

## **Sexual well-being and physical disability**

**Sally Lee & Lee-Ann Fenge, Bournemouth University**

### **Abstract**

The meaning of sexual well-being for physically disabled people is a little researched area of social work practice. The traditionally hidden nature of sexuality and sexual well-being in disability research means that practitioners have little evidence based guidance to help offer inclusive person-centred care. Because sexual well-being is a sensitive topic, and one which professionals can feel uncomfortable discussing, the absence of guidance reinforces the barriers to its inclusion in practice. So, although sexual well-being is potentially one of the most meaningful aspects of human life, it has rarely been addressed in health and social care practice (Taylor, 2011). As a result disabled people can experience discrimination regarding their sexual well-being, with the notion of asexuality or deviance remaining prevalent in their personal accounts. Sexuality and sexual relationships are often the source of disabled people's deepest oppression and therefore should be the focus for disability action (Shakespeare, 2000).

This paper will explore the importance of sexual well-being to personal identity, self-esteem and mental and physical well-being. This is particularly relevant to the context of social work with adults in England which is underpinned by the Care Act (2014) with its focus on promoting well-being. Issues for practitioners and future research will be identified.

### **Introduction**

This paper emerges from a larger literature review as part of doctoral study, exploring physical disability, sex, social work and well-being, which revealed the limited information specifically related to social work with disabled people and sexual well-being. When issues related to sexual well-being do arise in social work practice they are often focused on risk or negative sexual experiences (Shildrick, 2007, Myers and Milner, 2007), rather than the positive aspects of sexual expression linked to well-being. A key focus of the paper concerns sexual citizenship. A rights approach to social work alters the narrative from one of negative conception of dependency to a positive one of empowerment and entitlement

to full participation, including sexual citizenship. In terms of sexual well-being this requires social workers to:

'apply concepts of sexual citizenship and sexual rights to physically disabled people, emphasising the right to be free from abuse and the right to information' (Grossman et al, 2003, p95).

Sexual well-being is an issue of global significance and therefore of interest to an international audience. The World Health Organisation's holistic definition of sexual health encapsulates its multi-faceted nature including mind, body and environment demonstrating the centrality of sexual issues to human life and well-being:

"Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction."  
(World Health Organisation 2012 p6)

With the introduction of The Care Act (2014) in England, underpinned by the well-being principle, social workers are required to assist with the issues which impact on overall well-being, that is with concerns which really matter to individuals and their networks of support but one which may not feature in policy guidance. The literature indicates that sexual well-being is such a concern.

By demonstrating the link between sexual well-being and the well-being principle, this paper contributes evidence to both alert practitioners to the importance of sexual well-being, but also to support them in the inclusion of sexual well-being within Care Act assessments and other work. For although sexual issues have been traditionally problematic in social work practice with disabled people (Bywater and Jones, 2007), a strength of social work is its willingness to engage in sensitive subjects (Bywaters and Ungar, 2010).

## **Background to the review**

The larger literature review and research study arose from a practice question raised by a young disabled man, living in a rural area. He wished to gain further sexual experiences, but was frustrated by limited opportunities and funds to socialize, as well as his perception of other's attitudes towards him as a potential romantic partner. The stress arising from his situation and the frustration he experienced had a profound impact on his physical and emotional well-being. Searching for information and others ways of assisting him revealed the dearth of guidance available to disabled people and social work practitioners, and therefore the need to undertake a review to explore whether this gap in knowledge is replicated in the literature.

As this paper is situated within social work practice, the definition of physical disability used corresponds to the definition used in practice:

A person (P) has a disability if –

- a) P has a physical or mental impairment, and
- b) The impairment has a substantial and long term adverse effect on P's ability to carry out normal day-to-day activities (Equality Act 2010, Section 6 (1)).

However, this definition situates disability within the individual, without acknowledging the disabling socio-political context. Therefore to signify our alignment with the social model of disability, the term disabled people is used within this paper. This indicates that people are disabled by social context rather than any impairment, but does not deny that impairment has a significant impact. Theoretically the social model has been widely adopted by social work in its approach to physical disability, and reflects the profession's commitment to social justice declared in professional value and ethic statements (BASW, 2012). Yet, whilst individual workers may be committed to this model, and its developments such as the citizenship and affirmative models, the social structures within which social work operates limits what can be truly achieved.

### **The implications of legislation including the Care Act (2014) on social work practice**

The Care Act (2014) embeds the concept of well-being into social work practice with adults and provides the opportunity for social workers to creatively explore what impacts on well-being. The well-being principle 'creates a new statutory principle which applies to all the functions under Part 1 of the Act (including care and support and safeguarding), and means that whenever a local authority makes a decision about an adult, they must

promote that adults' well-being. However, well-being is a complex concept involving subjective and objective dimensions. It tends to be defined in two related ways: hedonia involving pleasure, and eudaimonia involving notions of living a meaningful life or flourishing (Gleibs, et al, 2013). As such it is a contested term, a social and cultural construction defined by the agent employing it (Ereaut and Whiting 2008). Every definition has implicit values, but each rests on what the definer thinks it means to be human, specifically a 'whole and well human' (Sarvimaki, 2006). This openness to interpretation leads to potential variation in application (Webber and Rickard, 2013). The government's vision of well-being for social care was set out in the White Paper, Caring for Our Future: Reforming Care and Support (2012) and the subsequent The Care Act (2014) which uses a definition of well-being relating to ten domains:

- personal dignity,
- physical mental and emotional health,
- protection from abuse and neglect,
- control over day to day life,
- participation in work, training and recreation,
- social and economic well-being,
- relationships,
- sustainable accommodation and
- contribution to society (Skills for Care; 2014).

These domains coincide with definitions used across other departments (Webber and Rickards, 2013) but also include aspects of particular significance to the operation of adult social care such as protection from harm and control over day to day life. The application of the well-being principle has the potential to reframe social work with adults with the concern for human well-being driving practice, allowing compassion to flourish.

## **Methods of the review**

This paper is informed by a literature review undertaken as part of a doctoral study into sexual well-being and physical disability by one of the authors. A systematic approach using key terms and data bases was used to gather literature around sexual well-being and physical disability including grey literature (blogs, campaign literature, media articles). Because the study was located in social work practice in the UK, the search focused from 1997 onwards to correspond with the reform of social care instigated by The Modernising

agenda. Therefore only seminal literature published before that time was included and only English text were searched.

Key terms included: sexual well-being, well-being, disability/ physical disability and sex, sexuality and disability/physical disability, sexual well-being and disability/physical disability, relationships and disability/physical disability.

Databases searched: Academic Search Complete, Bournemouth University Research Online, CINHAL Complete, Cochrane Library, Ebrary Academic Complete, Google Scholar. In addition the journals *Sexuality and Disability* and *Disability and Society* were hand searched and websites including *Community Care* and *Disability Now* were explored. This process yielded a total of 191 articles and reports all of which have been read as part of the wider study.

The search results a diverse range of sources, and was read critically using the Critical Appraisal Skills Programme (CASP, 2012) qualitative research appraisal checklist as a guide to assess the quality of the information and reveal the underpinning assumptions. Although the focus was on qualitative research due to the nature of the overarching doctoral research project, the search did not exclude any information which contributed to a thorough appreciation of the topic.

## **Findings**

### **Professional's discomfort discussing sex**

The notion of professional discomfort is a recurring point within the literature (Walters and Williamson, 1998; Guest, 2000; Weerakoon, 2001; McLaughlin and Cregan, 2005; Shuttleworth, 2010; Dyer and Das Nair, 2013; Blackburn et al, 2015). The barriers cited include fear of embarrassment, lack of time, lack of training and policy guidance, fear of not knowing what to do, fear of overstepping professional boundaries or fear of illegality and safeguarding concerns. Professionals still have difficulties recognizing patients and service users as sexual beings with the same sexual needs as others (D'ardenne, 2004; Kaufman, 2007; Owens, 2015). This reflects societal attitudes to both sex and disability which are so ingrained that overcoming inhibitions requires conscious effort and overt permission. Sexual activity is an important part of life at all stages of the adult lifecourse, and sexual satisfaction, touch, intimacy and love is directly related to the quality of life (Walters and Williamson, 1998; Tepper 2000; Browne and Russell 2005; Wiegerink et al, 2006). However service users often express relief and appreciation when professionals affirm their sexuality through discussion, and rarely find such discussions inappropriate

(Walters and Williamson, 1998; Aizenberg et al., 2002). Professionals need to feel confident and comfortable with their own sexuality if they are to be helpful to others, and this includes recognising their own and other's values (Medlar, 1998, Weerakoon, 2001).

The preparedness to discuss difficult and sensitive subjects can be viewed as a professional strength for social work (Bywaters and Ungar, 2010), but requires confidence and the provision of quality information and training. It is important that practitioners develop awareness of sexual well-being to enable sexual citizenship and the empowerment of disabled people. This will enable people with disabilities to protect themselves by raising awareness, confidence and sexual self-esteem.

### **Sexual well-being, self and identity as a disabled person**

Sexual well-being relates to how people experience their lives, specifically their sexual selves and human relationships. Well-being is not only the absence of problems or the presence of happiness, but concerns the person's experience of self-actualisation, social integration, expectation and equality of potential – mind, body and environment (Local Government Improvement and Development Report, 2010). The importance of sexual pleasure to personal identity, self-esteem and mental and physical well-being is an important aspect of this.

The dearth of realistic and positive cultural representations of sex and disability contributes to the 'otherness' of disabled people and increases fear and ignorance (Wendell 1996, Owens, 2015). For example the film *Me Before You* (2016) has been criticized by disabled people for being 'disability death porn' (Crippledscholar, 2016) and portraying death as being preferable to disability (Gilbey, 2016). This adds to the negative effect of impairment by making the loss or absence of positive body image negatively impact on the person's sense of their sexual allure (Walters and Williamson, 1998). Sexual and body esteem and sexual satisfaction are strong predictors of self-esteem and depression amongst disabled people (Taleporos and McCabe, 2002). Body changes as a result of physical impairment have been linked to anguish over changes in appearance and body image resulting in individuals withdrawing from social contact (Karlen, 2002) reducing personal well-being.

### **The impact of assumptions of asexuality on disabled people**

There have been significant improvements to the quality of life of people with disabilities

brought about by the years of campaigning by disability organisations, illustrated by legislation such as the Disability Discrimination Act 1995 and Equality Act 2010, which address access, employment and education. However sexual well-being has not been included (Shakespeare, 2000). People with disabilities still experience discrimination regarding their sexual well-being, with the notion of asexuality or deviance remaining prevalent in their personal accounts (Shakespeare et al,1996, McCabe and Taleporos, 2003, McLaughlin and Cregan, 2005, Esmail et al, 2005; Briant et al. 2013; Owens, 2015) and cultural representations of disability (Darke, 1999, Tepper, 2000, Milligan and Neufeldt, 2001, Harris, 2002, Gowland, 2002, Dune and Shuttleworth, 2009) . This perception of asexuality or deviance, with service providers tending to disregard sexual nature and needs (Shakespeare et al,1996; Milligan and Neufeldt, 2001), or over risk manage sexual expression, fails to recognise people's full humanity. As such it is both contrary to a holistic or person centred approach to social care and oppressive (Shakespeare, 2000). While physical impairment might affect a person's expression of their sexuality, it does not result in asexuality or deviance.

Non-normative bodies create anxiety that leads to the denial of sex having any place in the lives of physically disabled people (Shildrick, 2007). Social policy is silent on physically disabled people's sexuality because disabled people have been constructed as asexual. This silence is harder to contest and it is only through enabling the full embodiment of disability that the issue of sexuality will be opened up (Shildrick, 2007).

The narrative of asexuality is central to the topic of sexual well-being. It is a form of 'othering', creating a different, unequal 'them' whose very difference enables the dominant, able bodied from identifying with, and therefore thinking about disability. This inequality is experienced as stigmatizing, people become invisibly labelled, outside of the mainstream majority (Burke and Parker, 2007). This experience makes disability a political issue, created by environmental and societal structures.

Disabled individuals who identify as Lesbian, Gay, Bisexual, or Transgendered (LGBT) may experience double jeopardy as they have to integrate within two marginalised groups (Vaughn, Schoen, McEntee and McGrady, 2015). As well as negotiating stigma and assumptions of 'asexuality', LGBT disabled people can also feel disconnected from LGBT communities, and face discrimination from within them. It is therefore important that social workers understand the nuanced elements influencing identity including the intersections

of disability, sexuality, ethnicity and gender, as these will impact upon sexual well-being.

In the UK social work appears to be moving away from the International Federation of Social Work (IFSW) definition as it becomes increasingly concerned with policing, uncertain about its role beyond legislative operation (Graham and Shier, 2010). This leads to policy regimes which pathologise poor and marginalised groups (Lavalette and Ferguson, 2013). Understanding the mismatch between what social work could be and what it actually is in statutory practice enables students and practitioners to use their professional power, discretion, values and theories to recognise and create opportunities where their unique skills can be used to grow their resilience and work effectively with service users.

### **Vulnerability, risk and sexual well-being**

Disabled service users are often defined as 'at risk' and without agency thereby denying their rights (Joseph Rowntree Foundation, 2011). However, it is not disability that increases risk but rather society's response: the culture of risk avoidance sends the message that disabled people cannot and should not expect to lead full lives (Hoong et al, 2011). Therefore a significant factor in the achievement of sexual well-being is linked to societal attitudes. Human rights informed practice and research is important to challenge the protectionist approach where 'risk' is used to discriminate (Disability Rights Commission, 2006). Successive governments have:

'Shifted the focus of public services towards safeguarding people perceived to be vulnerable, and this has led to a heightened concentration on the prevention of risk rather than the enabling of rights' (De Than, 2015, p86).

Empowerment through the promotion of sexual citizenship, with its associated rights and responsibilities, is instrumental in protection from abuse and neglect, which the Care Act (2014) identifies as a well-being outcome which social workers are task to promote. To meet the new responsibility of prevention social workers need knowledge about how, why and to whom abuse occurs, thereby becoming skillful in identifying groups and individuals with whom the promotion of rights and education about rights is essential because safeguarding adults at risk of harm concerns human rights: all people should have sexual citizenship, access to justice, the right to a private life and to participate as full citizens.

The relationship between risk management and risk enablement is particularly relevant to this as 'social workers build managing safeguarding risks into care planning and managing risk is about balancing rights' (Hoong et al, 2011, p64).

Disabled people's historical exclusion from sex education (Shakespeare et al, 1996), social isolation and lack of privacy, impact on the access to the kinds of experiences that most people have as they develop sexual esteem. Marginalised people can experience 'othering' which enables abuse and neglect to occur. This leaves individuals vulnerable to abuse from services which neglect the opportunity to empower them by failing to acknowledge their full potential. Research indicates that disabled people are at higher risk, and experience higher levels, of targeted violence and hostility compared to non-disabled people. Disabled people are reported to be four times more likely to experience sexual abuse than non-disabled people (Cunningham and Drury, 2002, Quarmby, 2011). It is important to empower individuals by provision of accurate information and access to sex education, as consent and agency is about being able to make informed decisions and choices.

Person-centred approaches to risk and safeguarding locates the individual within their wider social context, including consideration of intimate relationships which the individual may have or aspire to. There are personal, social, cultural and practice barriers to social workers raising the issue of sexual well-being. This includes the fear of exposing service users to risk and themselves to accusations of unethical or illegal practice, as well as concerns about exploitation of third parties (personal assistants and sex workers).

### **Exploring the impact of relationships on sexual well-being**

It is important for practitioners to understand the complexity of change to relationships when one partner experiences disability. Partners can be a source of strength but also stress to each other, as in any relationship, however disability introduces particular positive and negative effects which, if acknowledged, can be used to assist the relationship and mitigate the negative. Disability, impairment and illness can affect both partners as 'Chronic illness changes not only how the couple see each other, but also how they see their world and how they are perceived socially' (D'Ardenne, 2004, p 293).

Relationship status is related significantly to mood and emotional well-being (McCabe and

Taleporos, 2003; Markey et al. 2007) and romantic partners are the primary positive influence of healthy behaviours such as diet and physical activity (Hwang and Johnston, 2007). The majority of adult's social experiences revolve around the lives they share with their partner so for health and social work interventions to be successful the consideration of partners and the social context is vital (Hwang and Johnston, 2007).

Different impairments have different impacts upon sexual function. Some individuals report a conscious 'shutting down' of their sexuality in the immediate post injury period, and an assumption sexual pleasure was now impossible (Richards et al. 1997). Other impairments such as brain injury (Oddy, 2001) can damage the areas of the brain associated with sexual functioning leading to the loss of confidence and increase in anxiety and depression affecting sexual functioning. Research into the impact of chronic pain indicates that it negatively affects intimacy and self-identity (Schlesinger, 2003), and long term health conditions can affect sexual relationships through specific physical effects and/or treatment alongside negative psychological effects on self-image (D'Ardenne, 2004).

It is important that social workers are aware of the diversity of experience that impairment and disability represents. Some disabilities can result in an increase in sexual activity and desire, and research into the positive sexual effects of Lupus amongst women unexpectedly found that for some women Lupus brought improved sexual functioning and relationships (Karlen, 2002). Disability may result in improved communication in relationships which in turn can improve sexual relationships (Esmail et al, 2007). The ability to talk and even joke about sexual difficulties is important (Parker, 1993, Westgren and Levi, 1999, Karlen, 2002 Esmail et al, 2007).

### **The impact of gender on sexual well-being**

It was not until the 1980s when disabled women started to write about their lives that feminism and disability connected, previously many disabled women felt alienated by the feminist agenda and forgotten by the disability movement (Tilley, 1998). Feminism has identified the ways in which women's bodies have been controlled by men through commodification, medicalisation and the law (Wincup, 1998). Women are seen as more connected to their bodies, controlled by biomedical processes and more aware of their bodies (Sheldon, 2002). Feminists have highlighted the contribution the media has played

in the objectification of women's bodies (Shaw, 1998) including unrealistic cultural ideals of beauty. By accepting these standards society creates disadvantages for all women (Wendell, 1996) but women with disabilities face discrimination in patriarchal societies both on grounds of gender and disability (Schlesinger, 2003).

Disability also compromises traditional notions of masculinity which are often defined in negative terms, for example not being emotional or dependent (Seidler, 2006). Gendered expectations are ingrained through the processes of socialisation and are not easy to relinquish. Sexual messages conveyed in our culture through the media are often unrealistic, which may lead a disabled person to assume their sexual life is over if they cannot meet those expectations. Disability challenges the social norms of male sexuality and genital functioning and performance, and disabled men who compare themselves with the social norms of masculinity are more likely to remain socially isolated as they do not live up to the ideals (Shuttleworth, 2000). The emphasis on male strength leads men to deny they need help which can then be masked in substance abuse or violence towards self and others (Tepler, 1999). For example, a phallocentric view of sex focused on the function of the penis (Sakellariou, 2006) can be oppressive to physically disabled men whose condition results in erectile issues.

Social workers need to be aware and sensitive of these potential threats to well-being amongst the people with whom they work. It is important to understand the physical impacts of impairments and disabilities, and to support those they work to draw on other ideals, such as interdependence or prioritizing emotional intimacy, potentially empowering service users to seek alternative methods of sexual well-being.

## **Discussion**

People with disabilities have the right to participate in society with equal access to the opportunities offered (Disability Discrimination Act, 1995, Equality Act 2010). They have the same sexual and social needs as everyone else yet still face many barriers. The Care Act (2014) has the potential to radically change the role of social work with adults. Eligibility for social care interventions is redefined as 'risk to well-being' as opposed to 'risk to independence' as previously set out in Fair Access to Care (DoH 2003, updated in 2010). The Act sits well with social work values including the concept of well-being and the assumption that the individual is best placed to judge their own well-being (DoH,

2014). However, practitioners and service users have expressed concern about how the Act is being applied (Anonymous, 2016; Carter 2016(a) (b)) and any evaluation is complicated by the wide ranging impact of public spending cuts on resources.

The Care Act (2014) extends the scope of personalisation within social care. However critics question whether in reality personalisation is a means of extending a market approach to care and reducing costs (Beresford, 2013). To date, personalisation has yet to be fully embraced by the profession which continues to express concern (Gardner, 2014). The challenge for practitioners is to accommodate a holistic focus within assessments which includes consideration of the importance of sexual well-being to overall well-being.

A recent House of Lords Select Committee Report (2016) exploring the impact of the Equality Act on disabled people reinforces the ultimate responsibility that government has towards ensuring the inclusion and well-being of all disabled people, including consideration of their sexual well-being needs. However, the report warns that to date legislation has had limited impact on improving the lives of people with disabilities.

### **How sexual well-being fits in social work assessments**

The difficulty practitioners may experience in discussing sexual matters is not a reason for the topic to be avoided. Social workers are skilled at managing encounters which are often intimate in subject matter and emotional in content, and have privileged access to individuals and their networks. As social work does not avoid other sensitive subjects avoidance of sexual well-being cannot be justified, especially as the:

“emergence of the sexual self (is) of central concern to the individual immersed in contemporary social life. Each citizen must now negotiate the sexed aspect of their self” (Dunk, 2007,p1).

To remain relevant to contemporary life knowledge of sexual issues is vital to the practice and education of social workers working with people dealing with the increasing complexities of modern society. Social worker’s codes of practice task them to advocate for rights (BASW, 2012), which includes sexual rights (de Than, 2015) and, in light of the Care Act, improving well-being. The notion of sexual citizenship is founded on a rights based approach, but has been largely absent from the disability movement and social

discourse (Shakespeare, 2003; Kunguade, 2010; Shuttleworth, 2010; de Than, 2015). This has resulted in the absence of any claim on state services or funding for sexual well-being. Sexual citizenship involves belonging to society, which gives rights such as to information, education and access to services, but also the responsibility to abide by the laws and codes of that society (Kunguade, 2010). It links to well-being through the recognition of human sexual and social natures

The promotion of sexual citizenship is core to well-being focused social work with physically disabled people because sex is an essential part of self-construction (Dunk, 2007), therefore physically disabled people claiming sexuality is “a bid for full subjectivity” (Shuttleworth, 2010). Assessment and review remains core to all forms of social work, at its best it is now an exploratory study of human well-being that forms the basis of decision making, and can be a positive intervention in itself (Coulshed and Orme, 2012). But assessment can also be an instrument of oppression depending on how it is approached by the assessor and organised by the agency. For assessment to be holistic, it should be undertaken ‘in collaboration with disabled people’ (Oliver, 2003:86). The Care Act (2014) allows for self-definition of need, prioritising the service user's voice. However this still requires professional assessors to interpret and organise what is considered knowledge and evidence according to organisational requirements. An emphasis on a scientific approach to evidence is at odds with the subjective aspects of well-being and service user perceptions as required by this legislation. However, it offers a means to address the oppression by prioritising the service user's voice within assessment, and extending access to advocacy. This is associated with a rights based approach and more radical forms of social work (Parton and O'Bryne, 2000). For social work practice to advance human rights it has an obligation to promote rights by actively challenging the discourse that creates injustice and inequality, and challenging the discourse of risk and vulnerability associated with disabled people (Hoong et al, 2011).

### **Implications for enhancing practice**

It is important that a rights approach to social work focuses on sexual citizenship and inclusion, thereby challenging notions of asexuality and dependency, leading to a positive narrative of empowerment and participation. Social workers can aid the promotion of sexual citizenship through the recognition of physically disabled people as sexual beings, raising awareness and sourcing accessible information. This includes awareness of the

impact impairment and physical disability can have on body image whilst balancing this with an affirmative model of disability (Swain and French 2000).

The Care Act (2014) embeds the concept of well-being into social work practice with adults and provides the opportunity for social workers to creatively explore what impacts on well-being. For social workers to be able to implement well-being into their practice they require an understanding of both how they and their agency define it. This includes an appreciation of how austerity potentially influences the way it is defined and consequently the ability to implement a holistic well-being agenda. If well-being is defined in terms of the individual, who has responsibility for the creation and maintenance of their own well-being outcome focused care and support, planning is likely to be different from that based on well-being defined in terms of communal, inter-relational responsibility and experience. Therefore whilst the Care Act (2014) promotes the principle of well-being, applying the principle has to be done within the wider social context. This comprises the crisis in adult social care funding (Beresford, 2013), cuts to disability related benefits, and an increasingly negative media and welfare policy narrative of disability (Briant et al, 2013), and reintroduces the language of deserving and undeserving all of which impact on disabled people's well-being (Duffy, 2016).

Social workers need to critically examine the situational factors involved in practice: its politico-economic context and the power relations involved (Parker, 2007), including how and why the law defines sex (Sexual Offences Act 2003) and disability (Equality Act 2010, (S6(1))), and determines services and need (The Care Act 2014).

### **Recommendations for policy and practice**

For government to achieve increased well-being across the UK population, and for the well-being principle of the Care Act (2014) to become embedded in to social work practice, a genuinely holistic approach is needed. This should be focused on the inclusion of marginalised groups, and the valuing of human sexual nature and needs. The austerity programme of the current and previous governments has stripped away many of the social structures which contribute to well-being, refocusing social work away from case work onto regulatory tasks and limiting the potential to encourage well-being

Practitioners can reclaim well-being and recognize its place in the values and ethics of practice. If government is serious about increasing national well-being, social workers are well placed to provide the evidence of the effects of social policy on citizens. This requires sexual well-being training to become a core part of the curriculum and practitioners and

agencies should also take responsibility for finding out about sexual well-being so they can provide advice and information as required.

Social workers need to locate consideration of sexual well-being within the service users wider personal, social, cultural context, exploring both personal and organizational barriers preventing the exploration of sensitive topics such as sexual well-being. This should include consideration of risk adverse practice and the need to balance this with a strengths approach appreciation of sexual well-being. The introduction of the well-being principle underpinning The Care Act 2014 means that social workers are tasked to support the well-being of service users. To achieve this they should understand the significance of sexual citizenship to social work values and an awareness of how one's own practice contributes to the construction of sexuality. Knowledge of these areas will help equip practitioners to challenge discrimination around sexuality and disability (Bywater and Jones, 2007).

With a shift in focus to 'risk to well-being' service users are given the opportunity to express how their circumstances impact on their subjective and objective well-being. Increased choice and control offered by Personal Budgets enables a personalised service based. Social workers have welcomed the potentially empowering aspects of these changes, but express concern about the political motivation of the changes during a time of austerity (Netten et al. 2012).

For government to achieve increased well-being across the UK population, and for the well-being principle of the Care Act (2014) to become embedded into social work practice, there is a need for a genuine holistic approach which values the layered aspects of human nature. Evidence indicating the negative impact of inequality across all of society (Wilkinson and Pickett, 2009) means the pursuit of factors which positively contribute to the many and not just the dominant few is required; this means the inclusion of marginalised groups and the valuing human sexual nature.

Further research needs to be undertaken into the experience of sexual well-being and how policy influences this including the impact of the Care Act (2014) on well-being. This can be achieved through in-depth qualitative research which explores the lived experience of disability and sexual citizenship. This should be practitioner led research, as social workers are ideally placed to engage with seldom heard groups to provide practice focused outcomes. This type of knowledge contributes to both local and national debates

about well-being and the meaning of sexual citizenship.

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