Tackling Violence

Against

Disabled Women & Girls

A Toolkit for Social Care, Housing, Mental Health and Safeguarding Services 2019

A User-Led Project by Vision Sense
with
Centre for Disability Research (CeDR) Lancaster University
and Against Violence & Abuse (AVA).

Funded by Big Lottery Fund through DRILL (Disability Research on Independent Living and Learning) Fast Track

Dedication

This project is dedicated to the memory of Jillian Grant.

Jillian was a vibrant 38-year-old blind woman, who was found murdered after a sustained and brutal attack, in North Tyneside on Christmas Day, 2017.

In her school days, Jillian loved to sing and participated in choirs. She loved to travel and lived independently for 10 years before her death. She was an active volunteer, a member of the VIEWS user-led group in Tyne & Wear and a speaker for RNIB.

Jillian thought that the man who murdered her was her friend. Mark Smith admitted her murder but took his own life in Durham Prison before his trial.

Jillian will not be forgotten. We dedicate this project to her memory and we will continue to work to end violence against disabled women and girls.

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The delegates who attended project events and all of our allies who are committed to working with disabled people's user-led organisations to end the violence, institutionalisation, neglect and abuse of disabled and Deaf people.

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www.avaproject.org.uk

The Project Partners were:

Vision Sense is a user-led, not-for-profit social enterprise, based in Jarrow, Tyne & Wear. It was founded in 2003 and is 100% user-led organisation of disabled people (DPO – Disabled People's Organisation). www.visionsense.co.uk

Against Violence & Abuse (AVA) is a leading UK charity committed to ending gender-based violence and abuse. It strives to improve services for survivors through our learning, resources, consultancy and end Violence Against Women and Girls through our policy, research and prevention work. www.avaproject.org.uk

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https://avaproject.org.uk/tackling-violence-abuse-against-disabled-women-girls/

Centre for Disability Research (Lancaster University) is a specialist research grouping that promotes and conducts high quality interdisciplinary research and research-led teaching about disability. http://wp.lancs.ac.uk/cedr/

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http://wp.lancs.ac.uk/cedr/research/tackling-violence-against-disabled-women-and-girls/tackling-violence-against-disabled-women-and-girls-conference-report/

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Contents

Introduction

What was the project?

'Tackling Violence and Abuse Against Disabled Women and Girls in Co-Production with Mental Health, Social Care and Housing Services 'was an 18 month partnership led by Vision Sense (a user-led organisation of disabled people based in Tyne & Wear), a national charity, Against Violence and Abuse (AVA) and the Centre for Disability Research (Lancaster University). It was funded by Big Lottery through the DRILL Project.

Why was the project needed?

Research to date shows that disabled people are significantly more at risk of hate crime and violence than non-disabled people (Emerson & Roulstone, 2014) and that women and girls are more at risk of violence and abuse than non-disabled women (Hughes et al, 2012). Although men and boys also experience abuse, the UN and European Conventions recognise violence against disabled women and girls as a gender-based problem.

However, most work to date has focussed on immediate crisis provision or specialist services such as refuges/police reporting (Shah, Balderston & Woodin, 2015). Joint working between partners in serious cases is often limited (Manthorpe & Martineau, 2013). Survivors tell us that information is needed about inclusive longer-term mental health services, housing and joint working between partners (Shah et al, 2015), to prevent re-victimisation and help victim-survivors to rebuild their lives, for independent living and longer-term safety (Balderston, 2013). This project addresses this need.

What were the project research questions?

The project aimed to answer these questions:

1. What do disabled/Deaf women and girls want from services to help them stay safe in the medium and longer term after violence and abuse?

2. What can service providers learn from Serious Case Reviews, Safeguarding Adults Reports and Preventable Death reports to prevent violence and abuse?

3. How can mental health, social care and housing providers improve longer term services for disabled/Deaf women and girls after violence or abuse?

4. How can services work together with disabled women and girls to create safer, inclusive communities?

What were the project values?

This project was underpinned by values to work in co-production (a partnership including a women's charity and a university but led by disabled people). The project was led from a social model of disability perspective, concentrating on barriers to equality of outcome for disabled or Deaf women who have experienced violence. It promoted the independent living of disabled/Deaf women and girls who are victim-survivors of violence or abuse. It ensured that the events and information were accessible to disabled/Deaf people in a range of formats accessible to them. This project is pan-impairment and cross-cultural; it resists isolation by including women with multiple physical and sensory impairments, mental health service survivors, people with the label of learning difficulty, Deaf women, BAMER women and young disabled women aged over 18.

What was the project designed to deliver?

This project delivery was:

1. Research ethical approval from Lancaster University, prior to undertaking the research

2. A review of the literature about longer term interventions after the violence and abuse of disabled/Deaf women and make recommendations for future prevention and services.

3. A review of Serious Case Reviews, Domestic Homicide Reviews and Preventable Death Reports relating to the violence and abuse of disabled women and girls to identify key learning and recommendations for service providers

4. Involvement with 60 disabled/Deaf victim-survivors of violence or abuse, including 20 interviews about the barriers and enablers to longer term survival, particularly in regard to social care, housing and mental health services.

5. Safety Ambassadors training for 15 disabled/Deaf women survivors of violence or abuse.

6. Interviews with 20 relevant service providers (mental health, housing and social work) in England and Wales, to discuss barriers and their needs to include disabled/Deaf victim-survivors in accessible services.

The project outputs were:

1. This best practice toolkit so that social workers, mental health and housing professionals can learn to recognise barriers in their services and how to make their services accessible, inclusive and relevant with disabled/Deaf victim-survivors after violence.

2. Disseminating learning and materials from the project with workshops to 60 professionals

   https://avaproject.org.uk/tackling-violence-abuse-against-disabled-women-girls/

3. A final conference sharing best practice at Lancaster University for 30 housing, social care and mental health delegates to disseminate findings:

   http://wp.lancs.ac.uk/cedr/research/tackling-violence-against-disabled-women-and-girls/tackling-violence-against-disabled-women-and-girls-conference-report/

4. Dissemination of findings to 60 qualifying and post-qualifying social workers and promote co-production with disabled people as a research tool for Lancaster University

5. Accessible information summaries

6. A peer-reviewed academic journal article (after the project end)

7. Monitoring, delivery and evaluation information as required by the funder

Section 1: Literature Review: Longer term interventions in mental health, housing and social care after violence and abuse of disabled/Deaf women and girls in Europe

By Dr Rebecca Fish, Centre for Disability Research, Lancaster University.

1) Introduction

The United Nations (1994) define violence against women and girls as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.'

The experiences of violence by non-disabled women fail to represent those of disabled women (Shah et al , 2016). Disabled and Deaf women and girls experience more systemic and individual violence throughout their lives (Polland et al, 2014; Thiara et al, 2011). Balderston (2013) shows that in the United Kingdom, disabled women are 2-5 times more likely than men and non-disabled women to experience sexual violence. Analogous with international studies, Khalifeh et al (2013) found a clear association between disability and physical and sexual abuse, with disabled people experiencing between 1.8 and 3 times more violence both within and outside the home. Further, they found the psychological impact to be greater among disabled people.

Some of the factors behind this include the increased risk of isolation, increased physical, emotional, and economic dependency as a result of lack of services, difficulties recognising and identifying disability related abuse, and cultural or societal barriers that get in the way of accessing support (Radford et al, 2006).

Distinctive forms of violence and abuse experienced by disabled women are described in the literature, such as the imposition of restrictions in terms of access to other people, mobility, medication or adaptive technology (Harpur & Douglas, 2014).

Fisher's (2017) review of the impact of child sexual abuse shows that resilience and recovery are possible for victims and survivors – if a positive and sensitive response is received from family, friends and professionals following disclosure, and if effective support services are available. However, there remains a lack of awareness and resources when it comes to support for disabled women who have experienced violence. Thiara et al (2011) contend that disability and domestic violence services work in isolation from each other, further disadvantaging disabled women. Additionally, Radford et al. (2006) found that reporting is difficult particularly when it is the carer who is perpetrating the violence. Importantly, if women need accessible or adapted housing, there may be fear of being re-housed or taken to a care home. Smith and Miles (2017) show that women and children who cannot access refuge are often left in dangerous situations.

Much work to date has focused on immediate crisis provision or specialist services such as refuges. Joint working between partners in serious cases is often limited and rarely involves disabled women.

The purpose of this project was to respond to disabled survivors who said that they need information about inclusive longer-term mental health, housing and social care support, in order to prevent re-victimisation and help survivors rebuild their lives in the longer term.

2) Literature search procedure

Four databases were searched in January 2018: The Web of Science, SCIE, SocIndex and Medline. Inclusion criteria were: published between 2008-2018, articles in English language and from comparable social policy domains/frameworks. The search terms were as follows, plus their derivatives and variations (e.g. woman/women, disability/disabilities):

- Woman OR girl (Including women, gender, victim, survivor)
- Disability OR impairment (including sight loss, Deaf, learning difficulty, mental health)
- Abuse OR violence (including stalking, assault, hate crime)
- Intervention OR services (including residential, treatment, resilience)

The search produced 132 articles which were individually examined to remove irrelevant articles (resulting in 17). Much of the work centred on lack of accessibility to shorter-term services, with very little research mentioning longer-term services and good practice. The articles were explored and arranged into themes which will be explored individually.

3) Reasons why disabled women do not approach services

The way society treats disabled people is important: Shah et al (2016) argue that the marginalised status of the disabled woman reinforces the notion that she is incompetent and powerless to resist or report perpetrators' advances, and therefore she becomes more likely to be victimized than a non-disabled woman.

Bashall and Ellis (2012) note how policy makers and society in general do not conceive the impairment-specific acts of abuse as domestic violence or hate crime but more as 'some innate vulnerability caused by their impairment' (p. 116). Abusers exploit the challenges presented by disability, knowing that this will limit a woman's ability to access support (Ballan & Freyer, 2012). If the abuser is a partner or carer, they may prevent women from accessing other sources of support. At the same time, women may be particularly reluctant to make a charge for fear they would be left with no one to provide the personal care they require to live independently. Women may also fear losing their home or being sent to live in institutional care (Hague et al, 2010).

McCarthy (2017) found that women with learning disabilities were not aware of services that they could approach, and when they disclosed their experiences of violence to professionals, often nothing was done because they did not specifically express the wish to leave their abusers.

Dixon and Robb's (2016) analysis of policy recommended that social workers and the police should adopt a common screening process to highlight groups of women who may be at risk of abuse. In addition, social workers should be trained to enable women with learning disabilities to recognise and make informed choices about abuse.

4) Accessibility of services

Smith and Miles (2017) highlight the lack of available and accessible refuge provision. Using data collected from the National Domestic Violence Helpline and caseworkers supporting women into refuge, they describe the decline in the ability of both refuges and other services to meet women's needs, in particular women with mental health support needs, disabled women and women with children.

Woodin and Shah (2014) report that many services are positioned in hard to reach places. Ramps, lifts, guidance systems and other accessibility features are not installed as standard, and information about services is not accessible to all women. Further, they found that attitudes to disabled women in specialised services were in need of improvement. Women need enough time for their needs to be met, and accurate, accessible information about their rights with regard to payment for personal assistance and translators.

Feelings of discrimination can affect the use of services. Kattari et al, (2017) found that although transgender and gender non-conforming individuals of all abilities experience gender-based discrimination when accessing social services, disabled transgender and gender non-conforming individuals experience higher levels of discrimination in support services and shelters.

The provision of refuges, helplines and counselling are useful to women (Woodin & Shah, 2014). However, survivors recommend that a specialist point of contact be established in each service, or network of services, in order to ensure that disabled women actually receive help appropriately.

Improved networking and co-operation, the establishment of a focal point of contact, and transparent referral procedures are deemed essential for improved service responsiveness and to prevent women from being sent around to different agencies in turn.

There are some instances of good practice in terms of accessibility, for example the provision of advocates (Lund, 2011), and receiving helpful support when taking legal action against perpetrators. Woodin and Shah (2014) describe a D/deaf woman receiving translation and explanations before and during a court hearing.

5) Mental Health services

Women using mental health services often are afraid to report domestic violence (Rose et al., 2010). This may be because of fear of social services involvement; concern that disclosure will not be believed or will result in further violence; fear of disruption to family life; or of potential consequences for immigration status. Rose et al's (2010) study also found that staff considered that it was not their role to deal with these disclosures. This is where collaboration between specialist and mainstream services is particularly important (Lund, 2011).

Imkaan (2014) used qualitative data from local health commissioners, voluntary sector specialists and women to highlight women's experiences of seeking support with mental health and their interactions with the mental health system. The findings demonstrate the need for a consistent gender-specific approach in the commissioning and delivery of mental health services.

6) Learning disability services

There is some research about the coercive treatment received by women in learning disability services and how this does not take into account previous experiences of violence and abuse (Fish & Hatton, 2017). Research investigating outcomes for people with learning disabilities moving out of institutional care does not generally mention gender or trauma informed treatment after institutional abuse. Some research with women with learning disabilities centres on protection and individualised responses to violence and abuse, such as interventions for self-esteem enhancement (Doughty & Kane, 2010).

McCarthy et al's research with women with learning disabilities who had experienced intimate partner abuse, found that social care staff do not respond to concerns quickly enough. They point out that taking an individualised approach, expecting people to find their own solutions, is problematic: 'Notions of 'choice' can be masked by people's lack of, or poor, experiences.' (McCarthy et al., 2017:277).

This is also discussed by Douglas and Harpur (2016), drawing on the narratives of women with learning disabilities about their experiences of engaging with the legal system in response to domestic violence. They advocate for supported decision making to improve the process.

7) Peer support

Peer support and counselling was helpful to disabled women survivors. Whether accessed as part of the system or independently, women found value in receiving and giving personal support to others. The vast majority of women in Woodin and Shah's (2014) study valued contact with these groups where they existed, as well as contact with disabled people's organisations and the Independent Living Movement.

In agreement, Balderston (2013:43) found that peer support was extremely valuable:

> The participants in our study who identify proudly as Survivors, disabled people, feminists or trans women seem to be safeguarded and protecting themselves more successfully, through identifying with each other in groups, not by passively receiving services.

Woodin and Shah (2014) found that disabled women discussed helpful factors in terms of three main areas: supportive relationships with individuals, assistance from services or the criminal justice system, and things that helped them with personal resources and strength. In all instances and throughout their lives, supportive contact with other people was the factor that disabled women experiencing violence found most helpful.

8) Housing

Housing is explored in the literature in terms of short and long-term support. Sullivan and Olsen (2016) point out the significant risk for homelessness of women with serious mental illness who have experienced domestic violence, and Baker et al (2010) show the importance of the intersection between housing instability and domestic violence. Women can feel re-victimised by housing agencies because of breakdowns in previous placements due to the behaviour of perpetrators (Clough et al, 2014). Baker et al (2010) recommend better connections between domestic violence and housing agencies, as well as developing housing options which respond to the diversity of survivors' needs.

9) Recommendations for longer-term support

Some of the literature uses an individualised approach to address longer term intervention, recommending safety promotion and prevention as well as training in self-defence skills of disabled women (Ballan & Freyer, 2012; Foster & Sandel, 2010). However, Woodin and Shah's (2014) research with 187 disabled women highlights the need for support services that recognise the particularities of violence against disabled women, and for both mainstream and specialised strategies to be pursued.

They recommend training of professionals about the oppression and marginalisation of disabled women rather than focussing on individual impairments and care arrangements. A focus on dealing with perpetrators was also recommended, beginning with the proper prevention of violence (starting with education in schools) through to the successful prosecution of offenders.

The expansion of specialised services overall was felt to be imperative, as well as extending parts of services that address accessibility problems, such as developing more outreach services. These might include providing alternative affordable, stable housing, or supporting a woman to live in her current home safely, by excluding a perpetrator from the home (Clough et al., 2014). This holistic focus was particularly important for women with mobility impairments in situations where there was a lack of accessible housing that disabled women could move to. Opportunities to facilitate connections and emotional safety, and taking up new activities, such as sport, education or employment were also recommended (Sullivan & Olsen, 2016).

David et al (2015) highlight four key principles that can optimize and promote the recovery outcomes of women: (1) peer support, (2) flexible services and resources, (3) supportive program leadership, and (4) gender-sensitive services provided by women. Each of these treatment principles fosters trust and helps to create safe psychological and physical spaces for women.

Flexible, long term funding and engagement is vital. Smith and Miles (2017) call for long term, sustainable funding solution for refuges, which would allow continuity of provision with contracts delivered for more than one year at a time.

In terms of housing, Sullivan and Olsen (2016) argue for a holistic focus that offers flexible funding and engagement. They recommend the Housing First model, which incorporates trauma informed practice, facilitating connections and emotional safety.

Recommendations from the literature review are summarized in the checklist at the end of this toolkit.

## 10)	Research gaps

In terms of recommendations for future research, Fisher's (2017) review identifies evidence gaps in research areas, including the impact of child sexual abuse on minority groups and disabled people. More information about good practice in terms of safe housing and flexible service provision is needed.

Section 2: What is the extent of violence against disabled women & girls?

By Dr Susie Balderston, Policy & Training Director, Vision Sense

Disabled people experience a different pattern of violence than non-disabled people; allies who recognise this are better able to prevent risk, escalation and provide safer services or interventions for survivors and disabled people in the community.   Research has found that overall, disabled people are 1.5 times more likely to be a victim of violence than non-disabled people; that is 1.6 times for people with intellectual impairments and 3.8 times more likely for mental health service users (Hughes et al, 2012). Disabled men and women in psychiatric services are 2–8 times more likely to experience sexual and domestic violence than the general population and victimization is a trigger for suicide attempts among patients (Khalifeh et al, 2015). Smaller studies have also identified sexual abuse against older people with dementia (Burgess & Philips, 2006) and higher rates of mental health service users in domestic violence refuges (Helfrich et al, 2008). Given the high levels of revictimisation (Nosek, 2006), the significant costs of violence against women (Walby & Olive, 2013) and the greater harm of hate crime (Iganski, 2001), prevention and intervention are crucial.

Institutional violence, sexual violence correlated with financial extortion (Balderston, 2013) and hyperviolence (Sherry, 2010), repeated and sustained attacks are much more prevalent against disabled people than in 'standard' models of what local authorities and police might consider domestic violence to be.

When non-disabled people concentrate on domestic violence as being the dominant model of violence against women, they often miss cases into which they need to intervene. The model and policy of tackling domestic violence (for example, IDVA) needs to extend to violence in institutions, which are often the 'domestic' setting where disabled people live. In addition, violence, neglect and abuse by nursing and support workers in disabled people's houses, care homes and accommodation, should also be included in the remit of domestic violence workers.

The lack of consent, relationships and sex education provided for disabled people, means that disabled people with a great deal of official surveillance in their lives are often perceived as perpetrators, or potential perpetrators, themselves. Sir Mark Hedley, in an important Court of Protection ruling[1], found a breach of Article 8 of the European Human Rights Convention, caused by delay to provision of sex education for CH, a man with learning difficulties. He awarded £10,000 in damages to CH, after the local authority breached his human rights by delaying him with the sex education, required to help him gain capacity to consent to sexual relations. CH was unlawfully told not to have sex with his wife for a year in 2015 (they had been married since 2010). CH had been threatened with s.30 of Sexual Offences Act 2003 (the offence of sex with someone who lacks capacity) and the Council had threatened to remove WH (his wife) from the home.

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[1] CH v A Metropolitan Council [2017] EWCOP 12

This judgement underlines the necessity of social services providing adequate mental capacity assessments within marriage and sex education for disabled people.

1) **Is violence and abuse against disabled people gendered?**

The capped Crime Survey of England and Wales figures (2012-2013) demonstrate that disabled women have twice the prevalence as family violence victims (6.9% v. 2.7% for non-disabled women). But this figure is likely to be higher still - disabled people are heavily under-represented in household surveys about crime – violence in prison, assessment units, residential care and hospitals is invisible in the major source of information, the Crime Survey of England and Wales (CSEW). The Crime Survey is not currently available in accessible formats (e.g. Braille, BSL, large print, easy words and pictures), for disabled or Deaf people to participate. In addition, sexual violence linked to financial abuse is experienced by disabled women to a much greater extent than that experienced by non-disabled women (Balderston, 2013).

Disabled women are reported to be between twice (Smith, 2008) and four times (Martin et al, 2006) more likely to experience sexual assault (Balderston, 2013) and domestic violence (Hague et al, 2010) than non-disabled women or disabled men. Whilst disabled men experience a significantly higher prevalence of violence than non-disabled men, for women, the attacks are more likely to be repeated, sustained and result in more injuries than for men (Walby et al, 2017). Overwhelmingly, violence against disabled people is perpetrated by men.

2) Are perpetrators of violence gendered?

With regard to perpetrators of domestic violence, research by Hester over six years, found that more violence (and repeat violence) is much more likely to be perpetrated by men. 78% of all male perpetrators had more 2-24 repeat incidents recorded – one man had 52 repeat incidents in six years (only 13% of men had one incident recorded). Conversely, only 62% of women recorded as perpetrators had only one incident - the highest number of repeat incidents for any woman was eight. The research found there were 400 incidents in 32 dual perpetrator cases, compared to only 181 across the 64 sole perpetrator cases. Men are significantly more likely than women to use physical violence, threats and harassment, whilst women recorded as perpetrators mainly involved verbal abuse against their partners. However, when women were alleged to be the perpetrator, they were more likely to have mental health service needs and were three times more likely to be arrested per incident; men were arrested once in every 10 incidents (in 11% of incidents) and women arrested every three incidents (in 32% of incidents) (Hester, 2013).

Research has also demonstrated that disabled and socially excluded women were over-represented in rape reports in the Metropolitan Police area, but these women did not enjoy equality of outcome in prosecutions (Ellison et al, 2015). 13% of rape complainants had learning difficulties (vs. 2% of other rape complainants without psycho-social disability (PSD)], 9% were homeless or reported as missing persons (vs. 2% of other rape complainants without PSD).

Police explicitly noted doubts about the credibility of the victim in particular in 37% of cases involving a complainant with a recorded PSD compared to only 17% of cases in which the complainant had no recorded PSD (Ellison et al, 2015). police officers should not be making credibility assessments about whether a victim can give her best evidence or will be believed at trial, which is the role of the Crown Prosecution using the full code test (with pre-trial interview, intermediaries and special measures if necessary).

 In fact, many disabled people end up being charged with crimes themselves; The Prison Reform Trust (2012) reported that 32% of adult offenders have an IQ under 80 (label of learning difficulty) and 60% of children who offend have a communication difficulty.

The outcomes of disabled people with regard to violence, abuse and neglect are dismal in England today; the United Nations Inquiry found 'grave and systemic human rights violations' with regard to UK Government's policies on people with disabilities, in relation to failure to meet their safety and human rights obligations (United Nations Committee on Convention on Rights of People with Disabilities, 2017).

3) Institutionalised violence

Many disabled people (despite international Conventions on disabled people's human rights) still live in segregated institutions (state, charity and privately run for profit). Despite the wholesale closure of NHS 100+ bed and long stay hospitals by 2006, many hundreds of disabled people have simply been moved to smaller institutions, still segregated and where violence, neglect and abuse is rife.

Safeguarding statistics demonstrate that there is at least a 20%+ occurrence of more frequent and severe violence, harm, unsafe restraint, serious neglect and higher death rate incidence in institutions than with intimate partner or domestic violence for disabled people. In England & Wales, for the 2016-17 reporting year there were 109,145 individuals that were the subject of 151,160 formal safeguarding enquiries that started within the year (a 6% increase of 6 per cent on 2015-16). Out of these, 35% of risks were of neglect and acts of omission. SOURCE?

 Out of all safeguarding enquiries ended in 2016-17, **44%** were located in the home of the adult at risk, but disabled people's 'home' is much more likely than for non-disabled people to be residential care or an institution, rather than a domestic dwelling.

However, some health and social care professionals continue to see residential 'care' as a viable option for disabled people fleeing violence, when perversely, institutions frequently increase the risks of violence, isolation, abuse, restraint, segregation and neglect still further. Over-protective services put people at greater risk of harm and are warned against by Skills for Care and Care Act Statutory Guidance (REFS). Sensible risk appraisal, not risk avoidance is important.

As Lord Justice Munby famously queried in this regard, "What good is it making someone safer if it merely makes them miserable?"

The systematic and institutional physical, sexual violence, neglect and abuse of disabled people remains rife. The Learning Disability Census (2015) found that even after the Winterbourne View scandal in 2011, there were still 3,000 people with learning difficulties in institutions at the end of Sept 2015. In the census, 39% of women compared to 22% of men had at least one adverse experience (physical assault, self-harm or accident) and at least one restrictive measure (restraint or seclusion).

Cases include widespread unlawful restraint practices involving medication and prolonged illegal restraints (including someone tied to a bed 16 hours a day). For example, 15 incidents of abuse were identified from December 2002-2005 at Orchard Hill Hospital, in Carshalton, Surrey, Osborne House in Hastings and a number of community homes in Sutton and Merton. The author of the Investigation report found: "Institutional abuse occurs when the rituals and routines of a service result in the lifestyles and needs of individuals being sacrificed in favour of the needs of the institution" (Abrams, 2007).

The UN Special Rapporteur on violence against women goes further, to explains that institutional or structural violence is gendered and consists of,

> "Any form of structural inequality or institutional discrimination that maintains a woman in a subordinate position, whether physical or ideological, to other people within her family, household or community," (Manjoo, 2011).

There is excellent practice evidence to tackle violence and abuse against people with learning difficulties / learning disabilities (e.g. CIPOLD http://www.bristol.ac.uk/cipold/), it may actually be the impairment specific services and the segregated nature of the 'care' itself which (re-)produces the violence and prevents disabled people leading safe, meaningful lives in their own home in the community. Many recommendations which could benefit safer services for people with other impairments who are subject to segregated services, restraint and neglect in mainstream provision, do not always reach other services (for example, those serving people with dementia, autism and disabled people without a formal diagnosis, for example those in custody and prisons).

A lack of resources in social care and welfare is often highlighted as a problem in preventing violence against disabled people. However, this may be a mis-conception to some degree. With regard to health and social care resources for disabled people, the resources are mostly concentrated in the hands of profit-making providers. For example, in 2015/16, £477.4 million was spent on keeping approximately 2500 people with learning disabilities in hospital (52% of providers were in the private sector, compared to 20% in 2006). On average a 5-year bed will generate £950,000 in income with a for-profit provider (Brown et al, 2017). Despite the high cost of privatised and segregated services, there are many thousands of cases of unsafe restraint practices, poor capacity assessments, a lack of independent advocacy, low-paid and un-trained staff in these segregated institutions, which the review of Safeguarding Adults Reviews and Serious Case Reviews in this project demonstrates.

4) Safeguarding adults?

Data from adult safeguarding enquiries (concluded under s.42 of the Care Act 2014), demonstrates that 60% of individuals identified as being at risk were female (NHS, 2017). Enquiries are required by a local authority under the Care Act, where it has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

     a. has needs for care and support,

     b. is experiencing, or is at risk of, abuse or neglect, and

     c. as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The s.42 enquiries in the graph below are highest in the North East of England, but this may be a sociological effect of poverty, community cohesion. It could also be an effect of better reporting in the area; several user-led organisations and advocacy groups have worked closely with commissioners to improve scrutiny of out-of-area placements over the years. More research is needed to ascertain the reasons why other areas have fewer reports.

Graph: S.42 safeguarding enquiries concluded by region (NHS, 2018).

(s.42 enquiries concluded)

	Physical Abuse	Psychological Abuse	Financial or Material Abuse	Neglect and Acts of Omission	Other Risk Types
London	24%	16%	18%	33%	9%
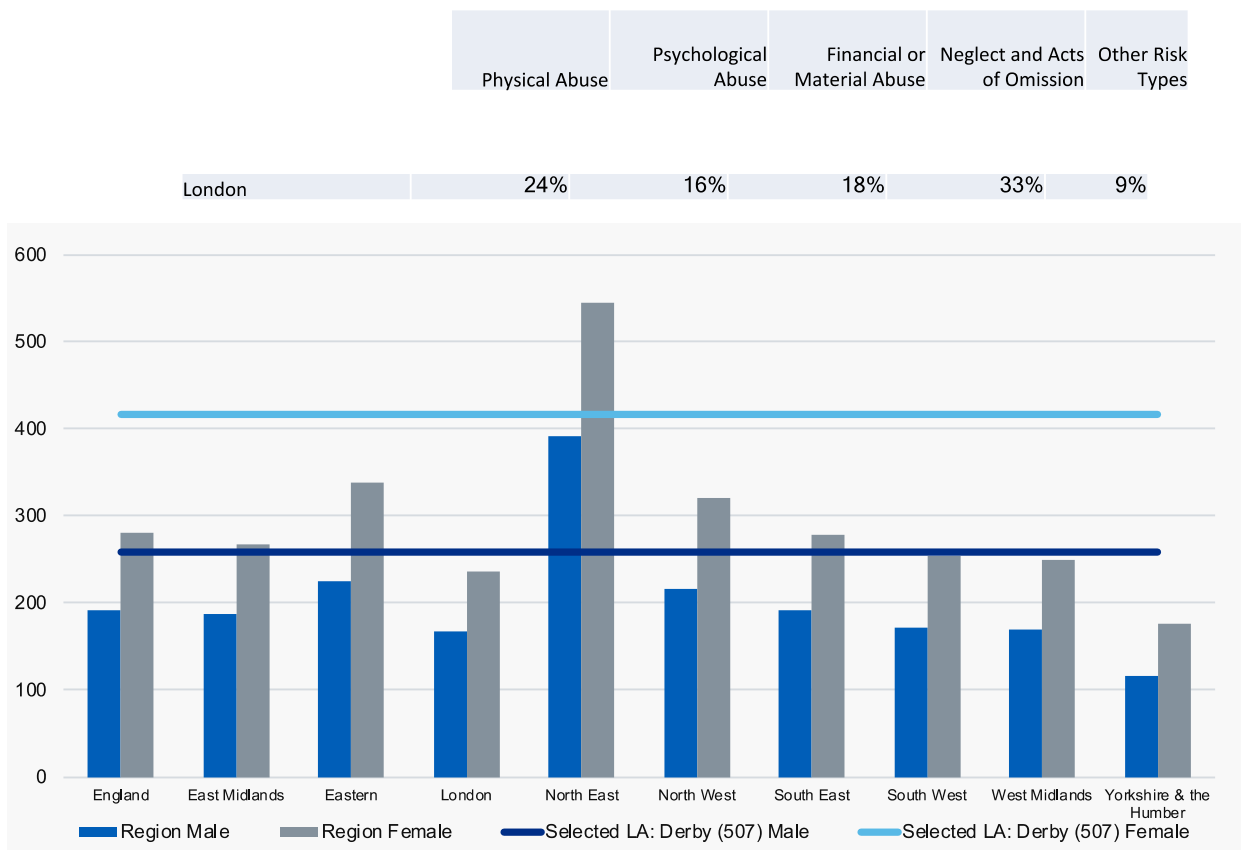
Note: The horizontal lines in the graph are for the indicative area of Derby (light blue line – women and black line – men).

Particular gendered harms from violence for women include pregnancy, abortion, greater HIV infection and HPV risks, infertility and gynaecological injuries. Women are most likely to be the main carers for children, but three times the number of women with learning difficulties have their children removed from them, compared to other women.

5) What causes disablist violence?

The history of segregation of disabled people (in institutions and 'special' segregated schooling) breeds fear and contempt of disabled people. Segregation prevents contact between disabled and non-disabled people in everyday society, in the same way that segregation against men and women of colour maintains positions of inequality and violence. Narratives of disabled people as 'scroungers' and undeserving welfare recipients, mobilized by Government to develop private sector profit from assessment and surveillance and maintained by media outlets also maintains these stereotypes (Briant et al, 2011). Large charities which run segregated services play a part in maintaining this social exclusion, by continuing narratives which invoke pity and 'othering' of disabled people, to maintain the income and power of non-disabled people over disabled people.

Segregation provides the conditions for hate crime and violence, when minority groups are estranged from others, in close proximity but without intimacy, which breeds fear and contempt (Mason, 2005). This is as much the case for disabled people in segregated residential homes and schools as it is for minority ethnic communities living in poverty and social exclusion. Paid staff in institutions are physically intimate with residents but not generally friendly or compassionate, or reciprocal with the people they work with. Contact without intimacy and lack of privacy can produce violence, regardless of the size of institution (Balderston, 2013).

Poverty is also statistically correlated with disablist hate crime (Emerson and Roulstone, 2014) and the policy of austerity has deepened these inequalities between disabled and non-disabled people. source

Overall, a stark lack of representation of disabled people in employment, leadership services and community roles maintains the inequality of disabled people which contributes to the legitimacy and extent of violence against disabled people In social care and policing, a patchwork of 16 different inspection bodies, no independent investigation of rapes or deaths of patients detained under the Mental Health Act and the lack of sharing of information between bodies, often means that opportunities to prevent violence are missed.

Many Safeguarding Adult Reviews remain unpublished, so that lessons cannot be learned from them (Flynn & Citerella, 2013), a problem that this project has sought to begin to address. A lack of training about working with violence victims and survivors in disability services, social care and lack of disability equality in victim services also maintains inequalities. Anecdotal evidence suggests that safeguarding reviews and Multi-Disciplinary Case Conferences into violence against disabled people often results in a lack of prosecution of the perpetrators.

The local arrangements in place for commissioning, licensing of 'care' homes and safeguarding often mean that institutional abuse across whole provider chains remain invisible and unaddressed between areas, despite the rise of the safeguarding 'industry' and a myriad of inspection bodies.

Section 3: Learning from Safeguarding Adults Reviews (SARs)

By Dr Hannah Morgan, Centre for Disability Research, Lancaster University

Introduction

Safeguarding Adults Reviews (SARs) seek to understand what has happened and what can be learned when someone who has care and support needs experiences or is at risk for abuse and neglect. The requirement to undertake them was introduced by the Care Act 2014 replacing a discretionary system of Serious Case Reviews (SCRs) and other forms of report based in large part on SCRs undertaken in children's services. As part of the 'Tackling Violence Against Disabled Women and Girls' Drill funded project, we asked what can be learned from Safeguarding Adults Reviews to prevent disabled women and girls being subject to violence and abuse?

The section of the toolkit provides an overview of the legislative and policy framework for 'safeguarding adults', which means promoting, upholding and safeguarding a person's right to live in safety, free from abuse and neglect as well as their wider human rights like the right to a private and family life. This framework relates to adults over the age of 18 who have care and support needs. Previously policy referred to 'vulnerable adults' (Department of Health, 2000) but the Care Act and other policy documents now talk about 'adults at risk' which recognises that vulnerability is not solely created by impairment or support and care needs but also about the situations and relationships that services (and a lack of services) create.

1) Safeguarding Adults Legislation

The Care Act 2014 introduced a general duty to promote well-being which is broadly defined and includes 'protection from abuse and neglect' s1 (2) (c). There is no set approach to promoting well-being. Local authorities are expected to meet the needs of those with care and support needs rather than provide a prescribed set of services. Chapter 14 in the Care and Support Statutory Guidance (Department of Health, 2018) replaces the *No Secrets* guidance (Department of Health, 2000) and defines safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. It goes on to say:

> Safeguarding… is about people and organisations working together to prevent and stop both the risks and experiences of abuse or neglect, while at the same time making sure that the adult's well-being is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and can be ambivalent, unclear or unrealistic about their personal circumstances' (Statutory Guidance 14.7).

The safeguarding duties created by the Act apply to an adult (over 18) who:

a) has needs for care and support (whether or not the local authority is meeting any of these needs)

b) is experiencing, or at risk of, abuse or neglect

c) as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect (s. 14.2)

This includes adults over the age of 18 who are receiving children's services and apply equally to all adults with care and support needs 'regardless of whether the adult lacks mental capacity or not, and regardless of setting' (14.5) [There are exceptions for prisons and Approved Premises].

The aims of adult safeguarding as they are outlined in the statutory guidance are:

- preventing harm and reducing the risk of abuse or neglect

- stopping abuse or neglect where possible

- safeguarding adults in a way that supports them in making choices and having control about how they want to live

- promoting an approach that concentrates on improving life

- raising public awareness so that communities, as well as professionals, play their part in preventing, identifying and responding to abuse and neglect

- providing information and support in accessible ways to help people understand the types of abuse, how to stay safe and how to raise concerns

- address what has caused the abuse or neglect

(s 14.11)

Adult Safeguarding is underpinned by six key principles:
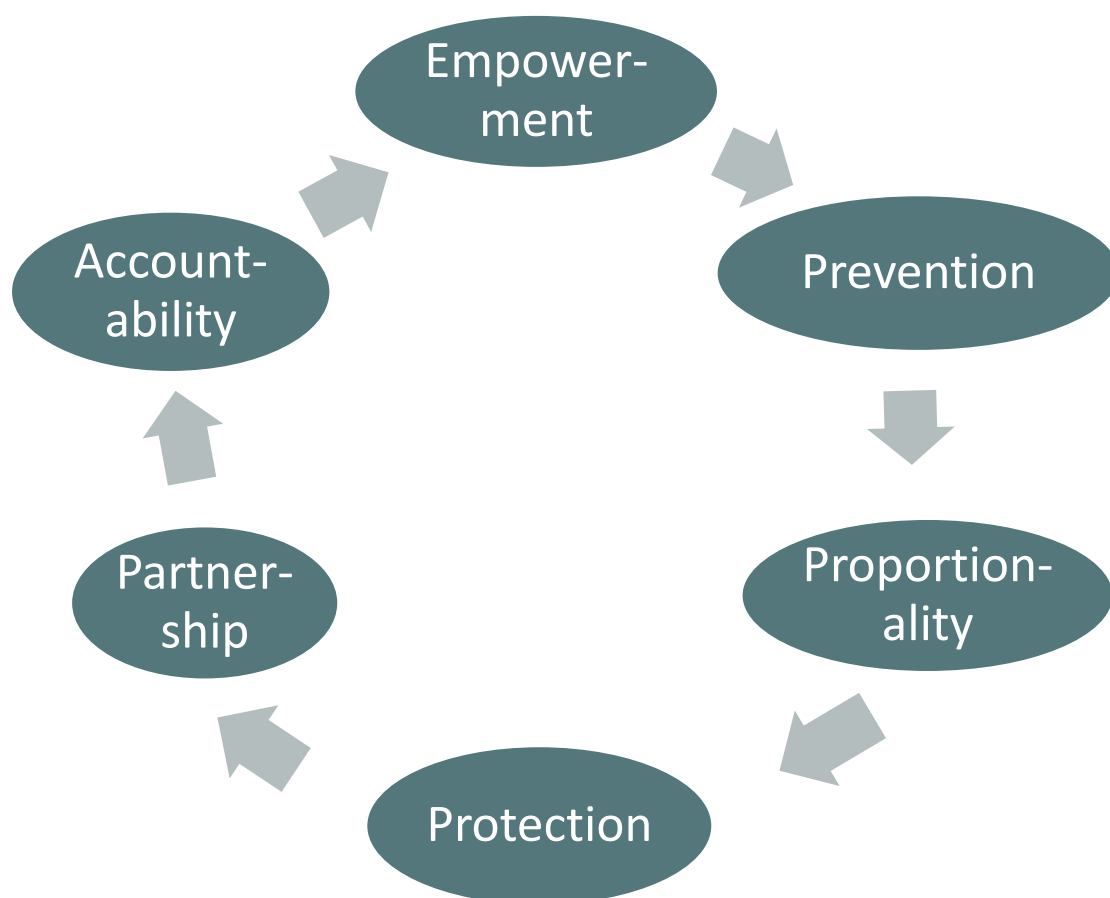
Empowerment – supporting and encouraging people to make their own decisions and informed consent

Prevention – it is better to take action before harm occurs

Proportionality – the least intrusive response appropriate to the risk presented

Protection – support and representation for those in greatest need

Partnership – local solutions through services working with their communities, which have a part to play in preventing, detecting and reporting abuse and neglect

Accountability – accountability and transparency in delivering safeguarding.

(Statutory Guidance 14.14)

The Care Act does not provide a definitive list or explanation of what constitutes abuse or neglect. Instead it gives an 'illustrative guide' to the types of behaviour or actions that may raise concern. The statutory guidance cautions against local authorities limiting their view of what constitutes abuse or neglect (s14.17). The guidance lists the following as types of abuse and neglect safeguarding processes should be mindful of while noting that exploitation is a common theme:

- Physical abuse

- Domestic violence

- Psychological abuse

- Financial or material abuse

- Modern slavery

- Discriminatory abuse

- Organisational abuse

- Neglect and acts of omission

- Self-neglect

Section 42 of the Care Act creates a duty for local authorities to make enquiries when it has

> 'reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there –
>
> > a/ has needs for care and support (whether or not the local authority is meeting any of those needs
> >
> > b/ is experiencing, or is at risk of, abuse or neglect and
> >
> > c/ as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.' Section 42 (1)

Throughout the Care Act there is an underpinning commitment to personalised, person-centred approaches and to avoiding set approaches which recognises that

> We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised; (Statutory Guidance 14.14).

Making Safeguarding Personal (MSP) is an initiative 'which aims to develop an outcome focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances'. Its purpose is to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'
- An approach that utilises social work skills rather than just 'putting people through a process'
- An approach that enables practitioners, families, teams and Safeguarding Adults Boards to know what difference has been made.

The MSP website has a wide range of resources including the publication of regular 'temperature checks' which measure progress, shares good practice and make recommendation for further development.

https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal

2) Safeguarding Adults Boards

The Care Act places a duty on local authorities to establish a Safeguarding Adults Board (SAB) to help and protect adults in their area experiencing or at risk of abuse or neglect. SABs (also referred to as local safeguarding adults boards or LSABs) can do anything which appears 'necessary or desirable' to achieve this. SAB membership includes the local authority, clinical commissioning groups (CCGs) and the police. It can also involve (and is not limited to) the emergency services, health and social care providers, Department of Work and Pensions, housing providers, probation, prison services, GPs, education providers, users/advocacy, carers, Healthwatch, Care Quality Commission (CQC), children's safeguarding boards and trading standards.

3) Safeguarding Adults Reviews

Before the Care Act there was no requirement for Local Safeguarding Adults Boards to undertake or publish serious case reviews (SCR). The previous policy framework *No Secrets* published by the Department of Health in 2000 did not provide guidance on a mechanism or process for reviewing cases in the way *serious case reviews* have been undertaken in relation to children. However, in the mid-2000s the Association of Directors of Adult Social Services (ADASS) published *Vulnerable Adult Serious Case Review Guidance: Developing a Local Protocol* (2006) which recommended a more consistent approach to serious case reviews.

Section 44 of the Care Act created the duty for SABs to arrange reviews when there is a concern that agencies could have worked more effectively to protect that person. The primary purpose of reviews to promote effective learning and action to prevent future deaths or harm happening again. A particular focus should be on

how organisations can better work together to prevent and reduce abuse and to explore good practice that can be applied in future practice.

There is still no requirement to publish SARs although SABs are required to include a summary of findings and recommendations in their annual review (although there is no requirement to publish this review).There had been no systematic collation of Adult SCRs, unlike NSPCC's national case review repository which was launched in 2013 and holds over 800 reviews and inquiry reports (NSPCC undated). The Department of Health has commissioned SCIE and Ripfa to develop a library and supporting materials which was launched in July 2018. However, the relatively small number collated prior to the launch (n = 96 published between 2015-18) compared to the number undertaken nationally (data published by the Department of Health states 90 SARS were produced in 2015-16 and 110 in 2016-17) is cause for concern.

4) Methodology

We initially sought to gather all Serious Case Reviews/Safeguarding Adults Reviews relating to violence and abuse of disabled women and girls since 2002. In the absence of a requirement to publish or central repository (at that point), and in a similar way to other studies of SARS, we used a range of search strategies including searching local Safeguarding Adults Board websites, broader internet searches, reviewing the existing literature on SCR/SABs and contacting our networks. Thus, this was inevitably a partial collection that was dependent on whether local SABs published (or continued to publish as many reviews were only available on line for short periods) reviews and on reports others had collated and where willing to share.

Existing Studies on SCR/SARs found for this review:

Aylett (2016) – a thematic analysis of 114 SCR summaries in adult safeguarding

https://www.emeraldinsight.com/doi/full/10.1108/JAP-04-2015-0012 [abstract only]

Manthorpe & Martineau (2015) – Adults with Learning Disabilities

https://academic.oup.com/bjsw/article-abstract/45/1/331/1739688?redirectedFrom=fulltext [abstract only]

Manthorpe & Martineau 2016 - People with Dementia,

https://journals.whitingbirch.net/index.php/SWSSR/article/view/975 [abstract and references only]

Manthorpe & Martineau (2017) Care Homes for Older People

https://academic.oup.com/bjsw/article-abstract/47/7/2086/2622355 [abstract only]

Braye et al (2015a & b) and Preston-Shoot (2016) – Self-neglect

https://www.emeraldinsight.com/doi/abs/10.1108/JAP-05-2014-0014

https://www.emeraldinsight.com/doi/abs/10.1108/JAP-05-2014-0015 [abstract only

A total of 136 reports of varying types and quality were collected up to February 2018. They were published between 2003 and 2017 with the majority (129) published from 2010 onwards. It is important to note there is often time lag between the incident being reviewed and the publication of the review, for example some reviews take place after criminal investigations or proceedings have been completed.

The reports were reviewed to exclude those that were not clearly related to disabled women or girls engaged with health, social care or housing providers. We also excluded those that were not representative of most cases, for example where isolated cases where the impairment was secondary to substance use or not material in the case. A more detail review of reports started with the most recently published (2017) and worked backwards across until the findings became outdated due to legislative changes, policy development and practice changes (c. 2010). Cases that were similar in findings and service recommendations to other cases extracted were also excluded to ensure the widest scope as not all cases could be extracted due to the resources available. A total of 35 cases were data extracted, during the current phase of research, to ensure saturation of themes in coding analysis (Damschroder, 2006).

5) Learning from SARs: case examples

The four case examples discussed below are illustrative and indicative of the common themes and concerns identified by our thematic analysis. They have also been selected because the SCR/SARs are publicly available.

Melissa (2017) Bristol

Melissa was a young woman (18 years old) who was diagnosed with Autism Spectrum Disorder and ADHD. She had formerly been a looked after child (LAC). Melissa had been placed in a privately-run care home that provided 'residential care for adults with a diagnosis of Autism Spectrum Disorder or Asperger's Syndrome'. The average age of residents was 33.

Melissa was strangled by a young man (19 years old who was also resident at the home) and died of her injuries four days later in hospital. Both Melissa and the young man (YA2) were in out of area placements a considerable distance from their home local authority and their families. Melissa's death was described as 'probable' given what was known about YA2s history and 'preventable' in that various opportunities to act were missed.

Key learning points:

- Melissa and YA2's **out of area placements** were largely a result of an absence of appropriate and available local provision.
- Hosting local authorities should be notified of out of area placements in their locality so they are aware of placements and potential issues (in relation to the victim and perpetrator).
- 'the accumulated experience and voice of children's services was not retained' - effective communication is key to a smooth **transition** between services
- The considerable risk posed to young women by YA2 was 'underplayed' and assessments written in 'uniformly positive language'. Full and accurate recording of safeguarding concerns is necessary.

The review recommended a central repository of SARS:

'to ensure that learning from such reviews is shared more widely and that arrangements are made to periodically analyse SAR reports in order to identify significant issues which could require a national policy response'.

Bristol Safeguarding Adults Board (2017) *Serious Case Review Following the murder of a young adult, Melissa', 18 years old, in October 2014*. Bristol: Bristol Safeguarding Adults Board. The full report, Safeguarding Adults Board response, a statement from Melissa's family and a practitioner briefing are available on the BSAB website:

https://bristolsafeguarding.org/adults/safeguarding-adult-reviews/bristol-sars/melissa-serious-case-review/

Amy (2015) Suffolk

Amy was a 52-year-old woman with learning disabilities, epilepsy, cerebral palsy and known bowel problems. She was living in a supported living scheme. Concerns about the staffs understanding of her health needs resulted in a safeguarding referral in early 2013. In April that year she was re-admitted to hospital following discharge earlier on the same day, this was the subject of a further safeguarding referral. She died in hospital a month later. Her cause of death was recorded as 'Aspiration Pneumonia, Faecal Impaction, Cerebral Palsy, Epilepsy'.

Key learning points:

- Amy's **known health problems** were not adequately managed in social care, the significance of managing her bowel problems was 'lost' when responsibility moved from the NHS to social care. There was a lack **of communication and information sharing**
- Social care staff require **specialist training to meet intimate personal care needs**.

- Failure to recognise that neglect is not always 'wilful'. Records showed staff showed 'clear empathy, compassion and concern for Amy' but didn't understand her bowel care needs.
- There were significant failures in the application of the **Mental Capacity Act 2005 and Best Interest decisions** across all agencies.
- There was no **named care coordinator**, coordinators should work 'within structures that facilitate professional independence, recognises the value of complementary professional skills and **encourages collaboration**, most particularly with people's families or representatives'

Flynn, M. and Eley, R. (2015) *A Serious Case Review Amy* Suffolk Safeguarding Adults Board & Suffolk County Council pp.55

https://www.suffolkas.org/assets/Working-with-Adults/SARs/SCR-Case-Amy-091015.pdf

There is an accompanying report for James (who died in similar circumstances in the same local authority area), SAB notes about constipation and a report about *factors leading to James' and Amy's Compromised Health* Status on Suffolk Safeguarding Adults Board website https://www.suffolkas.org/working-with-adults/safeguarding-adults-reviews/

Angela, Barry, Claire (2015) Sunderland

Angela (48) had diabetes and 'long term mental illness', Barry is her older brother and Claire, her mother. Angela refused her daily insulin injection for 5 days and her life was in danger. She was admitted to hospital as a best interest decision (under the Mental Capacity Act) and her condition was stabilised. Later, under the direction of the Court of Protection, she was discharged into 'accommodation in a

suitable setting'. She, her brother and mother had been subject to a history of concerns and were all described as 'vulnerable adults'. It was felt earlier opportunities to more effectively protect all three had been missed.

Key learning points:

- The need to understand and apply the **Mental Capacity Act** in a timely manner. Despite 'clear evidence from 2011' that Angela lacked capacity to make decisions about medical treatment there was a delay in assessing capacity and then in making a best interest decision.

- **Best interest decisions** must be made by the appropriate professional not a multi-agency case conference.

- Establish clear thresholds at which **self-neglect** (personal care, health and housing) should be recognised as requiring a strategic safeguarding response

- Audit how effectively **cumulative evidence of increased risk** ('low level' concerns) is identified and acted upon

- Better support to those with care and support needs who act as **carers/co-carers** to others (including recognising the complexity of these relationships)

- Consider how front-line staff and managers are supported to **professional challenge** decisions where it is believed they leave a person at risk.

Corkhill, R. (2015) *Safeguarding Adults Review Concerning 'Angela', 'Barry', 'Claire'. Final Executive Summary* Sunderland: Sunderland Safeguarding Adults Review (available through the SCIE SAR library – details below).

St. Michael's View (2013) South Tyneside

Patient A, who is described as frail and having dementia, died in 2010 after experiencing abuse and neglect in a residential care home. There is no reference to Patient A's gender or any other personal characteristics. However, she was named as JB (81) in the local press. The media report also details professional disciplining and criminal convictions in relation to the case including a prison sentence for 'wilful neglect'. The private company that ran the home had ceased trading by the time the serious case review was undertaken and could not be investigated. The care home was described as a having 'no effective measures in place to prevent abuse and neglect'

Key learning points:

- The requirement for timely annual continuing health care reviews for residents
- Promote better relationships between internal and external members of staff to avoid a 'them and us' culture and learning.
- Strengthening of identification of safeguarding concerns after **repeat admissions** (either of the same person or from a particular institution). Coroner's office should have a process for the central recording of all deaths from a case establishment.
- **GPs** require safeguarding training with an emphasis on institutional harm and especially whistleblowing.
- Importance of **families** having clear information about safeguarding protocols and where to get external help

South Tyneside Safeguarding Adults Board (2013) *Serious Case Review into events at St Michael's View Care Home Executive Summary* South Tyneside: South Tyneside Safeguarding Adults Board

A copy of the SCR Executive Summary is available on the Hampshire SAB *Learning from Experience Database*

http://www.hampshiresab.org.uk/learning-from-experience-database/serious-case-reviews/st-michaels-view-south-tyneside/

6) Learning from SARs: Common Themes

When a person moves out of a local authority area, any live safeguarding alerts must be passed to and acknowledged by, the safeguarding authority in the new area.

It is vital that the lives of disabled women and girls and the services that support and seek to protect them are situated within a **Human Rights Framework.**

SARs and the issues they address need to be located in a context of **wider evidence and literature that identifies issues and potential solutions.**

Inadequate or absent services creates vulnerability to violence and abuse and can be seen as a form of organisational and discriminatory abuse in its own right.

The assumption that being in care is safe/safer than being in the community is mis-guided, not supported by evidence. There is a tendency to focus on forms of abuse and neglect 'out there' rather than within services.

A lack of access to and support for **families**, to forms of **advocacy** (including that required by the Care and Mental Capacity Acts) and **peer support** isolates disabled women and girls and increases their vulnerability to abuse and neglect.

Poor, and unlawful, application of the **Mental Capacity Act** was common. All health, housing and care agencies need robust policies and training in place.

It is not yet clear whether the Care Act is being implemented appropriately for disabled women and girls and whether they are subject to **organisational and discriminatory abuse** in its application.

There is learning to be gained in relation to safeguarding from our knowledge of the partial and often problematic application of the Mental Capacity Act.

The failure to address **health needs** was a common theme. Disabled women and girls are dying preventable deaths and experiencing considerable harm and distress as a result of failing to manage and take a preventative approach to health conditions. This can include apparently basic issues like having accessible equipment to measure someone's weight as well as ensuring social care are fully appraised of health care needs.

There should **be information and advice** available for people who self-fund their care and support and for families so they can recognise abuse and neglect and know how to report concerns.

There is a lack of planning to anticipate the impact of transition to new providers, end of contacts and the failure of provider organisations. **Contingency arrangements** should be in place and this information should be available to women and their families.

Disabled women and girl's suspicions of services and service providers are often justified and based on past engagement with services. Staff need the skills and time to engage and build relationships, particularly in a context of '**self-neglect'** for example where women don't attend appointments.

7) **Helpful Resources**

Note: These resources are in addition to those in the references section at the end of this toolkit.

Social Care Institute for Excellence (SCIE) *The Care Act: safeguarding adults* webpages includes a range of resources including implementation support for SARS, checklists and resources for SABs, practice questions and an information sharing guide.

https://www.scie.org.uk/care-act-2014/safeguarding-adults/

SCIE (2015) Adult safeguarding: sharing information

https://www.scie.org.uk/care-act-2014/safeguarding-adults/sharing-information/

Safer CiC has compiled a comprehensive list of Safeguarding Adults Board websites across the UK

http://www.safecic.co.uk/crb-purchase/55-free-downloads-and-safeguarding-links/60-safeguarding-adults-board-links

Addendum: Since we completed our review of SARs Cumbria Safeguarding Adults Board has published a report *Judy Benn. The Critical Last Days A Significant Incident Learning Process*. The report was authored by Rohhss Chapman, David Blacklock and Louise Townson on behalf of People First Independent Advocacy. The report is significant because it is produced by a user-led organisation and, perhaps more importantly, it places Judy and her life at its heart.

http://www.cumbria.gov.uk/elibrary/Content/Internet/327/949/4332281949.pdf

Section 4: Learning from Service Providers

By Dr Aviah Day, Against Violence & Abuse (AVA), with thanks to Dr Lucy Allwright

This section presents the findings from 41 surveys and 6 in-depth interviews with respondents working in disability advocacy, housing, community support, adult social care and the women's sector.   Through this research a number of key themes emerged, which will be presented here as suggestions for best practice in safety planning for disabled survivors of domestic violence.

1) Accessibility

Disabled survivors of domestic violence and abuse are protected under the Equality Act (2010), which seeks to ensure that everyone has equal access to the support they need. The Act states that it is a legal requirement that public institutions such as the police, health services and local authorities take account of people with impairments when delivering and commissioning services. Despite this, the most significant theme that emerged from our findings was that most services remain inaccessible to disabled survivors of abuse:

> "A lack of [British Sign Language] interpreters is one of the biggest barriers to support our survivors face. Housing, social service, police, court, health services, all of them we face the same issues. We have to fight to get interpreters booked. Survivors have to go to court and everything gets delayed because no one has booked an interpreter. Social services will turn up to a client's house without an interpreter and then still try to do an assessment even though the client has no way of communicating." **DeafHope. IDVA 1**

"Most statutory and voluntary agencies don't have the budget to book interpreters. So they have this because for not supporting Deaf survivors. Housing often point-blank refuses to book interpreters. Some council do have video relay available which is helpful. But Barnet for instance say they have sign video relay, but when you ask for it you see a panic from the staff because it's out of date, they don't provide the service anymore, yet they still advertise the service." **DeafHope, IDVA 2**

Ensuring equal access to services is critical if disabled or Deaf survivors of abuse are to have any chance of living a life free from violence and abuse. Best practice suggestions that have emerged include:

- Review your organisation's equality and diversity protocols to ensure that clear guidance on accessibility is included

- Adapt the physical environment where service users are expected to access services to ensure disabled clients are not physically excluded.

- Consider making home visits. Rather than ruling out visiting a service users' home, consider carrying out a risk assessment on a case by case basis with the support of other agencies (for example, disability support services, domestic violence services).

- Include accessibility costs in the planning of a service.

- Where possible, ensure that video replay and hearing loop services are available, well-advertised, and up to date.

- Where possible, book BSL interpreters or have Deaf members of staff in your services who are trained and qualified to work with survivors

- Offer training in BSL and Deaf culture to staff

2) Assumptions about Disability and Violence Against Women

A further theme that emerged was that services often make assumptions about disabled people that can result in the needs of disabled survivors being unmet. It is important to recognise that disability can present in a range of ways, and that some people have 'hidden impairments' which means that a person's condition may not be immediately noticeable. Evidence emerged that some professionals may assume that those with impairments present as vulnerable or timid. Further, respondents indicated that disabled survivors had faced assumptions about their ethnic background and the nature of their relationships.

> I supported a blind survivor of domestic violence who was originally from Nigeria to get housing. When she explained to the housing officer that the perpetrator was smashing plates around her to frighten her, the housing officer claimed that this was not abuse but a 'relationship breakdown'. The housing officer suggested the perpetrator was 'stressed' from his caring responsibilities. She actually had a full-time job in an education setting and was highly independent" **Community Support Worker**

> "A lot of the disabled women I supported were sex workers, and I felt like my managers were reluctant to see them both as disabled and as sex workers, because somehow their disability would negate their agency and decision making, and somehow make them less responsible." **Housing Support Worker**

"Because she was in a same sex relationship with her carer, who was also her perpetrator none of the agencies involved saw what was happening as domestic violence. I think she was also dismissed as a nuisance by housing because her council property had been heavily adapted and now she wasn't safe there... housing were really unhappy about that" **Mental Health Support Worker**

Disabled survivors of abuse are as diverse and varied as any other section of society. To ensure that appropriate safety planning takes place, the following practice points have been raised:

- Be open minded to the ways in which disability and abuse may present.
- Actively unlearn any assumptions you may have about disabled people and survivors of violence.
- Take an intersectional approach; a survivor's impairment may not be the only need in their life and may not be the most important issue they are facing when they are seeking services.
- Be receptive to the ways in which disabled service users describe their relationships. This can include carers, partners and family members. These relationships may be distinct or may overlap, so it is important that the ways in which these relationships are defined are user-led.

3) Working Together

Respondents reported varied experience of multi-agency working, with some disclosing positive and effective working relationship and others facing more difficulties. A coordinated multi-agency response can help to address some of the additional barriers disabled survivors face when attempting to end violence and abuse. Respondents reported the following experiences of multi=agency practice:

> "I supported a disabled survivor who had experienced a lifetime of abuse. It got to the point where there was police involvement, unknown to the perpetrator. An IDVA sent a referral, they sent it as a safeguarding alert. But there was no evidence she had care and support needs. The IDVA gave me a time when the perpetrator would be having appointments, and then I would call round when he was out. So, through coordinating between the police, myself and the IDVA we were able to make an assessment, safely and then make sure her needs were met." **Adult Safeguarding Duty Worker**

> "Multi-agency working really comes down to the individuals. Some people are really interested, are really motivated and other professionals are just not interested. Social services is the hardest, children's social workers are the hardest. Every time we meet with them we have to explain about Deaf awareness and Deaf culture and then the next meeting it will be a whole new social worker. That becomes a delay in the process and can be dangerous" **DeafHope IDVA 1**

"One of the things that really helped was linking up with a disability charity who got funding for this survivor to get a laptop, so that she could continue with her studies." **Housing Support Worker**

Practice points for multi-agency practice include:

- Take the time to develop a coordinated safety plan as directed by the survivor. There should be agreement about the roles each agency will play and how information will be shared and relayed back to the survivor.
- Identify a single point of contact to relay information back to the survivor. This could be an IDVA, a disability support worker or anyone the survivor has a trusting relationship with.
- Be open to sharing knowledge and expertise with other agencies.
- Be open to learning from service users and professionals with lived experience
- Take an expansive view of the kinds of agencies that can offer support, such as those that can offer long term, educational, training, employment and wellbeing support as well as immediate risk management.
- Disabled survivors face significantly more barriers and delays in their journey towards a life free from abuse. Therefore, it is important that the professionals holding the case remain the same, where this is possible.

4) Specialism and Lived Experience

Many of those professionals with lived experience and specialising in disability service provision felt that it was important that other agencies valued and respected their knowledge and expertise.

> "Most social workers work on the assumption that Deaf parents can't look after their children because they can't hear. We get told 'what if there is an alarm, and they don't hear it go off' and we say well, bring in alternative equipment. We go to Court and we ask for an assessment by an independent Deaf social worker because they will get to know the person, they will have all the background knowledge. But we have to fight to get that because a lot of Deaf parents can look after their kids, they just need the right support". **DeafHope IDVA 1**

> "Training and education, when people do have it makes all the difference. Training in Deaf awareness should be mandatory; it shouldn't be optional for professionals. Especially statutory services that work with Deaf people, they should have that training before they meet deaf clients so they know what the issues are." **DeafHope IDVA 2**

Points for good practice include:
- If you are supporting a service user with a condition you know little about, be open to being led by them and seek support from specialist services.
- Consider whether you have the correct expertise to carry out an appropriate assessment and whether an independent specialist could be employed.
- Ensure that all staff that are likely to ever offer support to disabled survivors have full and detailed training by people with lived experience.

5) Intersecting and Additional Barriers to Safety

Although the discriminatory service response to disability can be an enormous barrier to safety alone, it is important to recognise that for some survivors, this is one of many obstacles they are navigating on a daily basis. The evidence presented has shown that disabled survivors may also face discrimination based on their ethnicity, nationality, sexuality, gender, involvement in sex work as well as many others. One area that was frequently raised as having created further barriers for disabled survivors was related to immigration and No Recourse to Public Funds.

> "I had this one client from Poland. Her first language was Polish and then Polish Sign Language was her second language, her third language was British Sign Language and then her fourth language was English. When I first met her we couldn't communicate. Over time, we gestured and eventually we kind of came to some kind of understanding. I tried to explain her rights to her and told her we have to sort out the communication issue first before I could support her with her rights. We had to use Google translate to get basic communication; we use role plays and pictures. It eventually worked and we got there from taking the extra time". **DeafHope IDVA 1**

> "Someone I supported had moved her from Kuwait to this country. She was 15 when she moved here, so she didn't know anything about British culture. She went to college, met a man and fell in love and her family rejected this man. They eventually got married and had 6 children. She

lived with her husband's family. She didn't realise at the time that she was being controlled, and actually she was being treated like a modern slave. She was being very heavily abused and exploited by her husband and his family. She would have been able to apply for a British passport, but his family had hidden a lot of information from her. She eventually regained contact with her family and told them. They called the police and that's when we got involved. It was a very challenging case because there was a big battle with immigration. They wanted all sorts of documents and evidence, which she didn't have. She then struggled with finding appropriate accommodation and housing because she had no recourse to public funds. So then it was a battle with social services to get them to agree to house her and the children. She has now been able to get access to public funds, has got housing and has been able to live free from violence. Communication was the main thing. She couldn't write a text or speak English or use BSL. She had no concept of the British system. It was about education. She feels deaf hope saved her life" **DeafHope IDVA 2**

"In one case we supported a physically disabled survivor who had no recourse [to public funds] ...I don't think it was legal but it wasn't safe not to." **Adult Safeguarding Duty Worker**

Areas for good practice:

- It is important to know that in England the Care Act 2014 states that Local Authorities are required to provide WHAT TO destitute migrants who do not

have children, where they have a disability, illness or mental health condition.

- Disabled survivors who are also migrants may require support for a considerably longer period then other service users.

- Take a flexible approach to communication if interpreters are not an option. Use google translate, gestures or role play alongside linking service users into ESOL and/or BSL courses where possible.

- Disabled survivors with insecure immigration status may require support from a greater number of services than other service users. This may include immigration solicitors, housing, adult social care, disability support and domestic violence services.

- Eligibility criteria will differ from agency to agency for those with No Recourse to Public Funds. You may need to do additional research on service users rights and engage in institutional advocacy. Rights of Women are an expert source of information in this regard (https://rightsofwomen.org.uk)

Section 5: What do disabled/Deaf women and girls want from services to help them stay safe in the medium and longer term after violence and abuse?

The research above and other work already exposes the extent and patterns of violence against disabled people. Disabled People's User-Led Organisations (DPOs/ULOs) have been working for many years to raise awareness of the problems, assist survivors, provide advocacy and improve services, but are not yet equal partners, or adequately resourced in statutory domestic violence, safeguarding, criminal justice or health and social care services.

This project builds on much valuable work, including a four country, Daphne III funded project which made recommendations for commissioners, mainstream domestic violence services and survivors rights (cf. Shah et al, 2015), as well as the Equality and Human Rights Statutory Inquiry into Disability-Related Harassment. However, a gap was identified about the needs of survivors in the longer term, after refuge or rape crisis services, which this project seems to address.

The recommendations from disabled or Deaf survivors in this project are:

1) **Accessible, safe services with no risk of harm, violence or neglect**

Nice Guidance (2014) in domestic violence service pathways explains that:

> "Health and social care service managers and professionals should ensure *front-line staff in all services* are trained to recognise the indicators of domestic violence and abuse."

The Welsh Government has committed to frontline civil servants and community services all being trained to recognise that violence may be part of the story in service users lives and NHS Scotland has embedded Routine Enquiry into its Action Plan on Gender-Based Violence. Citizens Advice has introduced Routine Enquiry into gender-based violence and abuse in many local offices in England and Wales, to ensure that they can support and refer survivors appropriately to specialist services, whilst accessing necessary financial provision in debt, welfare, housing and relationship advice for survivors.

Given the pervasive representation of disabled people using health and social care services, Routine Enquiry at the intersection of violence and disability can be very valuable. The first disabled or Deaf woman to use a service should not be expected to be an access expert who has to advocate for her rights.

Routine Enquiry into violence and access needs should be asked of every service user in relevant areas, in order to provide the necessary signposting to assistance that is required.

> I just want to be able to get help without having to explain my disability or my violence. If they just asked everyone, 'What do you need?' like Braille or words and pictures, and, 'Have you ever had violence?' that would make it so much easier. It gets exhausting having to teach everyone about everything I need. It should be their job to be able to help." (Service User, Wales).

Adopting the social model of disability (and training staff about it) is one of the first important steps to being able to acknowledge barriers in services and society. The social model explains that a person with an impairment is disabled by attitudes and barriers in society.

This defines disability not as a pathological lack of function to be pitied or segregated, but as, "The disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities." (UPIAS, 1976). By turning the focus of action onto organizational and societal barriers (using Disability Equality Plans and Impact Assessments for example) and away from disabled people's mistakenly inherent 'vulnerability', services can become safer. This is one of the reasons that vulnerability was removed from the Care Act (2014), to be replaced with requirement of protection from situational risk of exploitation, harm and neglect.

One common definition of intellectual disability explains that it is characterized by significant limitations in both intellectual functioning and in adaptive. This is arguably a definition more reflective of intellectually disabled services which fail to eliminate and prevent violence against service users, than one reflective of the service users themselves. As trauma-informed and trauma-responsive approaches explain, it is more important to ask, "What has happened to this woman?" rather than, "What is wrong with this woman?" (cf. Covington & Bloom, 2018).

In user-led programmes like Quality Checkers and Safety Ambassadors, disabled people measure the quality of health and social care services that they use nationally; this was widely adopted after the Mazars independent review into Southern Health NHS Foundation Trust in 2015.

In practical terms, the involvement and co-production of work with disabled survivors of violence can assist in cultural change and performance improvement.

For example, extending the remit of the Quality Checkers and Experts by Experience programme to include specialist 'mystery shoppers' and people with lived experience who have experienced violence, neglect and abuse, can help commissioners and inspectors to assess the safety of their services. Experts by Experience speak to people using services and their family/advocates on inspections of services. They may either do this face-to-face or on the telephone depending on the service to be inspected. They also observe how the service is delivered and speak to staff.

Findings from disabled people are used to support the inspectors' judgments on services and can also be included in inspection reports. Ensuring these teams include disabled people with a lived experience of violence can assist Inspections and Commissioning to be safer and more representative of the community they serve.

2) Stable, safe, accessible housing:

The key to a safe, meaningful life and independent living is stable, accessible housing. The general lack of provision for survivors of violence and people living in poverty is a problem, but the lack of accessible housing compounds this. If a disabled woman needs assistance to orientate herself in a new community, rehabilitation or independent travel support is often lacking, particularly if safety is not part of her support plan. One survivor of violence with a visual impairment told us,

> "Nobody can get a life and make friends if you are moving every few weeks from B&B to crummy flat. They were in different places – I had no help to work out where the buses were or how to get to the nearest shop."

Some good practice was found by specialist housing associations using a Housing First model and Reunite (which specializes in housing criminal justice involved women and their children), but this was in only a very few areas of the country. In many cases, survivors were housed in unsafe areas, near perpetrators of violence released from prison, substance users and gangs.

Adaptions may have been made to the house in some cases, but not to the safety of the area in which the woman was expected to live, furthering isolation and social exclusion.

Whilst any housing for survivors is valuable, being socially excluded opens the survivor up to further violence and abuse. Disabled people can be cuckooed (targeted by organized criminals who then use the premises for substance dealing and/or prostituting women) and the disabled person can often then lose their tenancy.

Thus, social relationships and community life must be important considerations in support planning; they are not just 'nice' optional extras – they are integral to keeping people safe and preventing violence.

3) **Pro-social relationships with friends and family**

It is self-evident that survivors of violence should have the human right to a family and community life and supporting any relationships which may be valuable after violence should be a priority. Resisting isolation can prevent the risk of violence and thwart common perpetrator attempts to remove people from their support networks. As one survivor told us,

> "It really helped living near my sister. He [the perpetrator] had ruined all my relationships and stopped me seeing people. So being able to help her out, like baby sitting and popping round for a cuppa, really helped me to move on. They tried to offer me a house miles from anyone and I didn't want to be more lonely again."

Another survivor explained:

> *"I* go to my friends and we talk about other things. We might fold washing and just talk or make some big pots of meals for both of us for the week. You don't have to cry or be loud, you can just be there, or she comes to my house and does the same. But it is good she has been through that as well so I don't have to explain all the time."

For disabled people who have been segregated (particularly out of area in long-stay hospitals and residential institutions), existing relationships with people not paid to be in their lives may be few and far between, particularly given the dis-investment in peer-support or self-advocacy groups.

In these cases, professionals must ensure that meaningful activity to build safe relationships are fostered as part of their support plan. This may include building a wider selection and trials of 'different choices to pursue meaningful activities and friendships, as discussed by Hollomotz (2014).

One survivor discussed how she had found a new hobby that enriched her life and removed the need for sleeping medication:

> "[The choir] is one night a week, gets you right out properly, then you are tired when you come back so I get a proper night kip. It's all sorts – not just hymns and that. We do African songs and classical. I've even been to the Sage [a prestigious music venue on Tyneside]. Never thought I'd ever do things like that! There's about twenty – proper members - so you can hide in the back and we all wear black so ye don't feel stupid with what you wear.

> I look forward to it. Then I practice at them as well. And you can talk to people there - like men – and not think they are ganna get you into bed, cos they're all for the singing."

It is contact between minoritized and mainstream groups (not segregated services where people with one impairment diagnosis are in contact with each other but not the wider community), which is a key tenant of the Public Sector Duties in the Equality Act (2010), to foster good relations.

Whilst this is often understood as an important priority to tackle hate crime against people from a particular religious or ethnic group to prevent violence, it is equally important in the prevention of violence against disabled people.

A survivor with learning difficulties who had used My Sister's Place (a refuge on Teesside which has grown to deliver services for diverse women) explained how the reciprocity between survivors enriched her life:

> "I look after old ladies from there. I go and visit them and put the kettle on. They think I pop in because I'm lonely but really I'm looking after them."

4) Peer support and involving survivors

The friendship of survivors can assist in 'recovery' after violence and abuse; it prevents women feeling alone and resists self-blame.

> If it wasn't for the group, I wouldn't have gone out…We are all ladies and all self-advocates. People like us [with the label of learning difficulty] come to the group and we talk about what we should do about problems. Then we say how we can help ourselves then we plan things.

Many women make these friendships in domestic violence refuges, but often disabled women experience a lack of accessibility and cannot therefore be placed in them. A disabled survivor in Tyne and Wear was placed in a budget hotel for many months after fleeing violence and this is not an uncommon story. There is only one Deaf women's refuge service in the whole of England, so Deaf women escaping violence cannot communicate closely with other survivors who do not have British Sign Language. This prevents peer support access which is essential to longer-term outcomes. It is the duty of the lead Commissioner for safety and violence services in local authorities and health services to ensure access for disabled people is resourced for mainstream domestic violence, rape and health services.

Many women who have used refuges go on to campaigning against violence, volunteering and employment in the sector in the longer term (as described by Solace Women's Aid), but this is not an option for disabled women when many mainstream services are not accessible in terms of physical, communication or cultural environments in these services. When mainstream refuge services work hard to include disabled women, the outcomes can be excellent:

"I know My Sister's Place. It was a refuge but it's grown. It's good for women cos you can say to people, I'm going to my sister's place. If they don't know what it is it sounds normal, not like a project. Clever, that."

The experience of this woman in a welcoming, gender-specific violence service is in stark contrast to that of another woman who was simply referred to one-size-fits-all mental health services which were not specialists in working with victim-survivors of violence:

"My doctor got me to go to CBT. I would have liked a woman therapist but they didn't offer me one. I went anyway and told the man who was doing it about my ex hitting me. He said, 'We don't cover that here – it's specialist' but the doctor just said that was all there was."

5) A choice of personal assistance

Given the levels of abuse, neglect and violence perpetrated by people employed in disability services and institutions, it is crucial that survivors are supported to make choices and be in control of who provides their support. This is required for all disabled people (and user-led organisations like Choices & Rights in Hull provide support for people to manage their own budgets and employment arrangements), but is particularly important for survivors of violence.

The low pay of carers and lack of consistency provided by private agencies and large charities that are not user-led, can be particularly frightening and traumatic for women who have already experienced sexual and physical violence at the hands of people who were in charge of their personal care. Personalisation does not only mean control of the budget, but control over who provides the care and how that is delivered.

One survivor told us:

> "I really didn't want just anyone doing my bathing, so the ability to choose who was looking after me, instead of an agency sending different carers, was really important for me to be safe. I mean they have a key – you don't want just anyone wandering in!"

This personal assistance must include support to parent, given the disproportionate number of disabled people who have their children removed from them, leading to impaired life chances and expensive 'care' for both the mother and child.

Report Conclusion

This research was user-led by Vision Sense, a Disabled People's User-Led Organisation, and co-produced with Against Violence and Abuse (AVA), a charity which aims to end violence against women and the Centre for Disability Research (CeDR) at Lancaster University. It was funded by DRILL, for the Big Lottery Fund.

This research has established that there are severe barriers to equality of outcome for disabled or Deaf women who are survivors of violence, particularly at the intersection of gender, disability, ethnicity, poverty and multiple disadvantage. Under-resourced public services and over-resourced segregated, privatised provision contributes to barriers to safety and longer-term independent living after physical or sexual violence, psychological or psychological abuse, institutional, domestic violence and hate crime in England today.

Equality of outcome and the return of life chances can be achieved, by co-production of solutions with disabled survivors who have a lived experience of violence. This could assist to remove and prevent violence that is correlated with poverty and segregation and tackle barriers in the complex and expensive national and local webs. A great deal of regulation in safeguarding, inspection, commissioning and for-profit or charity provision is not fit for purpose and is failing the disabled people it purports to serve.

We call upon our allies in mainstream services to work with user-led organisations to end violence against disabled people. In preventing deaths and improving safety, there should be "Nothing about us, without us."

Checklists for tackling violence against disabled women

Recommendations for all services

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Ensure full communication, information sharing and transfer of social care, health, education and policing knowledge (particularly safeguarding alerts) when people (either perpetrators, survivors or victims) move between services or geographical areas covered by different Safeguarding Adults Boards or agencies. The receiving organisation must also acknowledge receipt of the alert and take action.		
Adopt the social model of disability at policy level (and train staff to eradicate barriers in the service).		
Involve disabled women who are survivors of violence, neglect and abuse in commissioning, service provision, training and inspection, to address the lack of knowledge, recognise, improve disclosure and respond to violence and abuse.		
Improve accessible information about institutional violence and abuse, disablist hate crime and safeguarding.		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Prioritise commissioning user-led and self-advocacy organisations of disabled and Deaf people alongside agency multi-disciplinary teams and mainstream service provision in each local authority area. This can reduce isolation and improve access to services and employment for disabled people.		
Routine Enquiry into violence and access needs should be asked of every service user in housing, social care and health. Ensure that a service user has a chance to disclose personally, without other members of her care team/family being in the room or responsible for interpretation / communication. Remember that person may be coercively controlling or linked to the perpetrator so you may not get all of the information you need with in their presence.		
Schools and local authorities/safeguarding boards must provide adequate relationships and sex education for disabled people.		
Ensure that all staff have full and detailed equality training by qualified people with a lived experience.		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Capacity assessments and best interest decisions must be made by the appropriate professional (not unqualified staff).		
Introduce a process to enable front line staff and managers to professionally challenge decisions where it is believed they leave a person at risk.		
Audit how effectively cumulative evidence of increased risk ('low level' concern) is identified and acted upon, to prevent risk escalating and identify institutional or organisational problems earlier than at crisis.		
Strengthen identification of safeguarding concerns after repeat referrals or admissions (either of the same person or from a particular institution).		
Staff, volunteers and families must be protected from harassment or victimisation (particularly part-time or casual staff) if they raise concerns and should be protected by whistle-blowing regulations, even in private provider services and agencies.		
Health, housing and social care agencies and providers must put robust mental capacity policies and training in		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
place.		
Implement the Care Act requirements appropriately for disabled women and girls and remove (even unintentional) organisational and discriminatory abuse in privately owned services.		
Address health needs prevent deaths by managing and take a preventative approach to health conditions and public health concerns for disabled people as well as the 'general' community.		
Staff need the skills and time to engage and build relationships, particularly in a context of 'self-neglect' for example where women don't attend appointments, or where previous experiences of the service have been substandard, to build trust and confidence.		
Review your organisation's equality and diversity protocols to ensure that clear guidance on accessibility is included		
Adapt the physical environment where service users are expected to access services to ensure disabled clients are not physically excluded. Rather than ruling out visiting a		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
service users' home, consider carrying out a risk assessment on a case by case basis with the support of other agencies (for example, disability support services, domestic violence services).		
Include accessibility costs in the planning of a service or funding a project.		
Where possible, ensure that video replay and hearing loop services are available, maintained at least annually, well-advertised, and up to date.		
Where possible, book BSL interpreters or have Deaf members of staff (or a contracted organisation) for your services who are trained and qualified to work with survivors.		
Ensure consistency of caseworkers/named professionals over time, to build trust and so that survivors do not have to tell their story several times to different workers.		
Remember that violent outbursts, mental distress, self-harm and self-medication with substances or alcohol may		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
be rooted in an experience of trauma or violence and do not judge service users in these situations. Have staff trained in de-escalation techniques and have access to places of safety.		

Recommendations for Safeguarding Boards

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Where safeguarding alerts have been triggered, intelligence MUST be sent to the new local authority when a service user moves between areas.		
Where violence is found or suspected, professionals must work to meaningful improvement to people's circumstances and activities, rather than just on 'investigation' and 'conclusion'. Facilitating peer support and mental health services for victims after trial or safeguarding process is concluded is essential (e.g. Freedom Programme, self-advocacy or user-led group).		
Safeguarding Boards should make learning available in a summary of every SAR (as a minimum) for more than one year and hold local professionals accountable for changing practice each year, demonstrating how they have met the recommendations.		
Safeguarding Boards in different areas should notify their knowledge of risks and failures in out of area placements (including assessment units) to other Boards with residents in those placements.		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
The safeguarding board should ensure independent assessments and care and treatment review findings are passed to them if they have a resident in the placement as standard.		
SARs and Domestic Homicide Reviews must have due regard for – and report - gender, ethnicity and impairment (plus other diverse) intersections of discrimination and exclusion related to the case.		
A named care coordinator or lead case worker from one agency must be appointed in high risk cases and should collaborate, most particularly with people's families, advocates or representatives.		
SARs and the issues they address need to be located in a context of wider evidence and peer-reviewed contemporary literature that identifies issues and potential solutions.		
User-led organisations / Quality Checkers must be resourced and part of the Safeguarding Adults Review or Domestic Homicide Review processes where disabled		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
people are involved.		
Take the time to develop a coordinated safety plan as directed by the survivor. There should be agreement about the roles each agency will play and how information will be shared and relayed back to the survivor.		

Additional Recommendation for Coroners: Coroner offices should have a process for the central recording of all deaths.

Recommendations for social care and health services

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Improve access to user-led advocacy and networks of support planning, brokerage of personalised budget packages in safeguarding situations, particularly where financial abuse has been found or is suspected.		
Remove options of institutional and segregated care/education, particularly out-of-area placements, for under 16s as well as adults. All disabled people?		
Ensure that parenting support and education is provided for disabled people. Work with user-led organisations to reduce and prevent the extent to which children are removed from disabled parents (particularly those with the label of learning difficulties and after violence).		
All disabled people's support plans must include safety and justice elements, with prevention of restraint, de-escalation in crisis, reporting and support mechanisms for violence, neglect and abuse and meaningful community contact		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Ensure risk appraisal is not over-protective but allows the disabled person to achieve a safe, meaningful life with community contact, user-led advocacy and avoiding segregation or institutionalisation.		
Ensure that staff are not locating inherent vulnerability with the disabled person. Ensure up-to-date knowledge about the safeguarding provisions of the Care Act (2014), which includes a requirement to assess and safeguard people from situational risk of exploitation, harm and neglect. This can be done as an anticipatory duty, to risk assess your provision, without waiting for a Serious Case to change practice.		
Ensure at least one member of each person's support staff and community nursing team (including agency staff) are fully trained in violence prevention, intimate care dignity, mental health first aid, CPR and safe restraint practices. This must be checked by the social worker and not simply devolved to service providers.		
Recognise that neglect and abuse is not always 'wilful' or intentional, but still requires action and prevention.		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Establish clear thresholds at which self-neglect (personal care, health and housing) should be recognised as requiring a strategic safeguarding response.		
Families (including self-funders) must be given clear information about safeguarding protocols and where to get external help as standard, when a relative is admitted to an institution, care home or placement. E.g. Hull research – I have ref at home		
Personal assistance must include support to parent, given the disproportionate number of disabled people who have their children removed from them, leading to impaired life chances and expensive 'care' for both the mother and child. Trauma-informed support after a child is removed is necessary to ensure the woman does not simply have more children removed in the future and to maintain trust and confidence in official services.		
Ensure adequate advocacy, peer support for service users and support for families and carers (including that required by the Care Act and Mental Capacity Act) to prevent isolation that leads to violence and abuse.		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Ensure that meaningful activity and community contact to build safe relationships with people who are not paid to be in people's lives are fostered as part of support plans, to prevent the isolation which leads to risk of harm.		
The accumulated experience and voice of children's services must be retained, to ensure effective communication is key to a smooth transition between child and adult social care services. Young people must have opportunities away from their parents to discuss sex, relationships and safety.		
Ensuring gender-specific services which are safe for victim-survivors of violence (particularly in mental health services) should be commissioned, rather than a one-size-fits-all mental health services which were not specialists in working with victim-survivors of violence.		
GPs require safeguarding, institutional harm and whistleblowing training, particularly when they are responsible for residents of care homes/institutions/assessment centres/segregated schools.		

Recommendations for housing providers

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Address the lack of appropriate local independent living and supported community provision, to prevent the stepping up to too restrictive settings and out of area placements.		
Ensure survivors of violence are not housed in unsafe places, near known ex-perpetrators or other neighbourhood 'nuisance' or hate crime risks.		
Ensure support workers are separately employed by a body which is not the housing provider where disabled people live; if disabled people are to disclose abuse or neglect, they should not need to worry about their tenancy being at risk.		

Recommendations for service providers

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Adopt trauma-responsive practice to facilitate disclosure and 'recovery' after violence and abuse.		
Reach out to disabled people in segregated schools, residential homes and supported accommodation, and those with agency support workers in their own homes (the domestic setting for disabled people, where violence risk is highest, is different to that of non-disabled people).		
Ensure up-to-date knowledge and best practice is in place regarding mental capacity assessments and best interest decisions across all agencies and commissioned teams and services. Ensure that new/refreshed assessments are delivered when there is a change of circumstance.		
Timely annual health and social care reviews for residents of segregated schools, residential care homes and institutional placements.		
Promote better relationships between internal and external provider staff to avoid a 'them and us' culture.		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Promote joint learning opportunities based on multi-disciplinary team models for training.		
Follow Nice Guidance on domestic violence, which states: "Health and social care service managers and professionals should ensure front-line staff in all services are trained to recognise the indicators of violence and abuse."		

Recommendations for Commissioners & Inspectors

Recommendation	Action by (date):	Agency / Lead Person Responsible:
End out-of-area placements of disabled people. When commissioning providers of segregated placements (which is not recommended), authorities must ensure as a minimum that the ratio of staff to service users, pay and training of staff is adequate, to tackle institutional violence and preventable deaths.		
Include Quality Checkers and Experts by Experience in service inspections, Care & Treatment Reviews and include in the remit of the team considering the signs of violence, abuse, unsafe restraint and neglect, and/or identifying any best practice (e.g. Safer Wards provision) to prevent it.		
Monitor providers to avoid, prevent and tackle allegations of violence, neglect, unsafe restraint practices, poor capacity assessments, a lack of independent advocacy, and the use of low-paid and un-trained staff or under-staffing. Require annual disclosure of all incidents in facilities / of all of the provider premises in services you commission or inspect.		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Plan to anticipate the impact of transition to new providers, end of contacts and the failure of provider organisations. Contingency arrangements should be in place and this information should be available to disabled people and their families at least six months before existing provision ends.		

Recommendations for Police Services

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Build community links with disabled people in segregated schools, residential homes and supported accommodation, and those with agency support workers in their own homes (the domestic setting for disabled people, where violence risk is highest, is different to that of non-disabled people).		
Ensure that where violence is found or suspected and the case is investigated and/or sent to MARAC or other Multi-Agency meeting, the alleged perpetrator is arrested and investigated, corroborating evidence found, with the file passed to the CPS, wherever possible.		
Ensure that disabled or Deaf victims of violence and crime are supported to give their best evidence (e.g. with intermediaries, special measures, appropriate adults and pre-trial interviews where possible) and that full Police investigation is made of serious safeguarding cases.		

Recommendation	Action by (date):	Agency / Lead Person Responsible:
Where an interpreter is working with a survivor, ensure that they are trained to the level required by the Courts if they are taking a statement or evidence that might be used in prosecution and ensure that the same interpreter is not working with the victim and alleged perpetrator (particularly where there is a shortage of the required language interpreters in the area).		
Police must not fail to make charging decisions on a misguided perception about credibility of the victim; where there is a query about credibility, investigation files must be passed to the CPS for the full code test.		

Glossary

DHR	Domestic Homicide Review (DHR) is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.
IDVA	Independent Domestic Violence Advocates (IDVAs) support victims of domestic violence who are at the highest risk of serious injury. IDVAs should be accredited and have the experience, skills and knowledge to support clients and help to manage and reduce risk.
ISVA	Independent Sexual Violence Advisors (ISVAs) are trained to look after clients who have experienced rape or sexual assault. ISVAs should be accredited and qualified to explain the process of reporting to the police and also the importance of forensic DNA retrieval.
RE	Routine enquiry involves asking all clients at assessment in some relevant services (e.g. maternity, sexual health, housing) about whether they have experienced violence or abuse regardless of whether there are any indicators or suspicions of abuse.
SAR	A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. The aim is to identify learning, not apportion blame.
SCR	A Serious Case Review (SCR) is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death and there is cause for concern as to the way in which the relevant authority or persons have worked together to safeguard the child.

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