### **Discussion**

This study provides an important insight into five PWID’s experiences of coming out. Participants reflected on holding a dual identity, which was largely related to the compounding impact of multiple disadvantage or inequality. This seemed to interact with all aspects of their experience of coming out and identifying as LGBT+. Most participants had a sense that they had gained and lost things in the process and saw their experience as a journey that is ongoing.

Previous non-ID research has identified young people feel alienated and fear others’ reactions before coming out (Perrin-Wallqvist & Lindblom, 2015), which was a shared experience in this study. However, participants in this study described a unique feature of their experience related to their intersecting identities, in that they felt ‘abnormal’ due to having an intellectual disability *and* identifying as LGBTQ+. As well as this, participants had lived experience of being rejected due to their intellectual disability, which impacted on their exploration and disclosure of their

sexual identities. Additionally, research has found that young people without ID may not be believed by parents, who may hope their child is going through a 'phase' (Ghosh, 2020). However, not being believed is likely to be a more permanent feature of a PWID's experience as it seems to be related to perceptions of them due to their ID rather than developmental stage, as may be the case with young people.

Despite shared experiences, the meaning and value of coming out differed between participants, which is in keeping with coming out research in the non-intellectual disability community (Guittar, 2013). Participants in Guittar's (2013) study agreed that coming out was a transformative, ongoing process. This experience was shared by participants in the current study, although some important differences should be explored. Although participants saw their journey as ongoing, some of this was related to reliance on others to either support them or give them permission to explore next steps. For example, James has struggled to find intimate relationships due to the lack of availability of specialist organisations, and his intimate experiences are gatekept by his parents (e.g., access to dating apps). This demonstrates the unique challenge that PWID who identify as LGBT+ face, as they experience less control and agency over their coming out journey, which is largely dictated by those around them. This relates to research which has found that caregivers attitudes seem to conflict with their actions and what is experienced by those that they support (Correa et al., 2022).

As with non-ID participants in Klein et al's (2015) study, participants' personal and cultural contexts impacted their coming out journey. Although there were examples of positive and supportive contexts, much of this was related to the harmful impact of their systems. Community context has been found to be an important factor for people considering coming out, as Legate et al. (2012) found that disclosure was associated with more positive well-being in autonomy supportive contexts but not in controlling contexts. Community context is particularly important for PWID, who are more likely to be living in controlling contexts rather than autonomy supportive ones. Taken together, results suggest PWID who identify as LGBT+ hold a unique, intersecting identity which interacts with all aspects of their coming out story.

The results of this study can be seen through the lens of Social Identity Theory (SIT: Tajfel & Turner, 1979). Participants' sense of self seemed to be related to how they view themselves in comparison to people without an intellectual disability. They conceptualised people without an intellectual disability as having a stronger sense of identity, which resulted in more confidence and ability to express their sexuality. This

fits with previous research (e.g. Wheeler et al., 2007) and suggests that participants may have internalised stigma about their group identity, resulting in the perception that people without ID hold more positive and powerful identities.

SIT (Tajfel & Turner, 1979) can help explain some aspects of participants' coming out stories, as many participants seemed to attempt to enhance their social identity by not acknowledging their sexuality or purposefully withholding it from others and trying to 'fit in' with a higher status group. However, finding a community of similar others was a powerful experience that facilitated exploration of identity and represented acceptance. This is in keeping with previous research which found that contact with similar others was important for PWID who identify as LGBT+ (Dinwoodie et al., 2016) and that positive attitudes from support staff is important (Bates, 2020). As suggested by Brandscombe et al. (1999), a sense of belonging in a marginalised group seemed to act as buffer against prejudice and discrimination, which has important clinical implications. For some participants, finding a community also paved the way for advocacy, which brought a sense of purpose and meaning. Participants spoke about advocacy with pride, which is in keeping with research by Anderson and Bigby (2017) which found that self-advocacy provides possibilities for more positive social identities for PWID.

It is of note that all support groups attended by participants were specialist groups for PWID, some specialising in LGBT+ issues. Previous research has found LGBT+ communities are perceived as unwelcoming to PWID or people with disabilities (Toft, 2020), and participants in Dinwoodie et al's (2016) study felt unsupported by ID services due to their LGBT+ identities and felt LGBT+ services were ill-equipped to support PWID, reflecting an intersectional identity. Prior to finding support groups, participants in this study reflected on the negative impact of the lack of support they received with exploring their sexual identities, which was in part related to the scarcity of resources, support groups, or services. Access to support groups or services seemed to be determined by location or how able people are to connect online. Some felt that increased support would have made a significant difference to their coming out journey.

It was a challenge for the researcher to be aware of their biases throughout this project. As a cisgender heterosexual woman with no lived experience of coming out, it was imperative that beliefs and assumptions were critically examined at every stage to allow the researcher to understand how they shaped interpretation of participants' experiences. This was done through the use of a reflexive diary, research

supervision, and a peer IPA group. It was also important for the researcher to reflect on their experience as a clinician working with PWID who are accessing services due to distress. The use of a reflexive diary and supervision was helpful for exploring the impact of the researcher's joint identity as a researcher and a clinician, such as noticing when her clinical experience may lead to problem focused interpretations.

### **Limitations and future research**

Five people participated in this study. Although the number of six-eight participants has been suggested as an appropriate number of participants for IPA in doctorate studies (Turpin et al., 2007), Smith et al. (2021) recently suggested that 10 participants is an ideal number. Recruitment was difficult, which is a common issue in intellectual disability research as gatekeeping can lead to difficulties with gaining access to this population (Nind, 2008). This is likely to have been more difficult due to trying to recruit a minority within a minority. Thus, five participants was deemed acceptable, and all participants provided rich and thoughtful accounts of their experiences. However, it is important to consider that findings may not be applicable outside of this sample and further research should be conducted to explore the experiences of more PWID.

The participants in this study were all White British, meaning there is a lack of diversity in the sample and findings need to be considered within this context. Considering intersectionality, PWID with minoritised racial identities are likely to increase an additional layer of discrimination and barriers (McDonald et al., 2007). Additionally, only one woman participated, which is in line with the underrepresentation of women in intellectual disabilities research, particularly within the sexuality domain (Stoffelen et al., 2018). This likely reflects societal views on women as sexual beings. Women with intellectual disabilities are often described as 'vulnerable' by their support workers (Hollomotz, 2009), and may not see themselves as sexual beings due to feeling sexually 'unavailable' (Baron, 2002). Women with intellectual disabilities may feel less able or supported to explore their sexual identity and therefore appear less in the research. This is an important and interesting area of future research.

IPA requires a homogenous sample (Smith et al., 2021). The sample in this study are homogenous in the sense that they are all PWID who identify as non-heterosexual. However, two people identified as bisexual, and seem to share some experiences that the people who identified as gay did not. For example, both bisexual

people spoke of their anxiety around approaching same-sex people and compared this to the simplicity of approaching a person of the opposite sex. Alonzo and Buttitta's (2019) review of the coming out literature suggested that there may be a unique coming out experience for bisexual people, often facing discrimination from both wider society and gay or lesbian people. Future research could focus on the potentially distinctive experiences of PWID who identify as bisexual.

No participants identified as transgender. A review by Keates et al., (2022) found that there is a "dearth of literature" on trans PWID, and they are "lost in the literature" when they have been included. Considering the increasing politicisation of transgender issues within society, there is a need for research into this for PWID to ensure that this population are not left behind and unsupported.

The participants in this study were a self-selected sample, suggesting they felt confident and able to tell their stories. They may not be representative of many PWID who have not managed to access support groups or connect with similar others. This begs the question of whose voices we are not hearing in this study and the wider PWID literature. Future research could focus on the unheard voices, for example on people with moderate-severe intellectual disabilities.

### **Clinical Implications**

This study has important clinical implications and recommendations for practitioners can be made based on results. PWID may lack confidence in their thoughts and feelings and may not feel empowered to begin conversations. Practitioners should instigate conversations about sexuality to normalise sexual feelings and demonstrate acceptance of all identities. Professionals are often seen as safe people and were mentioned in all participants stories as facilitators of exploration of sexual identity, and positive reactions were affirming. Practitioners should aim to provide an inclusive and non-judgemental approach to support.

Coming out can represent accepting identity and living authentically. However, PWID identified negatives and positives associated with coming out and is not the only way PWID can live in line with their values. Practitioners should support PWID to consider their current context and how this might impact and be impacted by coming out. People supporting young people with intellectual disabilities should be particularly aware of their emerging sexual identity and should provide an open space to explore this with them.

Findings revealed PWID who identify as LGBT+ greatly value being part of a supportive community, and membership can promote a positive sense of self. This is in keeping with previous research which has found that specialist LGBTQ+ groups for PWID represent a safe space for people to feel different (Elderton & Jones, 2011). There is currently inequitable access to support groups for this group. Practitioners and services supporting PWID should consider proactively connecting people to support groups. Some are accessible online and PWID should be supported to access and attend these.

Previous research has found that mainstream LGBTQ+ organisations do not feel accessible for PWID (Toft, 2020; Stauffer-Kruse, 2007) and have been perceived as hostile (Ramasamy et al., 2021). Considering this, services should consider setting up a support/social group if there are none locally. Simić Stanojević et al. (2023) highlight the responsibility of mainstream LGBTQ+ organisations to outreach and make services accessible to PWID. The authors would support the steps identified in this study to increase PWID's access to LGBTQ+ support services and similar others.

The act of disclosing sexual identity is not the end of the coming out journey. Practitioners should support PWID to continue to explore their sexual identities and safely access relationships if they wish to do so. Participants had positive experiences of attending large events (e.g. pride). PWID should be supported to attend events for their own benefit but also, so more PWID are visible and represented at such events. Although safety and risk assessment is important, positive sexual identities should be encouraged and celebrated.

## **Conclusion**

In conclusion, this study adds to the limited literature on the coming out experiences of PWID who identify as LGBT+. Participants reflected on their dual identities and the complexities of their coming out journeys, which remain ongoing. Results highlight that even in 2023, PWID who identify as LGBT+ largely struggle to get their needs met, meaning there are important issues for people who support PWID to consider.



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## **Executive summary**

Although separate projects with individual research questions, these projects share a common theme of inclusivity, diversity, and understanding the experiences of marginalised groups.

## **Systematic review**

The use of inpatient settings for people with intellectual disabilities has been at the centre of many debates and government policies during recent years. Research suggests that transitions into and out of inpatient settings can be challenging for people with intellectual disabilities and those that support them. To the researchers' knowledge, there are no reviews bringing together the experiences of the people at the centre of the debates around inpatient care. The aim of this project was to illuminate the voices of people with intellectual disabilities, families, and staff to understand their experiences of inpatient transitions.

A systematic review of the literature identified 14 qualitative studies that met eligibility criteria. Studies were assessed for quality and synthesised using a narrative approach in order to tell a story about the current literature. Quality of studies was mixed, but common difficulties were identified such as the lack of consideration of the relationship between researcher and participant. Two overarching themes transcended all three groups: the psychological impact of transitions and things that helped or hindered this process. The psychological impact related to distress, loss, and responsibility, but also to the positive aspects of transitions. Helpers or hinderers of this process related to support, barriers, joint working, and other contextual factors.

Results are considered in relation to attachment theory, the NHS long term plan and integrated care systems. Recommendations for clinical practice are discussed, as well as recommendations for increasing the quality of qualitative research.

## **Service-related project**

It is well known that the clinical psychology profession lacks diversity and does not represent the communities that it serves in the UK. The University of Bath's Doctorate in Clinical Psychology training programme has committed to increasing access to diverse populations. Some clinical psychology training programmes are implementing a contextual admissions process, which involves considering an applicant's achievements within their personal context (e.g. deprivation).

Stakeholders from the admissions committee were exploring how to implement contextual admissions at the University of Bath, and this project was a result of this process. The aim of this study was to explore the contextual markers of current and past Trainee Clinical Psychologists at the University of Bath in order to provide insight into how admissions processes may or may not have disadvantaged groups and how this can be improved.

81 past and current Bath trainees completed a quantitative questionnaire measuring markers of deprivation, with 48 of the sample also completing an open-ended question on the impact of contextual markers on their journey to becoming a clinical psychologist. Quantitative results revealed that 69% of participants identified at least one marker of deprivation, 46% reported at least two, 30% reported at least three, 15% reported at least four, 9% reported at least five, and 2% reported six markers of deprivation. 31% of participants reported no markers of deprivation. Context analysis of the open-ended question revealed that many participants viewed their contextual factors as posing a challenge relating to resources, identity, cultural narratives, mental health difficulties, and accessibility. Participants also acknowledged the positive impact of their contextual factors which related to support and cultural narratives.

The results informed recommendations to the course, which they are using to continue developing contextual admissions, increase diversity, and to explore how trainees can feel supported to feel safe to discuss their 'invisible' social graces.

### **Main research project**

People with intellectual disabilities have historically been treated very poorly and their rights across many aspects of their lives have been ignored. Research shows that people with intellectual disabilities desire to have meaningful and intimate relationships but often struggle to access these. As a minority within a minority, people with intellectual disabilities who identify as LGBT+ face additional barriers and their voices often go unheard. Research suggests that disclosing sexual identity, often termed 'coming out', can be an important part of identity formation, although research understanding people with intellectual disabilities' experiences is lacking.

The aim of this study was to understand the coming out experiences of people with intellectual disabilities who identify as LGBT+. 5 participants were interviewed (three gay men, one bisexual woman, and one bisexual man), and the results were analysed using interpretive phenomenological analysis (IPA). IPA was chosen as it

aims to gain a rich understanding of how people have made sense of their experiences. Three group experiential themes with six subthemes were identified: a dual identity (who am I and who can I be? Double discrimination, the power of a community), a double-edged sword: the fallout of coming out, and the coming out journey (the impact of the system, the role of a catalyst, an unfinished journey). Participants made sense of their experiences as having negative and positive aspects, much of which related to intersectionality and how they have (and continue to) navigate their identities as people with intellectual disabilities who identify as LGBT+.

We hope that the results from this study will help people supporting people with intellectual disabilities to understand their experiences better. All the participants identified the importance of a community of similar others, which often involved staff members who were curious, open-minded, and inclusive. We encourage individuals and services to be proactive in supporting people with intellectual disabilities to access education, intimacy, and relationships.



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To the centre of my universe, my baby boy Bodie. Thank you for bringing joy and so many moments of lightness amongst the darkness. Thank you for reminding me of what really matters in life and for bringing me into the present moment. I hope that my journey will encourage you to follow your dreams. Moments with you have kept me going and I have been dreaming of the days when I get to spend more time with you. You will always be my reason for everything.

## **Research appendices**

### **Literature Review Appendices**

- Appendix A: CASP Checklist for Qualitative research
- Appendix B: PRISMA checklist
- Appendix C: Full search strategy
- Appendix D: Table of records excluded at full text review
- Appendix E: Example synthesis process – identifying concepts
- Appendix F: Example synthesis – conceptual overlaps

### **Service-Related Project Appendices**

- Appendix G: Ethical approval confirmation
- Appendix H: Contextual information questionnaire
- Appendix I: Participant information sheet
- Appendix J: Debrief sheet

### **Main Research Project Appendices**

- Appendix K: Ethical approval confirmation
- Appendix L: Capacity to consent questions
- Appendix M: Study recruitment poster
- Appendix N: Information sheet
- Appendix O: Interview schedule
- Appendix P: Debrief form
- Appendix Q: IPA analysis – Exploratory notes and experiential statements
- Appendix R: IPA analysis – developing PETs
- Appendix S: Key quotes table

## **Literature Review Appendices**

### Appendix A: CASP Checklist for Qualitative research

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

## Appendix B: PRISMA checklist

Section and Topic	Item #	Checklist item	Location where item is reported
<b>TITLE</b>			
Title	1	Identify the report as a systematic review.	8
<b>ABSTRACT</b>			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	5
<b>INTRODUCTION</b>			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	9-10
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	10-11
<b>METHODS</b>			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	12
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	11
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	11 and appendix
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	13
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	13
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	13
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	13
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	N/A
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A

Section and Topic	Item #	Checklist item	Location where item is reported
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	13-14
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	13 - 14
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	13 - 14
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
<b>RESULTS</b>			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	14 - 15
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Appendix
Study characteristics	17	Cite each included study and present its characteristics.	17 - 22
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	N/A
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	15, 16, 23
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A

Section and Topic	Item #	Checklist item	Location where item is reported
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
<b>DISCUSSION</b>			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	34 - 36
	23b	Discuss any limitations of the evidence included in the review.	36 - 37
	23c	Discuss any limitations of the review processes used.	39
	23d	Discuss implications of the results for practice, policy, and future research.	37 - 38
<b>OTHER INFORMATION</b>			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	11
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	11
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	11
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	44
Competing interests	26	Declare any competing interests of review authors.	44
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

Appendix C: Full search strategy

Database	Search Terms
APA PsycNet	<p>((<b>title:</b> (qualitative)) OR (<b>abstract:</b> (qualitative)) OR (<b>title:</b> ("interpretive phenomenological analysis")) OR (<b>abstract:</b> ("interpretive phenomenological analysis")) OR (<b>title:</b> (IPA)) OR (<b>abstract:</b> (IPA)) OR (<b>title:</b> ("thematic analysis")) OR (<b>abstract:</b> ("thematic analysis")) OR (<b>title:</b> ("grounded theory")) OR (<b>abstract:</b> ("grounded theory")) OR (<b>title:</b> ("content analysis")) OR (<b>abstract:</b> ("content analysis")) OR (<b>title:</b> ("discourse analysis")) OR (<b>title:</b> ("narrative analysis")) OR (<b>abstract:</b> ("narrative analysis")) OR (<b>title:</b> (interview*)) OR (<b>abstract:</b> (interview*)) OR (<b>title:</b> ("focus group*")) OR (<b>abstract:</b> ("focus group*"))) AND ((<b>title:</b> (inpatient*)) OR (<b>abstract:</b> (inpatient*)) OR (<b>title:</b> (ward*)) OR (<b>abstract:</b> (ward*)) OR (<b>title:</b> (locked)) OR (<b>abstract:</b> (locked)) OR (<b>title:</b> (secure)) OR (<b>abstract:</b> (secure)) OR (<b>title:</b> (forensic)) OR (<b>abstract:</b> (forensic)) OR (<b>abstract:</b> (unit*)) OR (<b>title:</b> (hospital*)) OR (<b>abstract:</b> (hospital*))) AND ((<b>title:</b> (transition*)) OR (<b>abstract:</b> (transition*)) OR (<b>title:</b> (transit*)) OR (<b>abstract:</b> (transit*)) OR (<b>title:</b> (admission*)) OR (<b>abstract:</b> (admission*)) OR (<b>title:</b> (admit*)) OR (<b>abstract:</b> (admit*)) OR (<b>title:</b> (discharge*)) OR (<b>abstract:</b> (discharge*)) OR (<b>title:</b> (leave)) OR (<b>abstract:</b> (leave)) OR (<b>title:</b> (leaving)) OR (<b>abstract:</b> (leaving)) OR (<b>title:</b> (move)) OR (<b>abstract:</b> (move)) OR (<b>title:</b> (moving)) OR (<b>abstract:</b> (moving)) OR (<b>title:</b> (change*)) OR (<b>abstract:</b> (change*)) OR (<b>title:</b> (detain*)) OR (<b>abstract:</b> (detain*)) OR (<b>title:</b> (progress*)) OR (<b>abstract:</b> (progress*)) OR (<b>title:</b> (journey*)) OR (<b>abstract:</b> (journey*)) OR (<b>title:</b> (transform*)) OR (<b>abstract:</b> (transform*))) AND ((<b>title:</b> ("learning disab*")) OR (<b>abstract:</b> ("learning disab*")) OR (<b>title:</b> ("intellectual disab*")) OR (<b>abstract:</b> ("intellectual disab*")) OR (<b>title:</b> ("learning diff*")) OR (<b>abstract:</b> ("learning diff*")) OR (<b>title:</b> ("cognitive disab*")) OR (<b>abstract:</b> ("cognitive disab" *))) OR (<b>title:</b> ("cognitive diff*")) OR (<b>abstract:</b> ("cognitive diff*"))))</p>
Scopus	<p>(( ( TITLE-ABS-KEY ( "learning disab*" ) OR TITLE-ABS-KEY ( "intellectual disab*" ) OR TITLE-ABS-KEY ( "learning diff*" ) OR TITLE-ABS-KEY ( "cognitive disab*" ) OR TITLE-ABS-KEY ( "cognitive diff*" ) ) ) AND ( ( TITLE-ABS-KEY ( transition* ) OR TITLE-ABS-KEY ( transit* ) OR TITLE-ABS-KEY ( admission* ) OR TITLE-ABS-KEY ( admit* ) OR TITLE-ABS-KEY ( discharge* ) OR TITLE-ABS-KEY ( leave ) OR TITLE-ABS-KEY ( leaving ) OR TITLE-ABS-KEY ( move ) OR TITLE-ABS-KEY ( moving ) OR TITLE-ABS-KEY ( change* ) OR TITLE-ABS-KEY ( detain* ) OR TITLE-ABS-KEY ( progress* ) OR TITLE-ABS-KEY ( journey* ) OR TITLE-ABS-KEY ( transform* ) ) ) ) AND ( ( TITLE-ABS-KEY ( inpatient* ) OR TITLE-ABS-KEY ( ward* ) OR TITLE-ABS-KEY (</p>



	locked ) OR TITLE-ABS-KEY ( secure ) OR TITLE-ABS-KEY ( forensic ) OR TITLE-ABS-KEY ( unit* ) OR TITLE-ABS-KEY ( hospital* ) ) ) AND ( ( TITLE-ABS-KEY ( qualitative ) OR TITLE-ABS-KEY ( "interpretive phenomenological analysis" ) OR TITLE-ABS-KEY ( ipa ) OR TITLE-ABS-KEY ( "thematic analysis" ) OR TITLE-ABS-KEY ( "grounded theory" ) OR TITLE-ABS-KEY ( "content analysis" ) OR TITLE-ABS-KEY ( "discourse analysis" ) OR TITLE-ABS-KEY ( "narrative analysis" ) OR TITLE-ABS-KEY ( interview* ) OR TITLE-ABS-KEY ( focus AND group* ) ) ) ) AND ( LIMIT-TO ( AFFILCOUNTRY , "United Kingdom" ) )
Web of Science	"learning disab*" (Topic) or "intellectual disab*" (Topic) or "learning diff*" (Topic) or "cognitive disab*" (Topic) or "cognitive diff*" (Topic) transition* (Topic) or transit* (Topic) or admission* (Topic) or admit* (Topic) or discharge* (Topic) or leave (Topic) or leaving (Topic) or move (Topic) or moving (Topic) or change* (Topic) or detain* (Topic) or progress* (Topic) or journey* (Topic) or transform* (Topic) inpatient* (Topic) or ward* (Topic) or locked (Topic) or secure (Topic) or forensic (Topic) or unit* (Topic) or hospital* (Topic) qualitative (Topic) or "interpretive phenomenological analysis" (Topic) or IPA (Topic) or "thematic analysis" (Topic) or "grounded theory" (Topic) or "content analysis" (Topic) or "discourse analysis" (Topic) or "narrative analysis" (Topic) or interview* (Topic) or "focus group*" (Topic) English (Languages) and ENGLAND or IRELAND (Countries/Regions)
EThOS	("learning disab*" OR "intellectual disab*") AND ("transit*" OR "admission" OR "admit*" OR "discharge*" OR "leave")
Google Scholar	"learning disability" "intellectual disability" "transition" "experience" "inpatient"

Appendix D: Table of records excluded at full text review

No.	Paper	Reason for exclusion
1	Cattermole, M., Jahoda, A., & Markova, I. (1990). Quality of life for people with learning difficulties moving to community homes. <i>Disability, Handicap &amp; Society</i> , 5(2), 137-152.	Wrong research question
2	Brown, M., & Paterson, D. (2008). Out-of-area placements in Scotland and people with learning disabilities: a preliminary population study. <i>Journal of Psychiatric and Mental Health Nursing</i> , 15(4), 278-286.	Wrong research question
3	none. (2007). A survey on the learning disability service user's view of admission to an acute psychiatric ward. <i>The British Journal of Developmental Disabilities</i> , 53(104), 71-76.	Wrong study design
4	Parkes, C., Samuels, S., Hassiotis, A., Lynggaard, H., & Hall, I. (2007). Incorporating the views of service users in the development of an integrated psychiatric service for people with learning disabilities. <i>British Journal of Learning Disabilities</i> , 35(1), 23-29.	Data not rich enough
5	Sutton, P., & Gates, B. (2020). Narrating personal experience of living with learning disabilities and mental health issues in institutional and community settings: A case study. <i>British Journal of Learning Disabilities</i> , 48(4), 323-331.	Wrong research question
6	Middleton, D., & Hewitt, H. L. (1999). Remembering as social practice: identity and life story work in transitions of care for people with profound learning disabilities. <i>Narrative Inquiry</i> , 9(1), 97-121.	Unable to gain access to full paper
7	Jahoda, A., Cattermole, M., & Markova, I. (1990). Moving out: an opportunity for friendship and broadening social horizons?. <i>Journal of Intellectual Disability Research</i> , 34(2), 127-139.	Wrong research question
8	Walker, C., Ryan, T., & Walker, A. (1995). A step in the right direction: people with learning difficulties moving into the community. <i>Health &amp; Social Care in the Community</i> , 3(4), 249-260.	Wrong research question
9	McGilloway, S., & Donnelly, M. (1999). Patterns of service use among people with learning disabilities discharged from long-stay hospital care in Northern Ireland. <i>Irish journal of psychological medicine</i> , 16(3), 109-113.	Wrong study design
10	Williams, E. M., Thrift, S., & Rose, J. (2018). The subjective experiences of women with intellectual disabilities and offending behaviour: exploring their experiences of 'home'. <i>International Journal of Developmental Disabilities</i> , 64(3), 132-143.	Wrong research question
11	Colbert, T., & Bent, C. (2017). Staying Connected: Combining music therapy and dance movement psychotherapy in an acute mental health setting. In <i>Working Across Modalities in the Arts Therapies</i> (pp. 30-41). Routledge.	Wrong research question
12	Daya, A., Dhillon, J., Taylor, M., & Yildiran, H. (2011). Thematic analysis of readmission into inpatient units for adults with intellectual disabilities: Two case studies. <i>Journal of Intellectual Disabilities</i> , 15(4), 279-288.	Wrong research question
13	Scior, K., & Longo, S. (2005). In-patient psychiatric care: what we can learn from people with learning disabilities and their carers. <i>Tizard Learning Disability Review</i> , 10(3), 22-33.	Duplicate

14	Blamires, K., Forrester-Jones, R., & Murphy, G. (2017). An investigation into the use of the deprivation of liberty safeguards with people with intellectual disabilities. <i>Journal of Applied Research in Intellectual Disabilities</i> , 30(4), 714-726.	Wrong research question
15	Chester, V., Geach, N., & Morrissey, C. (2019). Treatment outcomes from forensic intellectual disability services: The perspectives of patients and their family/carers. <i>Journal of Intellectual Disabilities</i> , 23(4), 473-485.	Wrong research question
16	Alborz, A. (2003). Transitions: Placing a son or daughter with intellectual disability and challenging behaviour in alternative residential provision. <i>Journal of Applied Research in Intellectual Disabilities</i> , 16(1), 75-88.	Does not separate child from adult data
17	Barton, R. (1998). A lifelong commitment: parental memories and reflections prompted by the impending discharge of long-stay patients with learning disabilities. <i>Journal of Learning Disabilities for Nursing, Health, and Social Care</i> , 2(1), 16-22.	Data not rich enough
18	Bourne, J., Selman, M., & Hackett, S. (2020). Learning from support workers: Can a dramatherapy group offer a community provision to support changes in care for people with learning disabilities and mental health difficulties?. <i>British Journal of Learning Disabilities</i> , 48(1), 59-68.	Wrong research question
19	Jahoda, A., & Markova, I. (2004). Coping with social stigma: People with intellectual disabilities moving from institutions and family home. <i>Journal of intellectual disability research</i> , 48(8), 719-729.	Wrong research question
20	Hickman, G., Booth, N., & Hoang, T. (2018). Reflections on introducing a Leavers' Preparation Group in an intellectual disability secure service. <i>Journal of Intellectual Disabilities and Offending Behaviour</i> , 9(2), 81-90.	Unable to gain access to full paper
21	Vaughan, P. (2003). <i>Meeting the needs of adult mentally disordered offenders</i> (Doctoral dissertation, Middlesex University).	Wrong research question
22	Bartle, J., Crossland, T., & Hewitt, O. (2016). 'Planning Live': using a person-centred intervention to reduce admissions to and length of stay in learning disability inpatient facilities. <i>British Journal of Learning Disabilities</i> , 44(4), 277-283.	Wrong research question
23	Salmon, R., Holmes, N., & Dodd, K. (2014). Reflections on change: Supporting people with learning disabilities in residential services. <i>British Journal of Learning Disabilities</i> , 42(2), 141-152.	Wrong research question
24	Taua, C., Neville, C., & Scott, T. (2015). Mental health inpatient experiences of adults with intellectual disability. <i>International Journal of Mental Health Nursing</i> , 24(6), 507-518.	Wrong setting
25	Salmon, R. (2009). <i>A Qualitative Exploration of the Understanding of Rule Bound Behaviours of Staff Working with People with Learning Disabilities in Two Residential Homes (Volume 1)</i> . University of Surrey (United Kingdom).	Wrong research question
26	Di Terlizzi, M. (1994). Life history: the impact of a changing service provision on an individual with learning disabilities. <i>Disability &amp; Society</i> , 9(4), 501-517.	Wrong research question
27	Salmon, N., Garcia Iriarte, E., Donohoe, B., Murray, L., Singleton, G., Barrett, M., & Dillon, M. (2019). Our Homes: An inclusive study about what moving house is like for people with intellectual disabilities in	Wrong setting

	Ireland. <i>British Journal of Learning Disabilities</i> , 47(1), 19-28.	
28	Fish, R., & Morgan, H. (2017). Working with men who self-harm in a learning disability secure unit: Staff perspectives.	Wrong research question
29	James, N. (2016). Supporting carers during assessment and treatment unit admissions. <i>Advances in mental health and intellectual disabilities</i> , 10(2), 116-127.	Wrong research question
30	Chinn, D., Hall, I., Ali, A., Hassell, H., & Patkas, I. (2011). Psychiatric in-patients away from home: accounts by people with intellectual disabilities in specialist hospitals outside their home localities. <i>Journal of Applied Research in Intellectual Disabilities</i> , 24(1), 50-60.	Wrong research question
31	Moya, H. (2009). Identities on paper: Constructing lives for people with intellectual disabilities in life story books. <i>Narrative Inquiry</i> , 19(1), 135-153.	Wrong research question
32	Edwards, L. (2021). <i>The Elephant in The Room; Mixed Methods study of Specialist Inpatient Facilities for People with Learning Disabilities</i> (Doctoral dissertation, University of Central Lancashire).	Wrong research question
33	Rolph, S., Atkinson, D., & Walmsley, J. (2003). 'A Pair of Stout Shoes and an Umbrella': The Role of the Mental Welfare Officer in Delivering Community Care in East Anglia: 1946–1970. <i>British Journal of Social Work</i> , 33(3), 339-359.	Wrong research question
34	Chester, V., Brown, A. S., Devapriam, J., Axby, S., Hargreaves, C., & Shankar, R. (2017). Discharging inpatients with intellectual disability from secure to community services: risk assessment and management considerations. <i>Advances in Mental Health and Intellectual Disabilities</i> , 11(3), 98-109.	Wrong research question
35	McConkey, R., McConaghie, J., Mezza, F., & Wilson, J. (2003). Moving from long-stay hospitals: the views of Northern Irish patients and relatives. <i>Journal of Learning Disabilities</i> , 7(1), 78-93.	Wrong study design
36	Heppell, S., & Rose, J. (2021). Men with intellectual disabilities and sexual offending histories: an exploration of their experiences of living within a secure hospital setting. <i>Journal of Intellectual Disabilities and Offending Behaviour</i> , 12(2), 84-97.	Data not rich enough
37	Samuels, S., Hall, I., Parkes, C., & Hassiotis, A. (2007). Professional staff and carers' views of an integrated mental health service for adults with learning disabilities. <i>Psychiatric Bulletin</i> , 31(1), 13-16.	Wrong research question
38	Parkes, J. H., Pyer, M., Ward, A., Doyle, C., & Dickens, G. L. (2015). 'Going into the unknown': Experiences of male patients in secure settings during environmental transition. <i>International Journal of Mental Health Nursing</i> , 24(1), 2-10.	Wrong research question
39	Niven, A., Gamman, L., Webb, A., Goodey, R., & Shankar, R. (2020). Transforming care in Cornwall: A review of the quality of the lives of people with learning disabilities a decade post-discharge from hospital. <i>British Journal of Learning Disabilities</i> , 48(4), 315-322.	Data not rich enough
40	Booth, T., Simons, K., & Booth, W. (1989). Perspectives of people with learning difficulties on relocation and community care. <i>International Journal of Rehabilitation Research</i> , 12(2), 167-174.	Unable to gain access to full paper
41	Sheerin, F., Griffiths, C., de Vries, J., & Keenan, P. (2015). An evaluation of a community living initiative	Wrong setting

	in Ireland. <i>Journal of Intellectual Disabilities</i> , 19(3), 266-281.	
42	Fuchs, K., & Ravoux, P. (2019). Transforming care: Developing a community enhanced intervention service. <i>Advances in Mental Health and Intellectual Disabilities</i> , 13(3/4), 133-143.	Wrong research question
43	Hollomotz, A. (2021). Successful community resettlement of men with learning disabilities who have completed a hospital-based treatment for sexual offending. <i>The British Journal of Social Work</i> , 51(1), 150-169.	Wrong research question
44	Yacoub, E. (2010). Low security: patient characteristics which lead to an offer of admission and staff perceptions in a unit for people with intellectual disability. <i>Advances in Mental Health and Intellectual Disabilities</i> , 4(4), 25-34.	Wrong research question
45	Fish, R., & Morgan, H. (2021). "Them two are around when I need their help" The importance of good relationships in supporting people with learning disabilities to be "in a good space. <i>British Journal of Learning Disabilities</i> , 49(3), 293-302.	Wrong research question
46	Dalgarno, M. F., & Riordan, S. A. (2014). Forensic learning disability nursing: what's it really like?. <i>Journal of Intellectual Disabilities and Offending Behaviour</i> , 5(4), 167-177.	Unable to gain access to full paper

## Appendix E: Example synthesis process – identifying concepts

(Sean, 136–137)

Patient discharges from inpatient services were not only delayed by bureaucracy but by limitations in the community infrastructure. Participants in both the inpatient and community groups expressed frustration that there were insufficient community placements for people to be discharged to upon leaving inpatient forensic services, with packages referring to specialist forensic community placements or non-forensic community placements.

But there isn't many places to go. Or you have to get a whole new care provision.

(Barbara, 188)

Frustration and 'stuckness' permeated these experiences, with participants experiencing the demands to discharge patients, but with limited options to achieve the mandated targets of TC.

There isn't the packages out there to manage people. All the people I work with need an independent package. There's not even the physical buildings, let alone the staffing that needs to go with it, and all the policies and procedures that they need to get in place before these people go. Services all over the country are closing beds.

(Jessica, 81–84)

An additional barrier to discharges from inpatient forensic services expressed by both participant groups was patient resistance to discharge. There were several factors which appeared to elicit this, with participants noting that patients linked the prospect of discharge to a loss of attachments, belonging, and security, prompting experiences of anxiety and fear, as detailed by Bill:

So when they're leaving here, they're leaving every- thing. Security, they're leaving all the people they know...

(Bill, 253–254)

This was also noted by participants in the community group, including Joan:

You know, some people just don't want to be out of hospital.



**AH** Abigail Humphries ...

Discharges delayed by bureaucracy and lack of community infrastructure

Reply



**AH** Abigail Humphries ...

Conflict between targets of TC and infrastructure... doesn't match up

Reply



**AH** Abigail Humphries ...

SUs can be resistant to discharge due to loss of attachments, belonging, security = fear and anxiety

**AH** Abigail Humphries

Also impacted by significant time spent in inpatient services and fearful of different society/changes in society

Reply

## Appendix F: Example synthesis – conceptual overlaps

### **Loss & change (admission and discharge)**

loss of relationships – sad

loss - safety and trust

Losing support and people who knew well but also friend and peer group

lots of change, unsettling, lack of information or containment. Chaos, unfamiliar staff (loss of attachment figures)

Loss of relationships, attachment figures, containment and trust, loss of familiar place, peers

Loss of important relationships, again no effort to maintain or understand importance of attachments

discharge = losing relationships, containment, loneliness

experiencing discharge as abandonment, attachment

Admission represented loss of relationships

Loss of relationships after discharge

admission as traumatic, scary, and unsettling. new setting, difficulty with being around unknown others

Reluctance to leave once settled

Misunderstood by staff after discharge. Very unsettling and communicating distress

Feeling insecure after transition (loss of attachments)

## Service-Related Project Appendices

### Appendix G: Ethical approval confirmation

21-020

😊 ⏪ ⏩ ↶ ↷



○ psychology-ethics <psychology-ethics@bath.ac.uk>

Tuesday, 20 April 2021 at 15:57

To: ● Abigail Humphries

Cc: ☉ Cathy Randle-Phillips ↕

Dear Abigail

**Full title of study:** Inclusivity within the Profession of Clinical Psychology: An Exploration of Contextual Markers in Trainee and Qualified Clinical Psychologists.

**PREC reference number:** 21-020

On behalf of the Committee, I am pleased to confirm that you have received a favourable ethical opinion for the above proposal from the Psychology Research Ethics Committee.

However please be aware that a researcher (or supervisor in the case of UG or Masters students) is responsible for ensuring full GDPR compliance. Please seek further advice from [dataprotection-queries@lists.bath.ac.uk](mailto:dataprotection-queries@lists.bath.ac.uk) if you have any concerns.

Under current Covid restrictions, if you are proposing lab based or field research involving in-person testing you will also need to get approval from the Psychology Research Restart Group (PRRG) before you can start to gather data. More information can be found here:

<https://wiki.bath.ac.uk/display/PC/Psychology+COVID-19+Home>

If you intend to display recruitment posters/materials, please ensure you obtain the appropriate permission to do so from those who manage the location(s) you choose.

Please inform PREC about any substantial amendments made to the study if they have ethical implications.

Please make sure you quote your unique PREC code, 21-020, in any future correspondence.

Rebecca Wise

On behalf of Psychology Research Ethics Committee



## Appendix H: Contextual information questionnaire

Please answer the following questions. Some of the questions may not apply to you, in which case please tick 'not applicable'.

### **1 First generation to go to university**

Are you the first generation in your immediate family to attend university?

Yes / No / Prefer not to say

Your immediate family is your parents and grandparents. If none of them went to university you can answer "yes", even if your brother or sister went to university (because your siblings are the same generation as you).

### **2 Free school meals**

Were you eligible for free school meals during your school years?

Yes / No / Not applicable / Prefer not to say

This question is designed to assess food poverty. If you did not have access to the free school meal system, then you can answer yes if your family was short of food during your school years. If free school meals were offered as standard in your location of education then please indicate 'not applicable'.

### **3. Income Support**

Did your household receive income support during your school years?

Yes / No / Not applicable / Prefer not to say

### **4. Looked after by local authority**

At any point, between the ages of 0 and 18 years, were you in care or looked after by a local authority for at least 3 months?

Yes / No / prefer not say

### **5 Estranged students**

At any point, between the ages of 0 to 19 years, did your relationship with your family breakdown to the point where you were estranged from and or lived apart from them for at least 6 months?

Yes / No / Prefer not to say

## **6 Young carers**

Did have caring responsibilities for a parent, child, or other relative for a year or more, between the ages of 11 and 19?

Yes / No / Prefer not to say

(Caring responsibilities include providing care to an individual with additional needs in relation to e.g. disability, physical or mental illness, drug or alcohol problems).

## **7 Refugee Experience**

Have you been recognised as a refugee by the UK government **or** have you been granted Humanitarian Protection by the UK government?

Yes / No / Prefer not to say

## **8 Participation in other programmes**

Please indicate if you received or participated in any of the following programmes for your previous higher educational experience?

- Did you receive an undergraduate degree offer on the basis of adjusted results for A Levels / Highers (or other equivalent school qualifications)?  
(This is usually something you would have applied and been accepted for through a University Access or Widening Participation scheme, alongside your application for your undergraduate degree).

Yes / No / Prefer not to say

- An income related bursary whilst you were an undergraduate

Yes / No / Prefer not to say

- Financial support for post-graduate education (e.g. a funded MSc). With the exception of bursaries attached to PhDs.

Yes / No / Prefer not to say

9 Please tell us anything you feel is important about the impact of contextual factors on training to be a clinical psychologist (e.g., impact on pre-training, impact on training experience, acknowledgement of factors before/during training). If you would prefer not to answer this question, please type N/A.



**Inclusivity within the Profession of Clinical Psychology: An Exploration of Contextual Markers in Trainee and Qualified Clinical Psychologists.**

**Participant Information Sheet**

**Who am I?**

My name is Abigail Humphries, and I am a Trainee Clinical Psychologist at the University of Bath. I am conducting this study as part of my Service-Related Project.

**What is this research project about?**

Many clinical psychology training programmes are developing blind and contextual recruitment processes. This is based on evidence that contextualising individuals' achievements using information about their educational and social background can lead to fairer and more inclusive selection processes. This research project aims to explore the contextual information and markers of deprivation that past and present University of Bath DClInPsy students have experienced. You have been chosen to participate as you are a current DClInPsy trainee or have previously trained at the University of Bath.

**What will I be asked to do?**

If you take part, you will be asked to complete a short questionnaire about your background and experiences pre-training. The study will take approximately 10-15 minutes to complete.

**Do I have to take part?**

Participation in this research is entirely voluntary, and you are free to make your own choice about whether you want to participate. If you decide to take part, you may skip any questions that you do not feel comfortable answering. You are free to withdraw at any time before completing the study, by selecting the withdraw button that is present on each page. If you choose to do this, you will be asked whether you consent to us using the data that has already been collected. Due to your data being collected anonymously, you will not be able to withdraw your data once you have completed the study.

**Will my taking part in this research be kept confidential?**

If you take part, your data will be collected anonymously. This means there will be no way to trace the information back to you or identify you personally. Only the researcher directly involved in the study and their supervisor will have access to your data and this will not be personally identifiable.

**What will happen to the information I provide?**

Once the project is completed, the information you have given to me will be kept safely by the University of Bath. If you give your consent, it may be used by other genuine researchers, with the University of Bath's approval, under the strict rules governing the confidentiality of your information.

### **What will happen to the results of this research?**

The information you provide may be used to inform the implementation of contextual recruitment processes for the DClinPsy at the University of Bath. It will be used to provide a baseline before contextual admissions processes are introduced. The findings of the research may also be published in research journals or used in presentations.

### **University of Bath privacy notice**

The University of Bath privacy notice can be found here: <https://www.bath.ac.uk/corporate-information/university-of-bath-privacy-notice-for-research-participants/>.

If you would like to find out any more information about the study or if you have any questions, please do not hesitate to contact:

Abigail Humphries  
Trainee Clinical Psychologist  
[Ah2769@bath.ac.uk](mailto:Ah2769@bath.ac.uk)

Dr Cathy Randle-Phillips  
Clinical Tutor/Lecturer  
[c.m.randle-phillips@bath.ac.uk](mailto:c.m.randle-phillips@bath.ac.uk)

### **Inclusivity within the Profession of Clinical Psychology: An Exploration of Contextual Markers in Trainee and Qualified Clinical Psychologists.**

Thank you for taking part in this project. The aim of this project is to explore the contextual information and markers of deprivation that past and present University of Bath DCLinPsy students have experienced.

Despite efforts to increase the inclusivity and diversity within the clinical psychology profession, current trainees do not currently reflect the diverse populations that they serve (Turpin & Coleman, 2010). It has been suggested that using contextualised information in the higher education admissions processes will help to address the underrepresentation of applicants from less advantaged socio-economic backgrounds (Boliver, Gorard & Siddiqui, 2015).

The questions you were asked to answer were taken from a form developed by the selection sub-group of The Group of Trainers in Clinical Psychology. The form was originally developed to be used as part of the central application process managed by Leeds Clearing House. Some courses will be using the information provided on this form to inform their selection processes later this year, whilst others will be using this information for audit purposes only. Some programmes will not be using this form.

We hope to use the data from this project to support the implementation of contextual recruitment for the Doctorate in Clinical Psychology at the University of Bath.

Your data will be used as part of a doctoral Service-Related Project and may be used in further published work. However, no identifying information will be included.

If you have any further comments or questions, please do not hesitate to contact:

Abigail Humphries  
Trainee Clinical Psychologist  
University of Bath  
[Ah2769@bath.ac.uk](mailto:Ah2769@bath.ac.uk)

Dr Cathy Randle-Phillips  
Clinical Tutor/Lecturer  
University of Bath  
[c.m.randle-phillips@bath.ac.uk](mailto:c.m.randle-phillips@bath.ac.uk)

#### References:

- Boliver, V., Gorard, S., & Siddiqui, N. (2015). Will the use of contextual indicators make UK higher education admissions fairer?. *Education Sciences*, 5(4), 306-322.
- Turpin, G., & Coleman, G. (2010). Clinical psychology and diversity: Progress and continuing challenges. *Psychology Learning & Teaching*, 9(2), 17-27.

If you have any concerns related to your participation in this study please direct them to the Chair of the Department of Psychology Research Ethics Committee, email: [psychology-ethics@bath.a.uk](mailto:psychology-ethics@bath.a.uk).

# Main Research Project Appendices

## Appendix K: Ethical approval confirmation

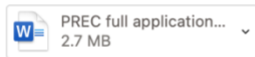
23 035



psychology-ethics <psychology-ethics@bath.ac.uk>

Thursday, 4 May 2023 at 14:31

To: Abigail Humphries



[Download](#) · [Preview](#)

Dear Abigail,

**PREC** reference number: 23 035

On behalf of the Committee, I am pleased to confirm that you have received a favourable ethical opinion for the above proposal from the Psychology Research Ethics Committee.

Please be aware that a researcher (or supervisor in the case of UG or Masters students) is responsible for ensuring full data protection compliance. Please seek further advice from [dataprotection-queries@lists.bath.ac.uk](mailto:dataprotection-queries@lists.bath.ac.uk) if you have any concerns.

Please inform **PREC** about any substantial amendments made to the study if they have ethical implications.

Please make sure you quote your unique **PREC** reference number in any future correspondence

Yours sincerely,  
Toby Wellington

Appendix L: Capacity to consent questions

	Demonstrated understanding?	
	Yes	No
<b>What is the study about?</b> <i>Mentions what it was like to come out/being LBGT</i>		
<b>What will you be asked to do?</b> <i>Mentions answering questions/doing an interview/talking about coming out</i>		
<b>Do you have to take part?</b>		
<b>Can you change your mind and stop taking part if you want to?</b>		
<b>Will the interview be recorded?</b>		
<b>Will your information be kept private so that other people won't know your answers?</b>		
<b>Will the researcher write about the findings?</b>		





## Do you identify as LGBT and have a learning disability?

Are you 18+ years old?

Would you like to take part in a study?

I would like to ask you some questions about:



- Coming out
- What it is like to identify as LGBT



It will take about 1 hour.

To say thank you, you will receive a £20 Amazon voucher.

If you would like to take part, or would like to have a chat about the study, you can email Abi:

Email: [ah2769@bath.ac.uk](mailto:ah2769@bath.ac.uk)



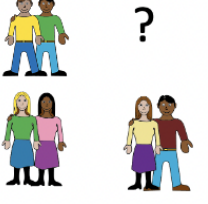



Ethics approval code: 23035

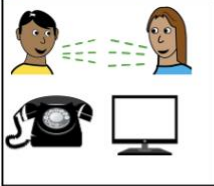

With thanks to Easy on the I for the use of their image bank - All Images/Resources copyright © LYPFT


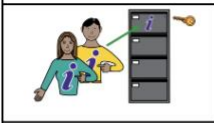




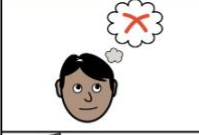

## Appendix N: Information sheet



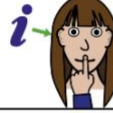

### Information sheet: Identifying as LGBT and having a learning disability








	<p>We want to know what it is like for people with learning disabilities to be lesbian, gay, bisexual, or transgender (LGBT)</p> <ul style="list-style-type: none"> <li>• Lesbian means women who are attracted to women</li> <li>• Gay means men who are attracted to men</li> <li>• Bisexual means people who are attracted to both men and women</li> <li>• Transgender refers to people who are now a different gender to the gender that they were given when they were born.</li> </ul>
	<p>We hope this helps us to:</p> <ul style="list-style-type: none"> <li>• Support people with learning disabilities who identify as LGBT</li> <li>• Know more about the lives of people with learning disabilities</li> </ul>
	<p>This study involves talking to a researcher. They will ask you questions about coming out as LGBT.</p>
<p><b>1 hour</b></p> 	<p>This will last up to 1 hour.</p>

	<p>This will be face to face, a video chat, or over the phone.</p>
	<p>It will be recorded. This so the researcher can remember what you say.</p>

	<p>To take part you must be:</p> <ul style="list-style-type: none"> <li>• An adult (18 years or older)</li> <li>• Have a learning disability</li> <li>• Identify as LGBT</li> </ul>
	<p>Information will be kept in a safe place on a computer. We will not use your name.</p>
	<p>4 weeks after the interview, the researchers will write down everything that you said.</p>
	<p>Then they will delete the recording.</p>

	<p>After that, we will not know whose interview is whose. You can drop out of the study up until this time (4 weeks).</p>
	<p>The project has been checked by a group of other researchers (an ethics committee). This is to make sure it is safe.</p>

	<p>People who take part will get a £20 Amazon voucher. This is to say thank you for their time.</p>
	<p>You can bring a support person if you want to. This can be anyone that you feel comfortable with.</p>
	<p>We know that sexual or romantic feelings are private.</p>
	<p>If there is a question you don't want to answer, <b>you can say no.</b></p>

	<p>You can <b>stop</b> the interview at any time.</p>
	<p>If you would like to take part, please email the researcher.</p>
	<p>You can ask the researcher questions about the study.</p>
	<p><b>You can choose</b> if you want to take part.</p>
  	<p>The researchers details are:  Abi Humphries (Trainee Clinical Psychologist)  Department of Psychology  Email: <a href="mailto:ah2769@bath.ac.uk">ah2769@bath.ac.uk</a></p> <p>Abi's supervisor's details are:  Dr Cathy Randle-Phillips (Senior Lecturer and Clinical Psychologist)  Department of Psychology  Email: <a href="mailto:cmd46@bath.ac.uk">cmd46@bath.ac.uk</a></p>
	<p>Ethics approval code: 23035</p>

### **Semi – structured Interview schedule**

Main questions are in bold text. Possible follow-up questions are in italics. X will be replaced by the label the participant identifies with, using their language (e.g., gay, lesbian, bisexual, trans etc.)

Introductions:

- Thanking for participating in study
- Reminding what the study is about
- Going through main points on the information sheet (e.g. not having to answer questions if don't want to, breaks, ending at any point etc.)
- Clarifying identification – e.g., “we are going to talk about coming out today. I wonder if we could start by thinking about which words you use to identify yourself. {What gender do you identify as? What is your sexual orientation?} – if needed
- Check okay to start

#### **Where did you learn about sex and relationships?**

*Did you have sex education in school? If so, what was it like?*

*Did anyone ever talk to you about same-sex relationships/trans?*

*Did your friends talk about same-sex relationships/trans?*

*Did you/do you know how to find out about sex and relationships?*

*Do you think you had the same information as someone without a learning disability?*

#### **Can you tell me about when you first knew you were X?**

*How old were you when you realised you were X?*

*How did you know you were X?*

*How did you feel about being X?*

*Did you tell anyone?*

#### **How did you decide to come out?**

*How old were you when you came out?*

*How did you decide who to tell?*

*Did anyone help you?*

*How did you feel about coming out?*

*What did you think people would say/how did you think people would react?*

#### **How did you come out?**

*Who did you tell first?*

*How did you feel when you came out?*

*Did you come out to all the people in your life at once?*

*How did people react when you came out?*

*How did you feel after you came out?*

*Was there anything that made it easier or harder to come out?*

**Can you tell me about how life was after you came out?**

*Did anything change after you came out?*

*Did anyone support you to find sex or relationships?*

*Did people treat you differently after you came out?*

*Do you think you came out at the right time?*

*Would you change anything about coming out?*

*Do you think coming out is different for people who don't have a learning disability?*







**Is there anything else about coming out that you'd like to talk about?**

Appendix P: Debrief form



**Debrief form:  
Identifying as LGBT and having a learning disability**

	<p>Thank you for taking part in this study!</p>
	<p>The aim of this research is to understand what it is like for people with a learning disability who identify as LGBT.</p>
	<p>The researchers will now listen to the audio recording of this interview. They will write down everything that you said. They won't use your real name.</p>
	<p>Then the recording will be deleted. After the recording is deleted, you won't be able to withdraw from the study. This is because we won't know whose interview is whose.</p>
	<p>You have 4 weeks to withdraw from the study. 4 weeks from today is .....</p>

	<p>We hope you found the study interesting.</p>
	<p>We hope the findings will help us to support people with learning disabilities in their relationships.</p> <p>We hope the findings will let us hear about being LGBT from the viewpoint of people with a learning disability.</p>
	<p>We hope that you enjoyed taking part in the study.</p>
	<p>If you found it difficult or upsetting, you can talk to the researcher if you want to.</p> <p>You can also talk to the LGBT foundation:</p> <ul style="list-style-type: none"> <li>• Telephone: 0345 3 30 30 30</li> <li>• Email: <a href="mailto:info@lgbt.foundation">info@lgbt.foundation</a></li> </ul>
<p><b>GP practice</b></p> 	<p>You can talk to your GP if you would like support with your mental well-being.</p>
	<p>If you have any questions about the study, please contact the researchers. Here are their contact details:</p> <p>Abi Humphries  Trainee Clinical Psychologist  <a href="mailto:Ah2769@bath.ac.uk">Ah2769@bath.ac.uk</a></p> <p>Dr Cathy Randle-Phillips  Clinical Psychologist and Senior Lecturer  <a href="mailto:Cmd46@bath.ac.uk">Cmd46@bath.ac.uk</a></p>



Appendix Q: IPA analysis – Exploratory notes and experiential statements

*Longing for normality*

You know, he's done everything before me because he's smarter than me because he went to grammar school. And he doesn't have my condition at all.

*Feels things are out of order because Darren has disability + brother does not. He has fulfilled life goals + Darren has not. Feels disabled because of this.*

**Abigail Humphries** 17:44  
Gosh, so that can cause a bit of conflict between you both?

17:50  
Yeah, I think he, I think he had to think twice before he brought a friend home or a girl home. When we both lived at home. Cuz... I think he would be... worried about how it would look if his girlfriend or his friend met me. And my disability isn't hidden. You can see that I'm different from the outside.

*Felt unaccepted by family as well as wider society due to disability*

*Feels his brother is embarrassed of him. Disability is visible*

*Feels different to others.*

**Abigail Humphries** 18:25  
Gosh, that must be hurtful.

18:29  
He would never say anything but, it's the way it looks.

*Unspoken tension in the family.*

**Abigail Humphries** 18:40  
Do you think your disability has... Would affect what your family might think about you being bisexual?

*Feels Family doesn't perceive bisexuality as abnormal + undesirable.*

18:51  
Yeah, they'd probably think another thing that's wrong with me.

*His family perceive things about him as deficits or anomalies (cumulative effect of disability + sexuality). "Abnormal" = 2 diff. different categories*

**Abigail Humphries** 18:59  
Gosh, that's really sad, Darren.

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Appendix S: Key quotes table

<b>Group Experiential Theme</b>	<b>Subthemes and quotes</b>
<b>A dual identity</b>	<p style="text-align: center;"><b>Who am I and who can I be?</b></p> <p>“(…) people without a disability, seem to know who they are and be able to talk about it more.... I think a lot of people think that people with disabilities don't have our own voices. Like a lot of people have a stigma about disability.” Leanne</p> <p>“Because with my disability, I don't really know the differences between friendships and a relationship.” Leanne</p> <p>“Massive difference. You don't have a learning disability. You're fine.” James</p> <p>“Massive [difference]. If you're able to do stuff without support, the world's your oyster.” James</p> <p>“And again, she said to me. Ohh yeah that means you are bi because you've actually been in a relationship with someone.” Leanne</p> <p>“Because with my disability, I don't really know the differences between friendships and a relationship. So I never really. I got on really well with a lot of females...” Leanne</p> <p>“I think it is because people with learning difficult probably a bit more nervous than people without learning difficulties.... I think shyness probably maybe” David</p> <p>“It is different to them. Most of them will be able to find out themselves.</p>

And...probably be more confident. Because they know they... They don't have a disability. Therefore they know what they're saying is right. Someone with a disability may think they are LGBTQ but they might be wrong." Darren

### **Double discrimination**

We had to go on web chat or something like that. That was very frustrating for me with someone with a disability and you'd have to keep messaging. I'm like sorry I mean this and... my spelling's not that good. And then I get frustrated and anxious." Ronnie

"Like we [PWID] should be treated that we've got our own voice. We should be able to voice our own opinion. Some of us, it might take us a little while to do it. But we should still be given that opportunity. Then they'll be able to understand us a bit better and actually take the time out to actually talk to someone and listen to them." Leanne

"There's absolutely nothing [support to find relationships] I can say that with hand on my heart cause I've Googled. I've looked. I've gone to places. You struggle to even find somebody cause I've got to do it a certain way. I can't go on this. I can't go on that." David

"I've got disabilities...um, I used to let it become a barrier. Also cause I was gay as well." Ronnie

"...I think we'll always will be fighting for equality for LGBT because once we've sorted 1 issue out, or you know, they'll be, they'll be another one. And then after something else and then we'll be fighting for equality on another issue. And another issue after that." Ronnie

"I, I don't think my family would accept it. Dad's pretty old school. And umm, I just don't think they'd accept it..I don't think dad actually likes me anyway. Because of my disability." Darren

	<p style="text-align: center;"><b>The power of a community</b></p> <p>“We were having a discussion about pride, and our leader said it was open mainly for people who felt that they needed to, like tell people who they were. But I then said to the leader, I think I might be bisexual. Could I please, like, join? And she said to me, ‘well done for coming out like that it’s a big step’.” Leanne</p> <p>“I know Facebook can be very toxic. We all know that. Because when I've said I'm struggling with my mental health or, you know, as an example, and I know we're talking about LGBT. People go “ohh Ronnie you're doing so much good work in the community. We we all love you.” Ronnie</p> <p>“To do with community members and stuff that I'm doing now, I don't get nothing like that now [abuse]” Ronnie</p> <p>“I just realised that I wanted to come out to be honest, and I let know and she, she's been helping me with that.” David</p>
<p><b>A double-edged sword: the fallout of coming out</b></p>	<p>“I said when I first said to him, I think I'm bisexual. it sort of seemed a bit...like...offish and he seemed to like it. Accept it. And then when I told him I was gay... I got a card with money in it. Must have posted it, begged off in the car and sped off and I haven't heard from him since the age of 18.” Ronnie</p> <p>“It was hard at first, but I don't know if it took me months, It took me years but. I'm okay without him now.” Ronnie</p> <p>“We all deserve the support that we all deserve, whether we're LGBT, ethnic minority, heterosexual, disability, we should all be treated fairly regardless, race, religion or sexual orientation.” Ronnie</p>

	<p>“Well, I said somebody. Why did you keep saying I'm going through this phase? It's not a phase it. It's true. And she goes its cos I've never really seen you in a relationship with a female before. (...) maybe I should just keep quiet again, not tell people because like the more I was telling people and the more I was feeling happy about it, the more they were making it into a negative thought.”</p> <p>Leanne</p> <p>After a while, I don't know whether it was months or years. I'm not sure, but after a while. He started to accept my partner... He respected him and he liked him. And then...Now we started to bond me and my X, we used to do things together anyway, but then we never, you know, like when families argue and bicker and stuff like that. But then we became closer.”</p> <p>Ronnie</p> <p>“Like I think cos I've lost already lost 3 friends by being open and honest about my sexuality.”</p> <p>Leanne</p> <p>“I felt like a weight has been lifted off of my shoulders. The fact that I could be open and honest about it without having to hide away, like in the background.”</p> <p>Leanne</p>
<p><b>The coming out journey</b></p>	<p style="text-align: center;"><b>The impact of the system</b></p> <p>“They don't think people with disabilities should... be allowed to obviously date or have a relationships. And...You know that was...That obviously would have knocked me back for a bit of time. (...) you couldn't hold hands with opposite sex, so you couldn't obviously do it with the same sex.”</p> <p>James</p> <p>“...books or anything in school or college or anything, or in the library about...like...how to tell who you really are. Well they have books like who am I? But again, that's like. Like who you are as a person...not, like who you are as a sexuality.”</p> <p>Leanne</p>

“Casual sex not allowed at all. And you don't wanna know how much that frustrates me.” James

“It [sex education] was basically don't hold hands. These are the parts of the body. Stranger danger, still at seventeen, sixteen, talking about stranger danger ha!”

“I think back then...I'll probably would have understood what it meant and where to go...if there would have been... like cause I can now these days there's like, they talk about LGBT in schools but back then there wasn't.” Ronnie

“It's kinda like I've always had to do that with my life like. From having a disability. And it's kind of like the same sort of thing with the sexuality is...I just pretend to be normal when I'm out.”  
Leanne

“Again, I don't think many people in my family would accept...Accept if I was in a relationship. Like with a girl. Like I think a lot of the family would be. Like not like...Acceptable. So I think it's just easier just to not bother.” Leanne

“I think that I think...I said could you help me to understand the differences between the sexualities and she said I don't know how to explain it.” Leanne

“And you know. I just feel like I had to... copy my mates and what they did and stuff like that, so yeah.” David

“I felt....odd.

I mean at that time it was still a taboo subject. “ Darren

### **The role of a catalyst**

“I think this guy may have changed me. I've never actually...Up until that time I've never been attracted to any guy. I was always

just focused on girls. But up until that point I don't think I was that... I think he changed my, changed it." Darren

"Uh... Just me being myself really. It's just like, in past I often feel like I had to be somebody else, but when I lived in London, I had to be... I felt like I couldn't be myself I had to be somebody else."

David

"...cause I've had um issues in the past where um I went out with the girls but they cheated on me in the past so."

Interviewer: "Do you think that's [being cheated on] got anything to do with being gay?"

"Yes, it's probably cause I, I had trust issues then." David

"And during covid, that's when I really did realise, this is who I am and this is what I wanna be." James

### **An unfinished journey**

"If you're male, you can't look at a man constantly like you'd look at a girl. Cos it doesn't look good. And that man might not be gay he might be straight as a dye. And if he found out he wouldn't like it."

Darren

"I sometimes do it, but I'm slowly, like, starting to get there."

Leanne

"I wish I was able to be like... I wish I didn't have to hide away from the world. I wish I was able to just tell people." Leanne

I'll just play it, just play it by ear. Just let nature take its course. Really." David

"Oh um....there's various dating agencies.



	<p>And Facebook. Plenty of Fish. Tinder. And you just dating by 50, Angel. On Facebook. And I'm under a dating agency called Meet and Match. And I'm still single. That's how that's going." Darren</p>
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