Stay Safe East Response to the Women's Health Strategy Call for Evidence – June 2021

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Our submission is in large print, so 18 pages long.

1. INTRODUCTION

Stay Safe East is a disabled people's organisation providing holistic advocacy and support services to disabled people across London who are survivors of gender based violence against women and girls, hate crime, abuse in institutional settings and other forms of targeted crime. We offer a small counselling service and peer support network. Our policy remit is national, working with VAWG sector organisations, the Home office and other government departments to include disabled survivors in policy and strategies and to ensure that the criminal justice system, health, adult and children's social care, housing and VAWG services respond to the needs of disabled survivors.

Stay Safe East's health expertise lies in the lived and professional experiences of our disabled staff, Board and volunteers, and of our clients, 85% of whom are disabled women (with a small number of transwomen) with a wide range of impairments and identities. All of us use health services – whilst we may one day praise the treatment we receive, another day we may decry the discrimination and insensitivity we have faced, in the case of some clients at the cost of their lives. 11 years of casework has shown the relationship between impairment, health and abuse to be complex, but solutions do not have to be complex. Our response is also informed by our VAWG Policy Advisory Group which includes organisations of and for Deaf and disabled women (SignHealth, Sisters of Frida, Disabled Survivors Unite), disabled academics and individuals and national VAWG organisations (Imkaan, Solace, Safe Lives, EVAW etc).

We focus on the health of *disabled* women and girls, and in particular on that of disabled survivors of abuse: domestic abuse (including by non-family members who act as carers or support workers), rape and sexual violence, forced marriage, FGM, cuckooing, misogyny, abuse in institutional setting etc. We have touched on the experiences of Deaf women, but defer to the expertise of SignHealth and their domestic abuse on the health needs of Deaf women.

2. HUMAN RIGHTS CONTEXT: THE UNITED NATIONS CONVENTION ON THE RIGHTS OF DISABLED PEOPLE

The United Nations Convention on the Rights of Disabled people (UNCRDP) should be the point of reference for the health rights of disabled women. Of particular relevance to our response are:

Article 6	**Women with disabilities**
Article 15	**Freedom from torture, inhuman or degrading treatment**
Article 16	**Freedom from exploitation, violence and abuse**
Article 25	**Health**

Persons with disabilities have **the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability**. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are **gender-sensitive**, including health-related rehabilitation. In particular, States Parties shall:

a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in **the area of sexual and reproductive health and population-based public health programmes;**

b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

c) Provide these health services as close as possible to people's own communities, including in rural areas;

d) **Require health professionals to provide care of the same quality to persons with disabilities as to others**, including on the basis of **free and informed consent** by raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care […]

f) **Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.**

3. SUMMARY OF RECOMMENDATIONS

Strategic

- A strategic and intersectional approach to women's health, which addresses the specific barriers experienced by Deaf and disabled women, Black, minoritised, refugee and migrant women, lesbians and transwomen and women living in poverty
- a trauma informed approach which recognises the complex impact of abuse (domestic, sexual, institutional etc) on women's health
- a social model approach which addresses disability as a social and economic as well as a health issue, and does not assume that disability automatically equates to poor health

Legal

- A specific duty on health providers to meet the needs of women

Evidence based

- Comprehensive data collection which drills down to identify gender and other aspects of health
- more thorough evidence on health outcomes for disabled women from diverse communities and with different impairments

Practical and accessible

- Access to a health advocate within the NHS
- Women only wards in the mental health system, with female patients able to work with female staff only if they choose
- Practical measures to address the needs of Deaf and disabled women and of abuse survivors:
    - easy access to BSL interpreters
    - accessible facilities such as examination beds, handrails, screening equipment etc
    - training for staff by disabled women
    - accessible specialist clinics for women survivors of abuse

Trauma and disability informed training

- Comprehensive training for women's health professionals on dealing with victims of trauma including disabled women
- Review IRISi training to be more inclusive of disabled women

- Review health IDVA domestic abuse training programme in hospitals (mandatory), as part of safeguarding training, so that it is inclusive of disabled women
- Comprehensive training for emergency staff

Keeping survivors safe

- Seeing all women including disabled women without partners, family members or paid or unpaid carers
- Using simple language
- Asking about safety

4. A STRATEGIC RESPONSE TO WOMEN'S HEALTH

A. A social model approach to health – placing disabled women's health in context

> "The social model of health emerged from the social model of disability, which has been strongly advocated by the disability rights movement. It was developed as a reaction to the traditional medical model. The social model of health examines all the factors which contribute to health such as social, cultural, political and the environment"[1]

The Word Health Organisation (WHO) recognises that the social or wider determinants of health are "the conditions in which people are born, grow, live, work and age. These conditions or circumstances are shaped by the distribution of money, power and resources at global, national and local levels".

Disabled women in the UK (and worldwide) face structural inequalities which impact negatively on their health. Amongst the most relevant are:

- Disablism and its intersection with racism, ageism, homophobia and transphobia impacts on the physical and mental health of disabled women throughout their lives.

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[1] https://www.cdhn.org/sites/default/files/downloads/FACTSHEETS%201_Screen%20View%281%29.pdf

- Higher levels of poverty than any other group in the population; poverty is the most significant factor in having a long-term health condition[2]
- A punitive benefits system which relies on health professionals as gatekeepers
- Lower qualifications and lower rates of paid employment at much lower pay than non-disabled women and men[3] particularly amongst women and men with significant levels of impairment
- Lower levels of independent living amongst younger disabled women than disabled men – disabled women are more likely to be living with family even as adults, or to be living in supported living or institutional 'care' where the risk of abuse, but also impacts on physical and mental health and accessing therapeutic or other treatment.
- Older disabled women are more likely to be living alone and receive minimal support, and most likely to be institutionalised.
- In the past 5 years, numbers of disabled people receiving social care have decreased, as has the amount of daily support they receive; this has a direct impact on disabled people's health, with more falls, hospitalisations and long term impact on health.
- Families where the parent has a learning disability are often over-represented in the child protection system; disabled single mothers are most likely to see their children taken into care or placed with an (often abusive) father – causing lifelong trauma to the mother.
- Disabled people generally are more likely to be living in unsuitable accommodation (inaccessible, overcrowded or in poor state of repair). Nearly all street homeless women have significant health issues which become long-term impairments. In London, disabled women who present as homeless are housed away from their support networks and their children's schools.

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[2] https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/outcomesfordisabledpeopleintheuk/2020

> A Stay Safe East client who fled domestic abuse with her children was placed in temporary accommodation for nearly two years in a house where she could not use her wheelchair, even in the living room which she had to use as her bedroom and was trapped; she could not access the kitchen or the first floor children's bedrooms. The impact of the domestic abuse and the daily barriers she faced had significant impact on the client's physical and mental health and that of her older daughter who had to provide care for her siblings. This was compounded by hostile interventions from children's social care, whose bias against her as a South Asian disabled mother led them to doubt her ability to care for her children. With the help of a housing solicitor, Stay Safe East was eventually successful in getting the client rehoused. Since moving to a fully accessible flat, the client's mental and physical health has improved significantly and her competency as a mother is now obvious.

B. Disabled women as victims/survivors of abuse

There is ample evidence that violence against women and girls (VAWG) has a direct impact on women's health. Disabled women (17.5%) are more than twice as likely to experience domestic abuse than non-disabled women (6.7%)[4], a significant difference which is mirrored in data on rape, sexual exploitation and other forms of abuse. Disabled women also experience specific forms of abuse which do not happen to non-disabled women: carer abuse (which Stay Safe East consider to be domestic abuse), abuse in institutional settings – as evidenced by widely reported abuse specifically against disabled women living in Winterbourne View and in Whorlton Hall. Yet disabled women are least likely to access support services.

The barriers[5] which disabled women face to accessing support in order to escape domestic and other abuse means disabled women stay in abusive situations for longer, and suffer additional trauma and physical injuries as a

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[4] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/outcomesfordisabledpeopleintheuk/2020 For more data, please see http://staysafe-east.org.uk/wp-content/uploads/2021/03/Stay-Safe-East-response-to-the-Home-Office-VAWG-Strategy-2021-25-14-pt.pdf

[5] For example, disabled women are often not believed; the abuse may exacerbated by interventions by adult safeguarding [5]; services are not accessible[5]. The fear of immigration authorities means migrant disabled women will rarely report abuse. Very few disabled women get justice.

result. In some cases, medical professionals may assume that a disabled woman has poor health or injuries because she is disabled – but it may in fact be because she is being abused.

As a result, women's existing physical impairments or health conditions are made worse, and many women develop acute mental health issues after abuse.

C. Disability and health

Much of the literature on health and disability sees impairment as being de facto ill-health. This serves to hide structural inequalities in health- as was seen during the Covid pandemic, when death rates for people with learning disabilities and older people in care homes were disproportionately higher – evidence is emerging that these deaths were caused not by vulnerability factors arising from impairment but from 'do not treat' orders[6].

> "The relationship between illness and impairment is a complex one. On the one hand, impairments do not constitute a `medical problem' but are merely a fact of life that disabled women live with. On the other hand, some disabled women may be more vulnerable to illnesses because of an impairment, or the effects of an illness on an impairment." [7]

There are significant differences in the levels and type of health inequality faced by disabled women and disabled men – yet the approach taken by most national policy and research is to treat disabled people as a homogenous group ("the disabled").

> "Research rarely looks at inequalities in access to health case for disabled people, let alone disabled women. In the UK, there are well-evidenced, long-standing inequalities both in terms of access to healthcare, unmet need, and health outcomes. However, there is only limited information about access to healthcare for people with disabilities. The available information shows that people with disabilities report worse access (including physical access into buildings) to services and worse satisfaction with provided services,

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[6] Call for urgent action to prevent learning disability deaths - BBC News

[7] N Begum. General Practitioners' role in shaping disabled women's lives in: 'Exploring the Divide' edited by Colin Barnes and Geoff Mercer, 1996, Leeds: The Disability Press, pp. 157 – 172). WOMENhttps://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Begum-Chap9.pdf.

> that their needs are not recognised, and that they generally face several barriers, both structural (e.g., lack of transportation), financial, and cultural (e.g., misconceptions about disability). Various studies have shown that disability is an added impediment in accessing health services.".[8] This study confirmed that **disabled women "are the most likely to have an unmet healthcare need".**

Poorer access to healthcare can lead to even poorer health, but it is discrimination and exclusion which pauses the greatest threat to disabled people's health, as evidenced by a joint report[9] on addressing inequalities in London, which Stay Safe East contributed to. Discrimination impacts on disabled women's well-being, life expectancy and on their access to health services. It is critical that the Women's Health Strategy addresses the intersection of sex and disability with ethnicity, age, sexuality and other factors.

5. DISABLED WOMEN'S HEALTH ACROSS THE LIFE COURSE

Throughout their lives, disabled women experience barriers to full health. Below are some examples gleaned from the women we are in contact with. This is a snapshot and not means comprehensive, but the common theme which emerges from our discussions is that disabled women are rarely listened to or respected as experts on their own bodies, with some notable exceptions, particularly from specialist clinics. The experience of the disabled women known to Stay safe East show that health professionals are ill-trained and ill-informed on the needs of disabled women:

> "The definition of culturally competent care should be broadened to include disability" [10]

It is worth noting in this context that cultural awareness around disability should include:

- Etiquette around the language of impairment
- Nothing about us without us: Speaking to the disabled woman, not her carer about/over her

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[8] Sakkelarou and Rotarou. Access to healthcare for men and women with disabilities in the UK: secondary analysis of cross-sectional data. https://bmjopen.bmj.com/content/7/8/e016614

[9] https://www.inclusionlondon.org.uk/campaigns-and-policy/facts-and-information/equality-and-human-rights/gla-disability-equality-issues-map/

[10] Lipson and Rogers. https://pubmed.ncbi.nlm.nih.gov/11982110/#affiliation-1

- Not dismissing disabled women as ‘neurotic’, hysterical, just wanting drugs, vulnerable, without capacity etc
- Not treating disabled women’s different bodies as objects of curiosity
- Sensitive use of language around impairment and not seeing disability as a tragedy but a fact of life
- Sensitive use of language around intimate body parts – especially when dealing with older women, some women from Muslim, Orthodox Jewish and other faith communities and from more traditional backgrounds
- Sensitive use of language around body parts - for older women, many Muslim women and others

Sexuality, fertility and contraception

- Young disabled women are often ill-informed about their own bodies, the onset of puberty, sexuality or safe relationships, or how to value themselves. Materials used in health education do not show different bodies, the information provided may make them feel ‘other’ or may simply be irrelevant, or inaccessible. Parents may also over-protected their disabled daughters. So disabled girls disengage.

  > At college (for women with learning disabilities), what they told us about sex was about not having babies. My condition means I can’t have babies. I switched off.

- Taboos about talking about sex, sexuality and our bodies are common in families across all communities – “*Our parents think disabled girls don’t have sex, so we have to find out for ourselves*” as one woman put it.
- There is a widespread assumption that disabled women – especially if they have learning disabilities or a genetic condition that may be passed on to the child - will/should not be mothers. Disabled women who become pregnant are not congratulated by their GP, they are offered a termination as the first ‘option’.
- As a result of these assumptions and a lack of information about contraception, and often as a result of controlling relationships, young disabled women may have little control over their fertility. Stay Safe East has worked with a significant number of women with

learning difficulties/disabilities who have had three or more children by their early twenties, usually in the context of abusive relationships, only to see each child removed by children's social care. These mothers are profoundly traumatised. We have deep concerns about support for mothers who have multiple children removed being conditional on 'accepting' an implant – as happened to a client of Stay Safe East who was told by Children's Service that if she took part in the programme, she may be granted contact with the children. She refused the contraceptive implant as she was not ready; she is now fighting for access to her children.
- Where women (and in particular women with learning disabilities or genetic physical impairments) are offered contraception, it is long-term implants or a contraceptive injection, often as the only option. Possible side effects or the impact on long-term fertility are not discussed or explained in a way they could understand, so women cannot be said to have given informed consent.
- Nurses and GPs do not understand the importance of explaining to blind women how to recognise a period, unusual bleeding or discharge through smell, taste and consistency rather than sight.
- There is a pervasive assumption that disabled women and girls are heterosexual- lesbianism and bisexuality are rarely mention in relationships education for disabled girls.

Breast, gynaecological and other preventative health case
Screening should be available to all women in the appropriate age groups, regardless of impairment. Yet this is often not the case.

Whilst preventative health care for women with learning disabilities has improved in the past few years, we still have clients who have never been offered a smear test or a breast check. It is not clear if their GP assumed they were not sexually active (which is not a reason for denying a smear test), or if no one thought their health mattered. The women themselves were unaware of the need for screening, we encourage them to attend and if necessary attend with them.

Multiple studies across different countries have evidenced the barriers to accessing screening equipment for the detection of gynaecological, breast and other cancers. [11] Yet current NHS screening remains inaccessible to women with physical impairments. The experience can be traumatic. Such discrimination increases the risk of breast cancer not being detected.

> One woman with a physical impairment and high levels of pain described the mammogram machine as ‘an instrument of torture’ and only had a partial scan the last time she attended the breast clinic, in spite of the best efforts of the radiographer.
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> Another woman who is a wheelchair user has been unable to have mammograms because of lack of access. This same woman received a standard letter during lockdown inviting her to a mammogram; when she rang, she was told it was on a mobile unit with steps only access. “The machines are not designed for women like me who are sitting down. I gave up years ago. I check my breasts, but it’s not the same thing.”

Smear tests are also difficult for women with physical impairments – and women are not listened to when they explain to medical staff that things can be done differently:

> “I had to explain several times to the nurse she could do the smear text with me lying in a different position, she didn’t believe me. She was really surprised when it worked!”

For women who have been abused, a simple screening can recall past trauma. Women may be anxious, terrified, or not know what to expect. Information sent Whilst some staff are sympathetic, others demonstrate a lack of training and empathy. As a result, women may not return for the next check-up or screening.

Positive experiences

Not all experiences are negative. One woman with learning disabilities said:

> My clinics do health checks all the time. They are very gentle with me”.

We have had positive feedback on two specialist services

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[11] For example a 2017 study found that disabled women less likely to access breast and colorectal screening. The lowest rate of participation was amongst women with high care needs and visually impaired women.
Floud, Barnes et al: Disability and participation in breast and bowel cancer screening in England. 2017.
https://www.nature.com/articles/bjc2017331

- The Bridge Clinic[12] is a sexual health clinic for people with learning disabilities, with two centres in London
- My Body Back is a specialist service for people who've experienced sexual violence[13] and offers cervical screening, contraceptive care, STI testing and maternity care innovation, with centres in London and Glasgow. Staff have been trauma trained. One woman who attended the My Body Back clinic said:

> " I was very upset and crying but I wanted to get the test done. They were patient – in all it took 1.5 hours to do the test, but we did it. I wish there were other centres like this."

Until the pandemic took hold, Stay Safe East advocates would accompany some clients to medical appointments, because they felt safe with us and trusted us to support them to explain their symptoms and wishes to medical professionals. for the sake of staff safety, this is not currently possible. we are concerned about the long term impact on our clients, who have missed appointments rather than go alone,

It was clear from our discussions that a trauma informed approach by health professionals is fundamental to disabled women survivors access preventative health services.

Women with life-long impairments or long-term health conditions
The links between abuse, being a disabled woman and health- and in this case life expectancy, are demonstrated in the – shocking but no unusual life experience of a Stay Safe East client:

> G was a woman with learning disabilities of South Asian heritage who initially came to Stay Safe East because of abuse by a paid carer. She then disclosed abuse since she was a child, attempted forced marriage by her family and repeated rape by the man the family wanted her to marry. G had a rare genetic condition which impacted on her physical health and left her at risk of kidney failure, but this information had never been shared with her support workers or the staff at the supported housing where she lived. As a result of the years of abuse by her family, G self-

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[12] https://gps.northcentrallondonccg.nhs.uk/service/the-bridge-service-islington

[13] http://www.mybodybackproject.com/. My Body Back also has a Glasgow clinic

> neglected; she developed an infection in her toe which eventually led to amputation. after several stays in hospital, she developed a severe kidney infection and eventually renal failure. Though her medical condition would have shortened her life, the abuse and the failure in communication over the risk of infections ultimately led to G's death at the age of 31.

Women told us they are often dismissed by health professionals, particularly where the condition is not visible – their pain is dismissed, with a strong gender and race bias:

> I have endometriosis, it took years to diagnose. I was told' periods are painful, get used to it'.

Black women with sickle cell anaemia told us about a lack of information about the risk of miscarriage associated with the condition (and with other conditions such as Lupus), and women not being referred for emotional support to help them deal with repeat miscarriages. The grouping of services into centres of excellence means long journeys to hospital appointments, and that more local A&Es are less well informed about sickle call and other conditions which affect Black communities. They also report that schools are not well informed about how to deal with sickle cell crisis in children, and may be dismissive of a child's pain. Thirty years on from campaigners raising the issue, some medical professionals still continue to dismiss women in sickle cell crisis as 'looking for drugs' when they ask for strong analgesics.

It is also worth noting that Stay Safe East has worked with a number of women who have become addicted to strong painkillers, including opiates (one woman was on 5 different painkillers, all of which had stopped working) at great cost to their physical and mental health, and often where the GP had failed to recognise that their distress and pain was in part due to abuse, or to deal with the root cause of the physical pain. Over-medication of women becomes a way of dismissing them.

Older disabled women

The impact of ageing on women with specific impairments or health conditions is not always well understood, in part because too many studies are gender neutral. Our older clients report being ‘dismissed’ and patronised by medical professionals.

Access for Deaf women

Access to women’s and general health services for Deaf women was problematic even before the pandemic, with poor access to interpreters, significant language barriers and lack of accessible information leading to significant health challenges in the Deaf community, including higher rates of HIV and of STIs. Organisations such as SignHealth were set up to address these inequalities. In March 2020 as the Covid pandemic grew, SignHealth committed a substantial sum from its reserves to fund a national free on-demand 24/7 remote interpreting service called BSL Health Access, in partnership with InterpreterNow. This enabled Deaf people to access medical services over the phone, free of charge. Though short term funding was given up by the NHS, the service had to close on march 31st 2021. This innovative service allowed 25,000 communications by Deaf people with health professionals. Stay safe east supports secure funding by the NHS for BSL Health Access which in a short space of time had become a trusted and reliable services for the Deaf community.

Remote consultations, digitalisation and charging for letters to the DWP

Easy access to their GP is essential to enable disabled women to maintain their well-being, especially if they have long-term health conditions. the Covid pandemic has seen a rise in phone and video consultations which present specific barriers for disabled women. For women who may not be confident about dealing with professionals, and professionals who may not communicate as well as they could with their patients, this may lead to serious health issues being missed. it is difficult enough for a woman who is anxious or embarrassed to speak about gynaecological matters in person with her GP or nurse, but it is much more difficult over the phone/video, especially if English is not her first language or she has a speech impairment or learning disability, or is very anxious, or simply finds using a digital phone video function difficult. It is to be hoped that remote consultations will not become standard practice.

Digitalisation of medical systems has created new barriers – for older and BAME women, visually impaired women and others in particular. Women are less likely to have digital skills, particularly in South Asian or other

BAME communities where men are more likely to be exposed to digital media in their work. GPs are now increasingly requiring patients to book appointments on line – indeed those who cannot do so may be at a disadvantage and not get an appointment. Health information about long-term conditions is online- for example management of diabetes.

> An older woman of Pakistani heritage said of her GP "they have forced me to become dependent". Whereas previously she could book her own appointments, she now has to depend on family members do make online appointments, as she has no digital skills. this is disabling her. In this case, there is no family abuse, but were there to be, this would leave older women at risk of further coercive control.

GP Charges for benefit letters

Stay Safe East employs a specialist benefits worker to support clients with their applications and appeals. The benefits system requires evidence of impairment from GPs and other health professionals, who act as gatekeepers- a good letter can make the difference between bare subsistence on ESA and getting Personal Independence Payment. Charges by GPs for a print out of patient records or a letter vary from £10 (rarely) to £50 (usually or more, a substantial sum for someone living on benefits. Stay Safe East, along with many other disabled people's organisations, strongly argues for the scrapping of such fees.

Access to advocacy

As mentioned above, Stay Safe East advocates often accompany clients to medical appointments as well as to assessments for benefits. For survivors of trauma, this enables them to speak out about their health concerns, ensure health professionals listen and cope with often difficult and intimate examinations. We would like to see independent health advocates made available to patients who face communication, access or trauma barriers.

Role of health professionals in preventing or identifying abuse

It is not common practice for health professionals to ask patients" Is anyone hurting you?" or "Do you feel safe?". Yet these simple questions may help prevent abuse. However disabled women are often accompanied to medical appointments by their 'carer', who may be a family member, a paid worker from their supported housing or residential care unit. They never see a health professional alone. This means that there is no opportunity to disclose or to be asked about abuse. Stay Safe East believes that all NHS patients must be seen alone on a regular basis by health professionals. The IRISi programme to train health professionals to understand domestic abuse must also be made inclusive of disabled women.

Sometimes medical professionals in effect collude ‘by omission’ with abusers:

> A 54-year-old woman was referred to Stay Safe East. it took weeks for our advocate, working jointly with a police officer to get her trust and for us to be let into the house- her abusive husband was by this time in custody. He had beaten her, starved her and manipulated her anti-depressant medication, reducing or stopping at times, and over medicating her at other times. She was confused, had lost the sense of time, and had not been out of the house for nearly two years. It emerged that the GP had conducted at least two medication reviews without the patient being present, with her husband speaking for her. The GP had not seen our client in three years. No one had questioned why her husband did not assist her to attend the surgery; no one arranged a home visit. Professional neglect had contributed to the abuse.
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> A woman with learning disabilities was kidnapped from her home country; she was pregnant and due to give birth and taken to hospital by the traffickers; none of the medical staff identified that she was disabled and was being abused; she delivered the baby – no interpreter was present, no one asked about the bruises. It was only because of a member of staff who spoke the same language overheard a conversation after she had given birth- the woman was being told by one of the traffickers that she had ‘work to do tonight” – a safeguarding alert was raised; police were called; the trafficker pretended to be her boyfriend, she was questioned in front of him about whether she was being abused by this man; no one identified her Learning

disability – they could not see past the fact that she spoke another language. She could not understand what they were asking; police left and made no arrest; she was eventually found sleeping rough. When social services eventually found she had Learning disabilities. they wanted to remove her child. She got legal support and access to an advocate and is now back with her family in her home country.

Communication

A white physically disabled woman who has no speech but has full capacity was admitted to hospital. She communicates in writing using a note pad and pen. Staff would regularly remove the pen and paper, would leave her in a position where she could not write, or would not read what she was saying. They often left her in positions where she went into spasm. Distress would make her condition worse and replicate her experiences of abuse. She was sexually assaulted by a female member of staff who was washing her. When she tried to report this, she was initially ignored.

D. Mental health

There continues to be an unmet need for services that respond to the specific needs of women with mental health issues.

Safety and well-being on mental health wards

Considering the wider context within which women enter and navigate the psychiatric system, i.e. one where they may have experienced male-perpetrated trauma, they should be granted the right to deal only with female staff on single sex wards. This would help reduce the risk of sexual assault and harassment[14]. We believe this would not only reduce the levels of distress experienced by women within the mental health system, but ultimately be more conducive to long-term recovery

Borderline Personality Disorder and gender bias

Stay Safe East is especially concerned by the current understanding of and treatment of those diagnosed with Borderline Personality Disorder (BPD),

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[14] https://www.cqc.org.uk/sites/default/files/20180911c_sexualsafetymh_report.pdf

also known as Emotionally Unstable Personality Disorder (EUPD). 75% of those in receipt of this diagnosis are women[15], the majority of whom have experienced childhood trauma[16]. Such a heavily gendered diagnosis, the overwhelming majority of its recipients being women, requires our interrogation. This gender bias brings into question the extent to which the BPD diagnosis individualizes and pathologises women's responses to the trauma that is so pervasive across their sex. This gendered trauma is exemplified in areas such as domestic abuse, where the latest ONS data reports 92% of defendants in domestic abuse cases were men and 77% of victims were women[17], and incidents of rape, where the latest figures show that women are statistically more than fifteen times more likely to experience rape than men[18]. As outlined above, we recommend a structural and attitudinal shift in how we understand patients meeting the criteria for a BPD diagnosis, involving trauma-informed care which validates and acknowledges the fact that these are typically survivors presenting with a natural response to trauma. This acknowledgement should serve to identify and locate the source of distress *outside* the individual who has experienced it.

6. COVID

There is no space here to look at the impact of Covid on disabled women survivors, please refer to our report written in the earlier days of the pandemic and the more recent report by Sisters of Frida. Any strategy on women's health must address the long-term impact of the pandemic on women, the increased inequality and the fact that thousands of disabled women and men have died unnecessarily[19]. These mistakes must not be repeated.

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[15] Skodol, A. E., & Bender, D. S. (2003). Why are women diagnosed borderline more than men?. *The Psychiatric quarterly*, 74(4), pp.349–360.

[16] *Zanarini, MC, Frankenburg, FR, Hennen, J, Reich, DB, Silk, KR.* (2006). Prediction of the 10-year course of Borderline Personality Disorder, *American Journal of Psychiatry,* 163(5), pp.827-832.

[17] Office for National Statistics (ONS). (2020) *Domestic abuse and the criminal justice system, England and Wales: November 2020.* Published online: ONS.

[18] Office for National Statistics (ONS). (2020) *Nature of sexual assault by rape or penetration, England and Wales: year ending March 2020.* Published online: ONS.

[19] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/coronavirusandthesocialimpactsondisabledpeopleingreatbritain/february2021
https://wbg.org.uk/wp-content/uploads/2020/06/Disabled-Women-and-Covid-19.pdf
https://www.sisofrida.org/wp-content/uploads/2020/05/The-impact-of-COVID-19-on-Disabled-women-from-Sisters-of-Frida.pdf

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