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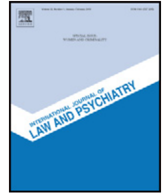

Preventing violence, exploitation and abuse of persons with mental disabilities: Exploring the monitoring implications of Article 16 of the United Nations Convention on the Rights of Persons with Disabilities☆

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ABSTRACT

Article 16 of the United Nations Convention on the Rights of Persons with Disabilities includes the right to be free from *all forms of violence, exploitation and abuse*. In pursuance of this aim, Article 16 (3) imposes an obligation on States Parties to '*ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities*'. Effective independent monitoring is viewed as a key mechanism to help safeguard people from violence, exploitation and abuse. This is highly pertinent in the wake of the highly publicized abuse of patients in care homes and hospitals in England in the last few years. This article examines the monitoring requirements of Article 16 and, by drawing on the author's research into the Care Quality Commission (the national health and social care regulator and mental health monitor) in England, assesses the extent to which independent inspection of hospitals and care homes can play a part in realizing Article 16(3) to prevent violence, abuse and exploitation of persons with mental disabilities. The potential scope and reach of Article 16 is extremely wide: this brings with it great potential but, at the same time, significant challenges for achieving effecting monitoring. Some of these challenges are explored and the paper concludes with some consideration of how monitors/inspectors, such as the Care Quality Commission in England, can strengthen their protection for people with mental disabilities, in line with the ethos and aspirations of the CRPD.

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1. Introduction

Over the last decade or so, the UK has witnessed a succession of horrific scandals relating to the abuse and ill-treatment of patients, particularly people with mental health and learning difficulties, by their care givers. For example, a public inquiry chaired by Sir Robert Francis QC in 2013 (the Francis Inquiry) found that hundreds of patients endured poor care and deficient treatment in Mid-Staffordshire hospital over a period of several years.[1] In a private learning disability unit, Winterbourne View in Bristol, residents were subjected to horrific and prolonged violence and abuse at the hands of support and care staff.[2] The tragic death of a young man with a learning disability, Connor Sparrowhawk, in a residential unit in Dorset in 2013 due to the neglect of the staff is another shocking example. Connor died by drowning following an epileptic seizure whilst in the bath. Southern Health, the provider responsible for his care, accepted the serious failings in the care provided to Connor which contributed to his death.[3] The Care Quality Commission (CQC – the independent regulator of health and social care in England) subsequently published a highly critical report on the unit where he died, finding that residents were still not being treated with respect or involved in discussions about their care and treatment.[4] As a result of Connor's death, in December 2016, the CQC published the findings of a review into all mental health and learning disability deaths in England, which confirmed that there is no single framework for National Health Service (NHS) trusts (i.e. local health care providers) that sets out what they need to do to maximize the learning from deaths that may result from problems in care. The review was unable to

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[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013) HC 947 located at http://webarchive.nationalarchives.gov.uk/20k 150407084003/http://www.midstaffspublicinquiry.com/report.

[2] NHS England (2014), *Winterbourne View: Time for Change* located at https://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf.

[3] Located at http://www.southernhealth.nhs.uk/news/archive/2016/trust-statement-regarding-connor-sparrowhawks-death/.

[4] Located at http://www.cqc.org.uk/sites/default/files/RW11V_Slade_House_INS1-1278665120_Responsive_-_Follow_Up_21-05-2014.pdf.

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identify any trusts that could demonstrate examples of good practice to ensure that learning is implemented. As a result, it concluded that '*learning from deaths is not being given enough consideration in the NHS and opportunities to improve care for future patients are being missed*'.[5] A report by the charity Mencap has recently concluded that these problems persist and there are still too many people with a learning disability living in similar units in the UK.[6] Indeed, more recently in November 2016, an undercover news report highlighted the same failings in the care and ill-treatment of elderly and disabled residents at several nursing homes in Cornwall.[7]

These incidents have, unfortunately, been all too common and they are a sobering reminder of the increased vulnerability of people with mental disabilities,[8] particularly those who are living in residential units and hospitals. Traditional conceptions of abuse in institutions are rooted in Erving Goffman's model of the mental asylum – a 'total institution' – in which almost every aspect of the inmate/patient's life is controlled by the institution.[9] People living in these institutions feel disempowered, degraded and depersonalized, and this occurs in both obvious and subtle ways. Their position and specific needs can make them more vulnerable to abuse, including physical, mental, financial/material as well as sexual abuse. Evidence suggests that people with mental disabilities are at increased risk of abuse, especially sexual abuse in institutional settings, which is 2–4 times higher than in the community.[10] However, it is not just a risk within institutions. With the changing patterns of care delivery and move towards community care in the UK since the 1960s, there is considerable evidence that similar abuses are widespread in the community, and disabled people suffer disproportionately higher levels of domestic abuse. This can come from partners, relatives, as well as personal carers/assistants and health/social care professionals. There is no doubt that the low status and pay of care givers, poor training/supervision as well as the challenging working conditions in the health and social care sector compound the risks. Chronic underfunding in the NHS and social care system in the UK puts staff and services under huge pressure, and consequently disabled people are placed in an even more vulnerable position.[11] Research by The Kings Fund in the UK has highlighted how care providers are struggling to retain staff and maintain the quality of care.[12] Many of the inquiries into the abuses in England mentioned above have also uncovered major systemic and management failures, many of which relate to the pressures placed on managers of balancing ever tightening budgets with demanding government targets.[13] This has led to a defensive culture in some parts of the NHS – '*concerned more with reputation*, *money and targets*' rather than compassionate care, which should lie at the heart of the NHS.[14] As a result, there have also been significant cultural and attitudinal barriers to overcome in the UK, in particular for staff to feel confident about speaking up to voice patient care and safety concerns.[15]

It is commonly accepted that people with disabilities are more susceptible to violence/abuse/exploitation, as their impairment may create isolation, accessibility and dependence issues: '*Their reliance on care increases their situational vulnerability to other people's controlling behavior and can exacerbate difficulties in leaving an abusive situation*'.[16] A World Health Organization funded global review suggests that disabled adults are at a higher risk of violence than non-disabled adults and those with mental illness are particularly vulnerable.[17] In England, people with disabilities experience twice the rate of sexual assault, domestic abuse and stalking than non-disabled people.[18] There is no doubt that:

> *The social context of disability*, *including factors such as inaccessibility*, *reliance on support services*, *poverty and isolation has a powerful impact on an individual's increased risk of violence*.[19]

People with mental disabilities can also be susceptible to exploitation, especially sexual in nature, due to their dependence on caregivers; emotional/social insecurities and often lower levels of education regarding sexuality/sexual abuse.[20] The increased risks to persons with disabilities have been well publicized and documented. Putting in place appropriate mechanisms to prevent such abuse is essential, yet presents challenges for national governments and authorities. The increased vulnerability of people with mental disabilities makes it more difficult for them to report abuse and less likely to be believed when they do disclose.

The Francis inquiry found that *effective* independent monitoring and regulation can play a part in promoting good standards of care and patient safety.[21] Following that inquiry as well as the report into

[5] CQC (December 2016), *Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England* located at http://www.cqc.org.uk/content/learning-candour-and-accountability.

[6] Mencap (2014), *Winterbourne View: The Scandal Continues* located at https://www.mencap.org.uk/sites/default/files/2016-08/Winterbourne_View_the_scandal_continues_0.pdf.

[7] Located at http://www.bbc.co.uk/programmes/b0844wq3 and the CQC response http://www.cqc.org.uk/content/cqc-comment-panorama-nursing-homes-undercover.

[8] The phrase 'persons with mental disabilities' is used here (in contrast to mentally disabled persons) in line with the terminology and approach adopted by the CRPD.

[9] Goffman, E., (1961), *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, New York: Anchor/Doubleday.

[10] Sobsey, D. and Mansell, S., (1990) The prevention of sexual abuse of people with developmental disabilities, *Developmental Disabilities Bulletin*, *18*(*2*,) 51–66; Sobsey, D. and Mansell, S., (1994) Sexual abuse patterns of children with disabilities, *The International Journal of Children's Rights*, *2*, 96–100; Sobsey, D. (1994), *Violence and Abuse in the Lives of People With Disabilities: The End of Silence Acceptance?*, Baltimore: Paul H Brookes Publishers.

[11] See for example The Kings Fund, *Is the NHS heading for financial crisis?* located at https://www.kingsfund.org.uk/projects/verdict/nhs-heading-financial-crisis; 'The state system to care for older and disabled people is under acute pressure and must be reformed', *The Observer*, December 2016 located at https://www.theguardian.com/commentisfree/2016/dec/10/observer-editorial-government-must-increase-funding-social-care. See also the very recent debate by MPs in the UK Parliament on the state of NHS and social care funding located at http://www.parliament.uk/business/news/2017/january/mps-debate-nhs-and-social-care-funding/.

[12] The Kings Fund (September 2016), *Social Care for Older People*. London.

[13] See the findings of the Francis Inquiry into the failures of care at Mid-Staffordshire Hospital NHS Foundation Trust (*Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (February 2013) HC 947 located at http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report. The Inquiry found that mismanagement, staff shortages and under-funding contributed to the inadequate, inhumane and sub-standard care received by hundreds of patients between 2005 and 2009 in Mid-Staffordshire hospital.

[14] Department of Health (February 2015), *Culture Changes in the NHS: Applying the lessons of the Francis Inquiries Executive Summary*, Cm 9009, Para 5.1; located at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403010/culture-change-nhs.pdf

[15] See *Freedom to Speak Up: An independent review into creating and open honest reporting culture in the NHS* (February 2015) located at http://freedomtospeakup.org.uk/the-report/. See recent concerns about the operation and implementation of the whistleblowing (i.e. when employees report certain types of wrongdoing at work) processes in the NHS located at https://www.opendemocracy.net/ournhs/minh-alexander-anonymous-pamlinton-clare-sardari/why-is-cqc-ignoring-or-even-suppressing-pri; and recent media coverage "NHS's first 'national guardian' resigns after two months", *The Guardian* 8th March 2016 located at https://www.theguardian.com/society/2016/mar/08/nhs-national-guardian-resigns-post-eileen-sills

[16] Public Health England, (2015), *Disability and domestic abuse: Risks*, *impact and response* London: Public Health England, (p. 4).

[17] Hughes, K., Bellis, M. A., Jones, L. et al., (2012), Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies, *The Lancet*, *379* (*9826*), 1621–1629.

[18] Public Health England, (2015), *Disability and domestic abuse: Risk, impacts and response*, London: Public Health England, (p. 9) located at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf; Khalifeh, H. et al., (2013) *Violence against people with disability in England and Wales: findings from a national cross-sectional survey*, 8 PloS one.

[19] Powers, L. E. and Oschwald, M., (2005) *Violence and Abuse Against People with Disabilities: Experiences*, *Barriers and Prevention Strategies*, Center on Self-Determination, Oregon Health and Science University, (p. 2). https://www.researchgate.net/publication/237835327_Violence_and_abuse_against_people_with_disabilities_Experiences_barriers_and_prevention_strategies.

[20] Regehr, C. and Glancy, G., (1995), Sexual Exploitation of Patients: Issues for Colleagues, *American Journal of Orthopsychiatry*, *65*(*2*), 194–202; Public Health England op cit. pp. 11–12.

[21] *Report of the Mid-Staffordshire NHS Foundation Trust Inquiry* (February 2013) HC 947.

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