

**Access to specialised victim support services for women with
disabilities who have experienced violence**

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**Comparative Research Report: Austria, Germany, Iceland and
United Kingdom**

**Report on Research with Women with Disabilities and Providers of
Specialised Services for Women who have Experienced Violence**

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Abbreviations

BME	Black and Minority Ethnic
CRPD	Convention on the Rights of Persons with Disabilities
DPO	Disabled People's Organisation (organisation controlled by disabled people)
EDF	European Disability Forum
EC	European Commission
UK	United Kingdom of Great Britain and Northern Ireland

Executive Summary

Introduction

This comparative report presents the results of empirical research carried out for the project: “Access to specialised victim support services¹ for women with disabilities who have experienced violence”. The data presented here should be seen in the context of the whole talk for the project, which encompasses three aspects, as follows²:

A Review of Law and Policy related to assistance for disabled women who have experienced violence: National reports from each country and a comparative report.

Empirical research on the situation for disabled women and for women’s support services: National reports from each country and a comparative report (this report)

Good Practice Recommendations and Practice: National reports from each country and a comparative report.

An overall summary report on the project.

Findings are presented in this report from empirical research into violence against women with disabilities³ in Austria, Germany, Iceland and the United Kingdom (UK). The research on which this report is based took place simultaneously in all countries between 2013 and 2014 and involved 187 women with disabilities (106 women in focus groups and 81 women in individual interviews) who had various kinds of

¹ Specialised victim support services, in this context, refer to organisations that are specifically designed to assist women who have experienced violence. The services specifically identified and included in this research were: refuges (shelters), women’s advice centres, helplines, intervention centres, specific contact or reporting points for women experiencing violence, and counselling services. While many services provided several of these types of assistance, others provided just one aspect of help.

² Reports and further information are available on the project website: *Access to Specialised Victim Support Services for women who have Experienced Violence* <http://women-disabilities-violence.humanrights.at/?q=publications>

³ The terms women with disabilities and women with intellectual disabilities are used in this report. However, we recognise the importance of terminology, its different meanings in different countries and the preferences of the women concerned. In some countries such as the UK, the use of the term disabled women is preferred in order to emphasise the ways that people are disabled by social processes, while in the other countries “women with disabilities” is preferred as a way of focussing on personhood rather than impairment or disability.

impairments, including women with mobility and sensory impairments, women with intellectual impairments, women with mental health conditions and women with multiple impairments. Specialised service providers assisting women who have experienced violence also took part in this study (602 responses to an online survey and 54 individual interviews with representatives from services). The numbers involved are presented here in order to show the scope of the research. It is important to note, however, that the focus is on exploring the issues involved in the problem rather than providing a statistically representative sample.

The project is funded by the EU Daphne III programme.⁴

Forms of Violence

Women with disabilities experienced a very wide range of types of violence. They reported experiencing the same types of violence as non-disabled women, but they also reported types of violence that were specific to disabled people, in a wider range of places and from more types of perpetrators.

Examples of abuse included physical, sexual and psychological violence, forced marriage and female genital mutilation. Women also reported being hit, spat on, punched, kicked, neglected, being denied assistance, being deprived of liberty, experiencing forced sterilisation and forced abortion. Very severe forms included being beaten, kicked, choked and attempted murder by suffocation. Sexual violence spanned harassment, assault and rape, sometimes sustained over prolonged periods. Psychological violence also featured frequently in women's accounts. In all countries women spoke of being treated with contempt, disregard for privacy, threats, oppression, being pressurised to do things they did not want to and being humiliated.

Domestic violence was substantial and highly damaging for a majority of women, but violence also encompassed institutional violence from carers where women lived in residential homes, or where they received assistance to live in their own homes. 'Hate' violence and crime was also described, where women experienced violence in relation to their identity as disabled women. Violence was often directed towards

⁴ Daphne III programme: http://ec.europa.eu/justice/grants/programmes/daphne/index_en.htm

perceived areas of weakness, such as attacks that focussed on women's impairments, often arising or increasing at the onset of impairment and at times when women needed more help, such as during pregnancy and childbirth or when migration status was uncertain.

Although violence was most prevalent for young adult women, participants reported violence at all stages of the life course and sometimes in many different settings.

Women's Understanding of Violence

Physical violence was the form most clearly recognised by participants, although other types of abuse, such as sexual and psychological, were recognised by some, especially where they had personally experienced it.

Women did not always recognise violence when it occurred, or in some instances time elapsed before they recognised abuse for what it was. For example, where perpetrators also provided care or personal assistance to disabled women, violence was sometimes seen by women as the cost of receiving that assistance. Women reported feeling there was no option but to put up with abuse if they were unable to leave home due to, for example, a lack of accessible safe places to live, or lack of portability of personal assistance. Fear of being put in an institution as a result of reporting violence deterred some women with disabilities from seeking help. These women worried that authorities would see violence as a sign of inability to cope and felt that services often did not recognise the reality of violence in institutions.

Access to and Knowledge of Rights

Knowledge of rights was variable, with only a few women well informed. Most knew a limited amount linked to their personal experiences but women with links to specialised women's organisations and disabled people's organisations (DPOs) tended to be better informed. Peer support groups also were good sources of information for women with disabilities.

The law on legal capacity was felt by some women to limit their rights and inhibit freedom of movement as other people took decisions for them. This issue has serious consequences for women concerned.

The individual actions of women notwithstanding, several countries reported insufficient implementation of women's rights and a lack of political will to address the problems.

Knowledge and Use of Services

There were significant barriers to the use of services. These included lack of knowledge about what constitutes violence and about acceptable boundaries. Many women with disabilities had not been taught about these; for example, some women had not received sex education while at school.

The majority of women did not state that they had been overtly turned away by services. Instead, a combination of lack of knowledge, fear about inaccessibility and concerns that the service did not address the problems they faced, combined to keep women with disabilities away from specialised services and to prevent specialised services from actively addressing their needs. Some women with disabilities who had contacted services before had been turned away and this put them off getting in touch again.

Barriers

A formidable array of barriers was identified by disabled women in relation to securing assistance and achieving a violence – free life. In addition to the barriers mentioned above, perpetrators and their collaborators isolated and undermined women in their attempts to escape violence.

As mentioned above, systemic problems, such as the way that alternative daily living support services could be obtained from disability services, could prevent women from leaving perpetrators where they relied on them for practical everyday help.

Barriers inhibiting access to women's support services included not being believed or being ignored, lack of information and lack of accessible information, inaccessible services, negative attitudes by service staff and lack of finances.

Power Imbalance and Inequality

Women with disabilities were clear that violence stemmed from power imbalances between themselves and perpetrators and in society more generally. For abusers, violence was simply a way of getting what they wanted. Violence typically became

worse at times when women's power decreased and when they needed more help, such as at the onset of impairment, during pregnancy and the birth of children and when migration status was uncertain.

Any realistic strategy for dealing with violence against women therefore must address systemic inequalities.

Helpful Aspects of Support

Contact with individuals who understood their situation and who could offer advice and practical help were valued very highly by women with disabilities in all countries. This support was often positively associated with turning points in women's lives in relation to escaping violence.

The individuals' attitudes and abilities were more important than their formal position. People in professional positions could be very helpful (but equally they could be abusers). Peer support organisations of women with disabilities provided a framework for relationships based on equality and were highly valued by almost all women in all countries.

Women with disabilities emphasised the vital importance of specialised support services for women, even if the majority had not made use of these facilities so far. Services that circumvented accessibility problems, such as outreach services, were well used and were an essential provision for women with disabilities.

Opportunities to help other women in the same position as themselves were also important for women with disabilities, providing chances to contribute to changing the situation for all women.

Personal and group self – reliance also developed in conjunction with improved opportunities (such as for education and employment). Women with disabilities exercised considerable strengths and determination in pushing forward improvements in their lives. This is the point with which service providers and policy makers should connect in order to make a difference.

Women's Service Providers

Some, but not all, service providers were aware of the problems faced by women with disabilities in respect of increased levels of violence. Most operated with an

ethos based on the importance of helping all women who have experienced violence, with women with disabilities included in those assisted. Consequently, issues of equity were expressed as concerns.

Use of Services

Levels of use of specialised services by women with disabilities were very low. While women with mental health conditions were largely understood and accommodated, women with other impairments were not. Services reported particularly low use of services by women with sensory impairments and women with intellectual disabilities.

Accessibility

Specialised service providers had a wide range of understandings about accessibility. Most thought of accessibility in terms of a range of adjustments that might be made to accommodate women with particular impairments. A smaller number thought of the concept in terms of barrier free environments.

Service providers focussed on supporting women who had experienced domestic violence. While as reported above, women with disabilities largely agreed that this was the most important problem they faced, providers often did not recognise the wider sources of violence faced by women with disabilities.

In some instances it was reported that collaboration with other services could result in women with disabilities being institutionalised, with the possibility of further violence. Very few service providers extended outreach support to women with disabilities living in institutions.

Challenges of Implementing Accessibility

Lack of funds was a consistent problem. Specialised service providers in all countries experienced more demand than they could meet. Therefore they faced difficult decisions about who they could help. In some instances service providers turned women with disabilities away because they considered they would be more difficult and would require more resources to help.

Problems securing co-operation with social service and other agencies were reported in some countries. Accessible housing and other services were particular issues.

Service providers also lacked information about the needs of women with disabilities. Some assumed they would need nursing care or excluded women who needed personal assistance as a matter of policy.

Women's low use of services was used in some instances as a way of justifying not developing accessible services. As women continued to not use services, this could turn into a vicious circle.

PR and the Provision of Information

Specialised services mostly did not set out to reach women with disabilities. This was often justified on the basis that they did not know how to reach them or lacked specialist expertise in talking to women with disabilities.

A notable exception to the generally muted approach to public relations work was where organisations developed outreach services. Although service development is not the same thing as PR work, it was very marked that in all cases these were reported to be taken up by women with disabilities, even when not specifically aimed at them.

Co-operation with Other Services

A large proportion of organisations had contact with other groups and collaborated with them in various ways. Contacts identified in the survey included health care organisations, counselling services and other organisations that were in the same or similar sector. Positive working relationships between agencies facilitated the referral of clients between services.

Uncritical contact with services could result in the overlooking of abuse and violence at the hands of service providers. With very few exceptions, services did not investigate institutional abuse.

Services had limited contacts with services run by people with disabilities (DPOs). They largely operated independently of one another and there were only a few examples of good co-operation, mostly in rural areas of low population density. The study found that networking and cooperation of specialised services with DPOs is an essential and highly relevant precondition for the improvement of services for women with disabilities.

Conclusions

There is potential for substantial development of important work to support women with disabilities who have experienced violence. The active engagement of women with disabilities and specialised service providers in this research is testimony to goodwill and commitment in this area.

Support services that recognise the type and extent of violence against disabled women need to be developed. At present, support services for women who have experienced violence only respond to the narrower range of circumstances common for women without disabilities (institutional, carer and 'hate' violence are not addressed). In responding to women with disabilities, both mainstream and specialised (aimed at women with disabilities) strategies need to be pursued. Training, orientation and targeted funding for services should be complimented by support for the work carried out by small organisations that bridge the gulf between specialised support services for women and DPOs.

Important questions remaining concern access to justice for women with disabilities. There are indications from all the countries that problems exist in this area but information on the exact problems is still patchy.

1. Introduction

This report presents the findings from empirical work carried out in four countries: Austria, Germany, Iceland and the United Kingdom (UK), between 2013 and 2015, with regard to the situations of women with disabilities who have experienced violence. It is specifically concerned with their access to the more general specialised support services that have been developed for all women who have experienced violence. A comparison of the perspectives of disabled women in the four countries and those of service providers is given, based on findings presented in four national empirical reports during the course of the project by the project researchers.

The research reported on here was part of a two year project funded by the European Commission through the Daphne III programme⁵: *Access to Specialized Services for Women with Disabilities who have Experienced Violence*. At the start of the project there was already a small body of previous research⁶ in each of the four participating countries that pointed to access problems for women with disabilities and the aim of this project was to look into this issue in more detail.

The research set out to answer the following questions:

- a) What are the needs and support requirements of women with disabilities who have experienced violence (from a range of sources: over time, places, variety of perpetrators)?

⁵ Daphne III programme http://ec.europa.eu/justice/grants/programmes/daphne/index_en.htm

⁶ See for example: Haraldsdóttir, F and JóhannesdóttirV. Verður fatlað fólk fyrir kerfislægu og menningarbundnu ofbeldi í íslensku samfélagi? [rafræn útgáfa]. Í S.B. Ómarsdóttir (ritstj.) Rannsóknir í félagsvísindum XII. (Bl. 143-150). Reykjavík: Félagsvísindastofnun Háskóla Íslands. Sótt 22. Janúar 2011: http://skemman.is/stream/get/1946/10251/25562/3/Rannsoknir_%C3%AD_felagsvisindum_XII_Stjornmalaf%C3%A6dideild.pdf ; Schröttle, M. , Hornberg, C. , Glammeier, S. et al. *Life Situations of and Pressures on Disabled Women in Germany. Short Version* (2013) <http://www.bmfsfj.de/BMFSFJ/Service/Publikationen/publikationsliste,did=201652.html>; Thiara, R.K., Hague, G., Ellis, B., Bashall, R. and Mullender, A. *Disabled Women and Domestic Violence: Responding to the Experiences of Survivors* (2012); Zemp, A. and Pircher, E., *Weil das alles Weh tut mit Gewalt: sexuelle Ausbeutung von Mädchen und Frauen mit Behinderung* (1996) <http://bidok.uibk.ac.at/library/zemp-ausbeutung.html> Jessica Kingsley Publishers.

- b) Are women with disabilities who have experienced violence aware of their rights and of potential support services?
- c) To what extent do specialised services for women offer support to women with disabilities who are victims and survivors of violence?
- d) Do services have the necessary resources to provide assistance to women with disabilities (e.g. knowledge, understanding, finance, sphere of influence)?
- e) What are the most important issues for improving access, including barriers and facilitating factors?

There are positive examples given in this report of where women's services offered assistance to women with disabilities. Nevertheless, the four national reports from this project show that women with disabilities often do not receive help from either the violence against women sector - because the services provided are often inaccessible - or disabled people's organisations (DPOs), which often do not have an orientation towards gender – based violence. However, this is an under-researched area and this study aims to add to the body of knowledge, with a view to informing future policy and service provision.

This research is exploratory and women with disabilities and specialised service providers were asked to discuss the most important issues arising from their experiences. There are many areas of overlap in the accounts of the two groups but it needs to be borne in mind that women with disabilities face a very wide range of barriers due to the multiple sources of violence (domestic, 'hate' violence and institutional / care provider violence) and the multiple difficulties are encountered in gaining access to assistance. Not all issues were mentioned by all participants in all countries and not all participants had experience of all the problems. To deal with this, the report has been written in such a way as to highlight the issues rather than the country or individual raising the point. Specific differences between countries are also discussed where they are significant.

This report is set out in two main parts. Following a discussion of the methods used in the research, the experiences of disabled women are discussed in terms of the circumstances and nature of violence and more specifically, their experiences in getting access to services. The second major part of the report presents the findings

from research with service providers. The pattern of service provision is described, followed by a discussion of service providers' views on assisting disabled women, perceptions of barriers to this and plans for the future. The findings from the research overall are discussed and finally an overall conclusion is presented.

2. Methods and Data Overview

2.1 Organisation of the Research Project

This research project investigated the problem of “Access to specialised victim support services for women with disabilities who have experienced violence”. The project was instigated and managed by the Ludwig Boltzman Institute of Human Rights in Austria, working in collaboration with partners, queraum (Cultural and Social Research Institute) and Ninlil (Empowerment and Counselling for Women with Disabilities). Empirical research was carried out by the project’s country partners, the Universities of Gießen (Germany), Iceland, Leeds and Glasgow (UK), and the Ludwig Boltzmann Institute of Human Rights and their partners, running from February 2013 to January 2015. Each country partner took specific responsibility for a particular aspect of the project although each country team took part in each stage of the research (see Appendix 1 for a full list of the project partners).

In each country a national advisory board of four to six experts was recruited: equally from organisations of women with disabilities and from specialised victim support services, providing assistance and direction to each project over the two years. Women with and without disabilities took part in the project as researchers, expert advisors and research participants. Country researchers convened advisory groups at key points in the project: at the outset, after the online survey and focus groups of disabled women, to review empirical work; at a mid-term meeting of all partners in Vienna and to formulate a dissemination and publicity strategy for each country.

2.2 How the Research was Carried Out

The research started from the premise that women with disabilities are experts in their own situation and experiences of violence. In each country 20 to 30 women with disabilities aged 18-65 took part in focus groups and 15 in individual in depth

interviews, with the exception of Iceland, where a smaller sample was recruited due to the smaller overall population size and small number of services⁷.

Service providers participated in an online survey and expert informants in individual interviews. Organisations that focussed on providing assistance to women who have experienced violence were contacted, with the aim of surveying a wide range of types of service in each country. These included DPOs that were specifically concerned with violence against disabled women, even if the overall organisational focus was elsewhere. However a systematic survey of all DPOs was not carried out where it was known that services were not extended to disabled women.

A summary of the research participants is presented in the table below:

Table 1 Overall Summary of Participants by Country

	Austria	Germany	Iceland*	United Kingdom
Focus groups of women with disabilities	5 groups: total 22 participants. Organised according to area: Tyrol, Salzburg, Upper Austria, Lower Austria, Vienna and Burgenland	4 groups with a total 39 participants in various regions of the country partly organised according to women's impairments (specific groups for women living in institutions).	3 groups with a total of 16 participants with a range of impairments.	4 groups: total 29 women in England and Scotland, partly organised according to women's impairments.
Interviews with women with disabilities	16 participants	16 participants	11 participants	16 participants
Online Survey	77 of a possible 141 participants (response rate 54.61%). Survey carried out via the internet.	442 complete responses of a possible 816. Response rate 54%. 363 of the services (women's sector) included in this report.	10 participants (response rate 100%). Survey carried out by telephone.	73 of a possible 187 (response rate 39%) Distribution managed by women's organisations in each part of UK.
Interviews with Service	15 participants – representatives	15 participants working in a	9 participants, of whom 7 worked	15 participants in all parts of the

⁷ Further details about the research methods used in each country are available in national reports on the project website: <http://women-disabilities-violence.humanrights.at/>

Providers	and staff members of organisations and services.	range of specialised services for women.	in specialised victim support services and 2 in disability services.	UK (England, Scotland, Wales and Northern Ireland)
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* As mentioned above, the smaller sample size for Iceland is due to the smaller overall population.

2.3 Women with Disabilities

Focus Groups with Women with Disabilities

Focus groups with small numbers of women with disabilities were organised in each country. Many women participants had experience of violence but this was not a requirement: to be eligible, women were only asked to identify as having a disability and to have an interest in the issue. Each country aimed for a wide geographical spread between the groups, to ensure the participation of women with a broad range of impairments and to recruit a diverse sample in terms of for example, age, urban / rural / large and small town living, geographical area, marital / family status, ethnicity and experiences. Some (but not all) focus groups were organised along impairment lines to make accessibility arrangements more tailored (easy language, sign language interpretation etc.). Women participating were asked semi – structured questions about their understanding of violence, knowledge and use of services, knowledge of rights as well as ideas for improvements and examples of good practice (see Appendix 2 for the interview guide). Women were not given a definition of either violence or accessibility in advance; instead they were invited to discuss what they understood by the terms. Although many women did in fact talk about their experiences of violence, this was not a requirement and the emphasis of the questions was on support structures and systems and access or lack of access to these.

Focus groups were facilitated by two moderators (three in Austria), one of whom was in most instances a woman with a disability. One facilitator asked questions while the other acted as scribe during the meetings, which were recorded with the permission of all attending. Recordings were later transcribed and analysed by country researchers. Some women taking part in the focus groups were later invited to take part in the individual interviews.

Individual Interviews with Women with Disabilities

A biographical approach to the guide for interviews was developed, which involved asking women about violence through their lives: childhood, young adulthood and older adulthood. (See Appendix 3 for the interview schedule). This enabled researchers to gain an insight into the links between different types of violence and its incidence over time in women's lives.

In taking a life course approach, two potential problems were borne in mind. Researchers took steps to avoid the possibility of re-traumatisation that can arise from the re-telling of violence episodes in women's lives, especially the recounting of childhood experiences. Discretion was exercised when asking questions and in some instances some questions were not asked.⁸ Additionally, researchers ensured that access to support services was available to women taking part should this be needed. Second, this approach was not intended as an endorsement of any particular theories about causes of interpersonal violence and victimisation that use explanations based on learned behaviour over the life course. The aim was simply to be alert to the possibility of violence beyond single incidents experienced by women and to gain a more accurate picture of overall experiences.

The individual interviews were carried out with the full consent of those taking part, and at a time and place that was mutually agreed. Again with agreement, all interviews were recorded and the recordings transcribed later. Participants were given individual pseudonyms, except in Iceland, where the small population size made additional steps to preserve anonymity essential.

⁸ In the German interviews, adjustments were made to the questions asked and timing. For example, some women were provided with a few sample questions from the interview guide in advance so they could prepare for the interview and anticipate the level of stress that they should expect. Also, for some participants, the full range of questions was not asked.

2.4 Service Providers

Online Survey

Survey questions were developed by project partners at the University of Gießen in Germany and administration of the survey was carried out by queraum in Austria. Comprehensive questions were asked of service providers regarding the types of services they provided, the degree to which women with various impairments used their services, the degree to which their services were accessible and plans for the future (see national reports for the questions asked).

Country researchers made contact with respondents and sent follow – up requests for completion. Participation was greater in some countries than others. In the UK difficulties were experienced due to the high security settings of service providers' computer software, which had to be overcome by the provision of individual links to respondents. Nevertheless, a high degree of interest and support for the work was generated through the survey and many offers of assistance were made to researchers in all countries.

The following table gives details of the types of services in each country that participated.

Table 2: Types of Assistance Offered by Services taking part in the Online Survey (multiple answer set)

Type of Women's Service	Austria %	Germany %	Iceland %**	UK %
Refuge	25.8	44.7	10	62.3
Advice Centre	48.5	33.3	10	36.1
Helpline	7.6	22.7	10	57.4
Counselling Centre for women who have experienced violence	9.1	44.9	40	31.1
Specific contact point for women with disabilities	4.5	1.9		18.0
Contact point or counselling for	4.5	2.4		8.2

women with disabilities				
Contact point or counselling for women with disabilities	7.6	0.9		6.6
Something else	15.2		30%	50.8
Total Percent of Cases	122.7%	166.7%	100%	270%

Note: Totals are greater than 100% due to the provision of more than one kind of service.

** Results from Iceland are not comparable due to small sample size.

Interviews

In each country expert interviewees were recruited following an expression of interest when participating through the online survey and also as a result of direct contact from researchers. Again, a diverse range of services included, for example, refuges / shelters for women, helplines, counselling and information centres and a few Disabled People's Organisations (DPOs) that ran violence support services specifically for women. As with the interviews with women with disabilities, these were held at times that were mutually convenient and mostly in person; a few were conducted by telephone or Skype. Interviews were recorded, transcribed and analysed by researchers.

3. Research Findings: Women with Disabilities

3.1 Perceptions and Understanding of Violence

Women with disabilities were asked about their understanding of violence and its impact. All women clearly identified and understood forms of violence that they had personally experienced or knew of.

For me, violence is when a person abuses a situation in order to dominate another person in whatever way - on a physical and mental level - and in order to oppress them and gain pleasure from dominating. Well, I think, and that's particularly important for me, if it is a psychological thing. (Austria)

However women did not always recognise the diversity of violence affecting women with disabilities more generally. In some instances, violence was only recognised for what it was as participants spoke about it:

I started....thinking after the focus group, I started wondering; 'Yes wait have I been harassed and stuff, yes, yes of course.' See, I just had not reached to the place where I could understand that it was, indeed, sexual harassment. (Iceland)

Nevertheless, the effects of violence could be all – encompassing; described by one woman as “a tornado that starts small and then it rips the whole land.”

Some differences emerged between countries regarding the types of violence that women with disabilities spoke about. In Austria and Germany, domestic, institutional and 'hate' violence were all described. However in Iceland institutional violence, or violence by care providers, emerged as a major concern. Recent scandals in respect of institutional violence may have influenced the reporting but it was difficult to ascertain this definitively. Conversely, in Austria and the UK women with disabilities mainly emphasised domestic violence. In the UK there is a quite well developed campaign against 'hate' violence and abuse by care workers but this is very much led by DPOs and separate from the concerns of specialised women's services. Despite many unknown issues therefore, it is possible that a number of structural and cultural influences shaped the concerns of participants in the four countries.

Forms of Violence

Violence existed on a continuum, ranging from lesser violations of personal boundaries⁹, to extreme and sustained attacks.

Physical violence was the form most clearly recognised by participants. Examples included being hit, spat on, punched, kicked, neglected, being denied assistance, being deprived of liberty, experiencing forced sterilisation and forced abortion. Very severe forms included being beaten, kicked, choked and attempted murder by suffocation. Sexual violence was also frequently mentioned, spanning sexual harassment, assault and rape, sometimes sustained over prolonged periods.

Psychological violence also featured frequently in women's accounts. In all countries women spoke of: being treated with contempt, disregard for privacy, threats, oppression, being pressurised to do things they did not want to do and being humiliated. Bullying and exploitation were especially emphasised by women with learning difficulties. Other forms of abuse included teasing, being made fun of and being stared at, or even hearing it suggested that a child would be better off dead:

And then there was this woman, who said – she was totally appalled by seeing a disabled child – and she said to my father, thank God I didn't get it back then, well, such a child just needed some kind of injection." (Germany)

The problem of forced marriage arose in particular in relation to black and minority (BME) women with disabilities. For example two UK BME women who survived forced marriage spoke of bullying and manipulation from spouses and family members.

As well as these more familiar forms of violence, it is important to point out that for women with disabilities violence was frequently focussed on their impairments. Mobility aids might be removed or destroyed, the wrong medication might be given, or other acts perpetrated that were directed towards the body. Such actions could further impede women's ability to resist domestic violence and/or sexual violence.

⁹ What is judged by others to be a 'small' incident of violence should not be interpreted as small in its effect on women concerned (see Kelly, 1988)

Women described trauma, depression, chronic pain and eating disorders, low self-confidence and lack of trust as resulting from violence.

Places where violence happens

Violence was experienced in a wide range of locations. All women described the home and family as the major location of violence and one that had a devastating impact. However, local neighbourhoods, residential facilities, schools, work places, and public transport were also implicated. Although some women with disabilities experienced abuse in just one place, many women experienced violence in multiple locations, especially over the life course.

The effect of violence was to reduce access to places and to increase social isolation and exclusion. An Icelandic woman with disabilities, for example, explained how she had stopped participating in the activities of a sport following prejudice and bullying from other members of the association.

I was a member of a sports club and some people did not want to talk to me, just because of who I am..... 'This is a strange person, I can't be bothered to talk to her.' They called me stupid because I didn't know as much as they do. You know, they maybe knew something more than I did and I was supposed to be stupid because I didn't know as much. (Iceland)

As well as exclusion from particular places, transgressing personal boundaries limited women's willingness to participate in certain places:

Hearing people get to know that close body contact is part of deaf culture. However, they inappropriately exploit what is seemingly normal. Hearing people learn, for example, that tapping a deaf person's arm is allowed. But instead they slap deaf women on the bum or touch intimate parts of their upper body. (Germany)

More encompassing were the rules that governed services for women with disabilities and residential institutions in particular. Here, inequalities and differences in power were set into the systems by which places operate. Routine procedures could result in violence:

I state it here and now, that the women in this group home, they suffered from violence. Not physical but emotional violence, tyranny and were often degraded. And I just, and I know these group homes, and I know that this is still happening. There is a system, or a form, into which everybody living in the group home is forced into. (Iceland)

To a lesser degree, women mentioned other places such as workplaces. Schools were important sites of bullying, bad treatment and violence for children. Disputes often arose over use of specific areas such as designated car parking places for disabled people, where despite formal agreement, special use for disabled people only was contested by non-disabled people.

In summary therefore, there were few places where violence never arose. However, violence arising from current or former intimate partners and from service workers were mentioned most frequently by the women taking part in this research and was the major focus in Austria, Germany and the UK.

Perpetrators

In line with the points made above, a very wide range of perpetrators were identified. Family members, and spouses and partners in particular, represented the major threat. For some BME participants other immediate and extended family members were implicated as perpetrators or collaborators of perpetrators. Professionals and service workers were also identified, as well as strangers, passing acquaintances and neighbours. As noted above, some members of the public appeared to feel free to violate women with disabilities' personal space, despite the best efforts of women to take evasive action in advance.

Isolation of victims was common to all experiencing domestic abuse but overprotective parents and legal guardians were described as especially isolating. Deepening of dependency by constantly accompanying women wherever they went was also experienced as a form of psychological violence.

3.2 Perception of Violence on a regional / national level

A wide variation in knowledge and understanding was apparent among women taking part in this study. While some women were relatively well-informed about the wider issues, others had limited or little knowledge.

Some participants pointed out that there is a very high level of unreported violence against women with disabilities and some women considered this to be a major problem. The issue of violence was said to be often treated as taboo even though it could potentially affect all women. Lack of belief in society about the possibility of violence against women with disabilities was considered to exacerbate it, encourage concealment and to be symptomatic of the fact that the needs of women with disabilities were not taken seriously. On a more optimistic note some women felt that the taboo surrounding discussion of violence had reduced in recent years; however this view was not held by all, perhaps due to the still patchy and uneven provision of services that was commented on by participants in several countries (see also below).

Women also noted several other important issues. D/deaf women felt that they were more likely than other women to experience violence and the relative disadvantage of BME and financially insecure women was also commented on. The important link between violence and overall well-being was highlighted in all countries, for example, through the high incidence of mental health problems among women with disabilities who have experienced violence.

The structural organisation of services was implicated by several countries and especially by Icelandic women in the creation of unequal social relationships that underlie violence. Having limited choice in where to live and who provided assistance were conditions felt to open the door to violence.

The points raised by women with disabilities here indicate that they were aware of violence against women with disabilities as a general phenomenon and of the increased disadvantage of certain groups of women. By and large they did not make links with laws and policies, however, and they did not comment on the potential for this.

3.3 Experiences of Violence and Support over the Life Course

It was not a requirement for this study that women provide a full history of violent incidents over their lives. However, participants were asked about their experiences

of violence over time, in order to gain a broad perspective on the problems as experienced overall by women with disabilities. Their various experiences are described below.

Childhood and Adolescence

Many participants had experienced violence in childhood, with psychological violence mentioned most frequently. Experiences included being made to feel guilty, being threatened, humiliated, being frightened, belittled, neglected and insulted.

Also emphasised by women were sexual, physical and emotional violence, as well as bullying and neglect. Many of the incidents described were very serious, including incidents of repeated rape and severe beatings. It is also important to note that some women stated that they has been beaten because of their impairments.

Most frequent perpetrators were fathers and (less often) mothers, other family members (especially brothers) and people closely associated with the family or child. Many spoke of being beaten frequently by adult family members: parents, grandparents and stepmother. A deaf woman spoke of her experience of physical violence as a child:

Back then I was wearing a hearing aid around the neck, with wires leading to the ears. Once he hit me on the ear mould and I started to bleed. It was terrible. And the basement with the hearing tests! I was so scared. This was so scary for me as a small child. And my grandfather dragged me down there. (Austria)

My brothers used to beat us up a lot; maybe because they wanted to be - yes, in other words that's right - they wanted to be in control. They were controlling us, they were controlling all the sisters. (UK)

Outside the family, violence was also experienced in school, especially residential or boarding schools, during childhood and adolescent years. Experiences were given of being ostracised by the whole school, of not being allowed to play or being locked up, being held down and forced to eat, being excessively physically manipulated by a therapist, to the extent of bones being broken, and of having a duvet removed by male staff in the mornings were all mentioned by interviewees and focus group members.

As noted above, this study did not set out to recruit a representative sample of women with disabilities, and therefore does not seek to make recommendations on the basis of numbers of incidents. Nevertheless, the high incidence of sexual abuse mentioned by women in this study is cause for concern and the problem warrants further investigation. The number of incidents reported stands in sharp relief in comparison with the assumptions that some women reported in relation to their sexuality: many said that it had been assumed that they were asexual. Lack of sex education in childhood was reported by some women with disabilities in all countries. In consequence, some women reported that they had difficulties understanding sexual boundaries and recognising sexual abuse. Again, some women only recognised the abuse later in their lives, and their lack of knowledge can only have exacerbated their powerlessness in the eyes of perpetrators.

Adulthood

Although women with disabilities often became more autonomous in adulthood, in the sense of having more formal rights, they did not necessarily escape violence.

For some, childhood violence extended into adulthood and for others who had escaped violence as children, adulthood marked the beginning of violence. Violence in adulthood took place against a backdrop of reduced opportunities to take part in many areas of adult life, including education and employment.

There's nothing new at work, it's always the same routine. I feel like a donkey there. It's like when I was a child, back then no one thought I was capable of anything either. It's the same attitude now and then. (Austria)

Being less able to defend oneself or having fewer connections and opportunities often corresponded with increased violence. Times of transition were danger points, such as the onset of impairment in this instance:

When I fell ill, it got worse, that's when he got his grip. He got his grip, you know, I was in hospital for four months, three months, two months, five weeks has actually been my shortest stay prior to coming here. (UK)

Violence in adulthood encompassed psychological, emotional, sexual forms. While in some cases fathers continued to abuse, increasingly partners and spouses rather

than older family members became the predominant perpetrators of domestic violence.

For other types of violence, service personnel and other residents, especially in institutions, but also service workers assisting women in their homes, were implicated. Strangers, neighbours and members of the public were also frequently mentioned.

New forms of violence were also apparent as women entered adulthood and parenthood. Women experienced impairment – related abuse from perpetrators, aimed at weakening them further and keeping them isolated from others. Women living in institutions spoke of violations of privacy, neglect, being pressurised to do things they did not want to do and being humiliated. As with violence in other settings, service-related violence was always characterised by control and domination of staff members. Women in institutions often were subjected to sexual violence and abuse.

Before I knew it he was lying in my bed with me. That was one of the caregivers. He had his pager with him, and it was obvious that he wanted me and I told him to fuck off, he took my hand and said: `You've never touched a penis, right? You've never been with a man, right, and don't you want to know what it's like?' (Austria)

BME women in the UK discussed forced marriage, where women were coerced into marriage, often with the collusion of family members. While distinct from arranged marriage, it could also be associated with it, as shown in the quote below:

All my three brothers... they arranged or forced my marriage because my dad had passed away when I was sixteen. I was twenty at the time and he was about forty; or he could have been sixty. You know he never told me his age! And for the sake of me starting to talk to my sisters and my brothers I got married but I stayed in India for ages; eight months....My husband wouldn't let me come back to England. I tried to commit suicide a couple of times and they [the husband's family] just got fed up and sent me back to England. (UK)

Financial abuse also became apparent as women entered adulthood. This was mentioned specifically in the UK, while women in other countries included it under other forms of violence. Men aimed to restrict and control women's access to money in order to isolate them and to prevent them from being able to do things.

Men, they can see a disabled woman and think she's an easy touch and I've had that a lot through the years. It's like they see a vulnerability and they might as well see pound signs (UK)

Motherhood could be very problematic for women with disabilities compared with women without disabilities, not least because of the societal disquiet reported about mothers with disabilities, who were sometimes seen as incompetent or as carriers of faulty genes to their children. In some countries women reported that others had made decisions on their behalf when they became pregnant or became mothers. Parents with disabilities feared that their children might be taken away and so were sometimes reticent to report a violent partner. The problems were illustrated by one UK focus group participant who reported that a social worker had told someone she knew (a mother with intellectual disabilities) that she had to stay with a violent partner if she wanted to keep her children, on the basis that he would help her to look after them. In several countries women with disabilities stated similarly that were viewed as incompetent and did not receive the support they needed or the opportunity to show they could handle motherhood.

Despite these experiences, positive developments were also reported. Resilience was also a feature of women's stories and in some instances this had been built up over a considerable period:

I had to go through this period, and I've accomplished it, so I'm very self-confident now, and when I was a child my confidence wasn't that strong, but now, it makes you stronger and stronger.....I just learned that because of my experience in life – if you don't start defending yourself, you'll drown. (Germany)

I'm also very enthusiastic about having accomplished this. Well, instead of falling into despair or getting bitter, I now take it with a great deal of humour and with patience and explain to the people how situations could be and how they appear. (Germany)

Viewing experiences of violence over the life course therefore allowed a longer term perspective to be taken over the life course. The women taking part in this study were under 65. However some noted that targeting of violence may change as disabled women age into later adulthood. The greater likelihood of living in an institution for all older women, as well as the increased likelihood of financial abuse

by family members may well be an issue affecting women with disabilities in particular ways. This possibility remains an issue for further investigation.

3.4 Women's Knowledge about their Rights

There was a great deal of variation in women with disabilities' knowledge about their rights¹⁰. Although a small number were well informed, most had a more limited or partial picture of just one aspect of the law. Participation in legal processes had helped some to become more familiar with aspects of the law and procedure. Other sources of information were support organisations, such as peer support groups of women in similar situations to their own, contact with DPOs, employment and involvement in education at university.

There were also variations in the depth of knowledge. Some had heard of the CRPD for example but many women were not sure of its exact provisions or of the degree to which it had been implemented in their country. Women highlighted the problem of lack of appropriate education in terms of content: needed information about rights and what was not available, and the way it was delivered (e.g. in easy language, oralism in schools etc.) was often not accessible to women with disabilities.

I have seen this Convention from the United Nations and have gone over it. And, for example, the rights to interpretation, interpretation to sign language are stated there, and we have pointed this out, but it makes no difference. (Iceland)

Even where rights were known by women, they felt that political will to implement them was often lacking. Rights were considered to be of limited use if they were not implemented in a practical sense and the root problem of prejudice and discrimination sometimes made the law ineffective. Rights on their own were therefore considered to be insufficient. Some women who were well informed

¹⁰ While women participants in Austria and in the UK focus groups felt reasonably well informed, participants in interviews in Germany and the UK felt relatively uninformed, as did those women in Iceland. All participants agreed that there were women with more and less knowledge than they had and there was also variation within each of the samples of women in each country.

overall pointed out that laws and other information about rights were not available in accessible forms to women with disabilities and even when well available it was difficult to know how and where to claim rights. Distribution problems were also said to be sometimes hamper access to accessible information where it existed.

The issue of legal capacity was raised as a particularly acute problem by women in Iceland; however legal guardianship is an issue that also affected women with disabilities in the other three countries and in Europe more generally. The Icelandic national report notes that legal capacity judgements had been used to remove rights from women with disabilities to make decisions about even very basic things in their lives such as this instance where following a judgement women were moved far away from where they lived and experienced what they felt to be a dramatically reduced ability to make decisions in their lives:

So, because I didn't know the rules nothing could be done. I could not go out to smoke because they said: "If you go out to smoke your rights would be completely removed". You have to read the text. I couldn't respond. I could do nothing. They were all there against me. They just said: "It is for your own good."

In summary, therefore, limited knowledge, information and access to redress severely limited the access of women with disabilities to their rights and in some instances the law on mental capacity itself limited freedom of movement.

3.5 Knowledge about and use of Services

In all countries, the relationship with support services was not straightforward and overall, specialised services concerned with violence played a relatively minor role in women's lives. Nevertheless, all women agreed that the help that services offered was essential and very necessary for women. Most women had used forms of therapy services at some points in their lives and some had spent time in clinics and with private psychologists. A few women in all countries had attended self-defence classes and some had used counselling. A few women with disabilities in most countries had used refuges, but fewer women with sensory or physical impairments had done so, with problems of accessibility given as a reason for this. Further details about overall patterns of service use at national levels are given by service providers in the second part of this report.

A minority of participants stated that the service provision in their area was adequate. Where women knew of services they thought that other women with disabilities experiencing violence were not aware of them. Women who had links to the service system in some way, such as through working in services or having links to DPOs and peer support groups tended to be better informed and some women expressed the opinion that over the long term there were more services provided and better recognition of the problems of violence against women.

However, many participants did not have any contact with services at all and a number of reasons were given for this. A lack of knowledge and information was combined with poor knowledge about who to turn to. As mentioned above, some women in all countries lacked necessary guidance about what constituted violence and unacceptable behaviour. Fear about whether a service might be inaccessible deterred some women, as did the assumption that as women with disabilities they would not be helped. Gaining access could be problematic in the first instance, and some women reported suspicion from service providers about whether they had a need for a service. Communication and interpretation problems were mentioned by D/deaf women. Finally, the perceived stigma of using specialised services was a deterrent for some.

A particular problem was that there was often no-where to go for women experiencing institutional abuse at the hands of care providers. Often the only recourse was through the complaint systems of care providers themselves and this route was clearly unsatisfactory. Women recommended that the provision of support services be separated from provision of housing services as a way to allay this problem.

It is a bit difficult if an interest group both provides services and is in a struggle on behalf of the interests of the group. They need to separate that. (Iceland)

To summarise, in focus groups and interviews the majority of women did not state that they had been actively and overtly turned away by services. Instead, a combination of lack of knowledge, fear about inaccessibility and concerns that the service did not address the problems they faced, combined to keep women with

disabilities away from specialised services and to prevent specialised services from actively addressing their needs.

3.6 Experience of Barriers

A formidable array of barriers was identified by women with disabilities in relation to securing assistance and achieving a violence – free life. Some of these overlap with the problems mentioned in the previous section; however, the issues here also encompass the position of women with disabilities in society as well as specific barriers encountered at particular times.

Not Being Believed or Being Ignored

In all four countries, women reporting violence stated that they were often simply not believed by other people. There were many examples of women's accounts being dismissed by service staff, the general public and family members and this was especially the case if there were no witnesses to violence. Occupying a marginalised status in society, many women with disabilities did not seek help on the basis that they were unlikely to be helped (see further discussion below).

Some women with cognitive impairments stated that they had been cast by perpetrators as 'deranged'; as making accusations because of their impairments, and that this made them reticent to bring charges. Such accusations were reportedly often believed and might lead to a woman's testimony being discounted in court.

Power imbalances were prohibitive for women living in institutions, where staff might have almost total control over daily lives. Staff in institutions were said to be often be poorly trained and therefore unaware of how to recognise and counter violence. Because staff did not know how to react, they often referred women on to other services rather than helping them directly, something that could cause additional confusion and stress for women concerned.

Family members were sometimes the first people that women turned to for help. However, many women stated that they were not always receptive and in some instances were hostile.

I think the thing that hurts me the most was probably my parent's reaction ... they must have been thinking do they phone the police, if they do, you know, it'd be a big scandal; it would be in the paper - all this kind of thing. A sort of

shameful situation and I remember hearing my mum saying that “she’s young, she’ll just forget about it if we don’t mention it”. And it was just swept under the carpet. (UK)

Similarly, participants stated that the ‘keep it in the family’ philosophy was usual in the Asian community and this could often be a barrier to accessing external support.

There are a lot of Asian women where the women are suffering because of the way their husbands treat them. They are completely unequal; they are treated like a slave and like a real second class citizen. So often I see that within the hearing Asian community. It’s not always how the husband treats them but the whole family treats them. Maybe by the mother in law, she’s told to do this and do that. (Focus Group BME Deaf Group, UK)

Lack of Information and Inaccessible Information

Problems with lack of accessible information have been mentioned above. However additional difficulties were such that women with disabilities often made poor use of services. Some women with disabilities did not have access to the internet, which in all countries was the most common way that services provided information. Lack of accessible information applied to specialised victim support services, other support services and the criminal justice system. It was felt by some that there was insufficient publicity by specialised support services and that when there was, it was not clear that women with disabilities would adequately supported. Women reported not making contact for this reason.

Additionally, lack of information, while common amongst all women with disabilities, was especially a problem for D/deaf women and women with learning difficulties. Even where sign language was available, for example on an organisation’s website, this did not mean that signing staff were necessarily employed by an organisation. Confidentiality was a clear cause for concern with worries expressed about involving children as interpreters when reporting violence. D/deaf communities are often small and there were concerns about the discretion of interpreters (where these were needed) when meeting counsellors, in dealing with the personal effects of violence. Some D/deaf women reported preferring to not seek help at all because of these problems or not using any interpreters when seeking help from agencies. Reporting to the police by D/deaf women was also inhibited where children needed to act as interpreters because women did not like to cause distress to their children. Budget

cuts to services in the UK were reportedly leading to fewer interpreters being available and a smaller overall pool, creating more problems for confidentiality in that country.

Internal Inhibitions

As stated above, many women themselves did not feel confident enough to get in touch with services. Lack of confidence for some stemmed from such things as not having been listened to and lack of opportunities to share experiences with women with and without disabilities since childhood. Consequently, women with disabilities often had low self – esteem and self-confidence, which made it difficult for them to stand their ground. When combined with purposeful strategies used by perpetrators to keep women isolated, this acted as a powerful inhibitor to seeking help.

Inaccessible Services

Women with disabilities in all countries brought up the issue of inaccessible services. Examples were given where a woman with a support assistant could not be accommodated or where there was no accommodation useable by a woman with a mobility impairment. In the same way, women often reported not being able to attend service premises at all, due to physical inaccessibility of the location. One woman, for example, could not find an accessible local female gynaecologist and had to attend a clinic of a male; another could not locate an accessible trauma therapist. Although in some instances services organised external alternative accommodation and services, being seen as an ‘inconvenient client’ was felt to be embarrassing.

As well as physical barriers, negative attitudes by service staff were reported to be a significant problem. Many staff were said to be largely unaware of negative attitudes in society, including the possibility of their own. In some instances getting access to a service could present many problems; as a ‘real fight’ and waiting times for some services were prohibitively long in some areas.

Rural service scarcity was raised as an issue by women with disabilities in Iceland and Austria in particular. In some areas there were no services and in others, transport presented specific problems. For example, in Iceland a woman’s use of a service could be obvious to everyone on public transport because there was nothing else in the locality: this was a significant deterrent to using the service.

Finances

Money and access to it was also a major barrier for some women with disabilities. Some women were financially dependent on the perpetrator and had very little money of their own. This dependency made it very difficult for women to escape the cycle of violence to which they were subjected.

D/deaf women were often in a position of having to pay for translation costs. Two examples are given in the German national report: from a deaf woman who spoke of uncertainties about who was responsible for paying for an interpreter during counselling sessions and another instance where the additional costs of support needed meant that a woman was not able to stay in a trauma clinic. Even though services to women who have experienced violence in Germany are free, the fear of additional costs could act as a deterrent to seeking help.

Women were often poorly situated with regard to employment. As well as gender based labour market segregation that disadvantaged women, discrimination against people with disabilities also kept many women with disabilities out of employment that generated good wages. Worries about whether they might manage financially again kept women from reporting violence, looking for support and/or leaving violent partners.

Power Imbalances and Additional Factors

Violence against women with disabilities was considered to be higher in all countries than for women without disabilities and to be a possibility in almost any situation. Certain women such as sensory impaired women, BME and poor women were considered to be especially at risk. Power imbalances underpinned violent relationships and for some women it was reported to be unremitting over long periods of time. Rather than the characteristics of perpetrators, it was the positions of power that other people held in relation to women with disabilities that participants identified as the problem. Relative powerlessness was identified as stemming from a number of factors, including: the perception that women could not fight back, the degree of control exercised over women (as by residential service providers, for example) and restrictions on reporting imposed on women by themselves due to fear of losing things that were needed, such as assistance or accessible housing. Where women received personal care they were particularly at risk. In all countries

women's impairments were often targeted for violence. For example, mobility aids might be removed or made ineffective or women might be over-medicated.

Violence was reported to be greater at times when the power imbalance increased. Some key flash points in women with disabilities' lives were consistently mentioned as trigger points. However the intersectional impact of disablism could give these experiences additional unpleasant twists.

In common with all women, women with disabilities in this study reported increased domestic violence just before and after childbirth. Requiring additional assistance with daily life when faced with the responsibility of young children, some women with disabilities reported that they felt they had no option but to remain in violent relationships. For some women, the alternative was to have their children taken away, if it was judged that they were not able to manage on their own without support. As two mothers who had learning difficulties described the situation:

Participant 1: [If they left a violent partner] it's very likely the parent with the learning disability would have their children removed from their care instantly. And I was put in that situation where that did happen but when they did ask him to leave the family home, they didn't put that support in for me so they moved him back in anyway because he was my support to look after the children.

Participant 2: When I did turn to anyone for help it went all wrong so in the end I nearly lost the kids, I did lose the kids for at least a while..... I was branded as the worst mum in the world. (Focus group, UK)

Where women with disabilities did not have a settled living arrangement, as was the case for migrant women, the uncertainty regarding their residency status could also militate against seeking help. Reporting violence was also reported to be culturally stigmatising and made more difficult when rejecting a violent perpetrator could mean being ostracised from a given minority community. Problems in this regard were also reported by D/deaf women: because social circles were so small it was sometimes difficult to totally escape from perpetrators who were also D/deaf.

This section has provided an overview of some of the main barriers identified by women with disabilities in the four countries. Further specific details and examples are provided in the national reports.

3.7 Helpful Aspects of Support

Women with disabilities discussed helpful factors in terms of three main areas: supportive (or unsupportive) relationships with individuals, assistance from services or the criminal justice system and things that helped them muster personal resources and strength.

In all instances and throughout their lives, supportive contact with other people was the factor that women with disabilities experiencing violence found most helpful. People who listened to them, helped them understand what was happening, encouraged them to get assistance and to seek justice were highly valued. This support was often positively associated with turning points in women's lives with regard to experiences of violence. Some described, for example, the important part that their family members had taken in helping them to recover from the effects of violence. Other people who were mentioned as particularly helpful were frequently relatives and friends, teachers, instructors, doctors, social workers, mobile caretakers, psychologists and psychotherapists. As adults, examples of helpful individuals included people who were personal assistants, mobile caregivers, social workers, doctors and refuge support workers. However it is important to emphasise that women singled out the support of the individuals themselves, rather than the profession, as the source of help. As described above, women with disabilities equally gave examples of people working in the same positions who had been unsupportive in various ways.

Services were also vital sources of support and all women with disabilities agreed on their importance. For example, the Austrian national report points out that about half of the women participating had used specialised women's support services (refuges, helplines and counselling) and all who had done so spoke highly of the support they had received. In all countries, specialised services mentioned as being particularly helpful included self-defence classes, self-help-groups, peer counselling and empowerment movements.

There were also some instances where women with disabilities had received helpful support when taking legal action against perpetrators. For example a D/deaf woman

mentioned the provision of detailed translation and explanations before and during a court hearing that were particularly thoughtfully provided.

Whether as part of the system or independently, women with disabilities who had experienced violence found value in receiving and giving personal support to others. Of those with access to it, independent peer support and counselling was mentioned in particular by women as being helpful. This should not be automatically assumed however, as one woman said she found contact with other distressed women with disabilities stressful. The vast majority however valued contact with these groups where they existed, as well as contact with DPOs and the Independent Living Movement. In all countries women described the value to themselves of helping other women in a similar situation to theirs and some women with disabilities had completed training as counsellors or taken on other support work for women who had experienced violence. Opportunities to take up new activities, whether sport, education or employment also were described as helpful factors.

To balance this it should be noted that women with disabilities also clearly valued basic necessities, such as a safe place to live and this is discussed below. However the importance of knowledgeable, personal support from individuals should clearly not be underestimated, especially at pivotal points in women's lives, such as during the process of escaping violent perpetrators.

Personal Self Reliance

Quite often a number of small steps were taken towards establishing a violence – free, independent life. Women with disabilities emphasised the way that the support of others helped them to draw boundaries concerning acceptable behaviour and to name abuse for what it was. In doing so, women spoke about how they were able to able to have an increased say over what they did and what happened to them:

I started to ask, 'what I should do'? And then he would ask in return, 'what do you want to do? This is your body, you control it'. No-one had said that to me before, you know. It didn't occur to me that it was my body and that I controlled it, it would never have occurred to me. So it was, you know, a bit of a shock for me. Of course, I understood as soon as he said it, and of course it was so. But even so it was somehow, it was new information to me. (Iceland)

Examples of the ways that women took more control of their own lives was through gaining personal assistance that could replace the abusive care of individual perpetrators or care facilities and being more assertive in their dealings with others. In so doing they developed greater understanding and realisation of their rights. At the same time they were able to develop more supportive and equal relationships with others, further strengthening personal well-being.

3.8 Suggestions for Improvement and Good Practice

As noted in the national reports, tackling violence against women with disabilities requires action on a very large number of fronts. Women in this study were asked about the measures that they would prioritise.

In all countries women with disabilities emphasised the need for greater equality between people with and without disabilities and between women and men as a means of undermining the inequalities that underpin violence. Women with disabilities highlighted important immediate issues related to alleviating violence and securing help to counter it in relation to this. Two main aspects will be discussed here: increasing individual support through improved access to specialised services and increasing accessibility and equality in everyday life in society.

Increasing individual support through raising awareness and building self – esteem was considered essential for countering violence. Support services were also deemed vital for countering the effects of violence, helping to prevent it and to stop it from re-occurring. Women with disabilities pointed out the urgent need for accessibility measures, especially with regard to infrastructure.

The need for a safe home was a priority, particularly for women with experiences of institutions and care facilities and it was emphasised that children with disabilities need to grow up in families not institutions.

Women stated that many services need to be re-located so that they are local and could be reached easily, rather than positioned in hard to reach places. Ramps, lifts, guidance systems and other accessibility features needed to be installed as standard. Accessible information about services was a priority, while information was also needed that was accessible to *all* women rather than just specially developed for

women with disabilities and they needed accurate information about their rights with regard to payment for personal assistance and translators. Enough time needed to be allowed for women if they required it.

Attitudes to women with disabilities in specialised services were also seen to be in need of improvement. Raising awareness and the level of knowledge and understanding through continuing training was recommended through two different strategies. First, general awareness training of all service staff was deemed necessary, so that there was an understanding of women with disabilities' needs in terms of accessibility. Second, in several countries women recommended that a specialist point of contact be established in each service, or network of services, in order to ensure that women with disabilities did actually receive help and were assisted appropriately. Less emphasis was placed on an advocate's position inside the system in Germany and some women here felt that a position as an outside might be beneficial. The degree to which shortcomings of specialised services might be improved was debated. Some women expressed views in favour of separate services, for example for D/deaf women, while others favoured services that provided for all women.

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

The expansion of specialised services overall was felt to be imperative. At the same time other recommendations concerned extending parts of services that got around accessibility problems, such as developing more outreach services. These might involve trying to support a woman to live in her home in a safer way or excluding a perpetrator from the home. This was particularly important for women with mobility impairments in situations where there was a lack of accessible housing that women with disabilities could move to.

Continued efforts to change attitudes in wider society were also strongly recommended. Awareness training for service personnel, mentioned above, also needed to be extended to other agencies, in particular the police, other criminal

justice organisations, and to training for professionals such as doctors and social workers. This training needed to incorporate an appreciation of the oppression and marginalisation of women with disabilities and not just training about their impairments or an orientation towards care. A focus on dealing with perpetrators in order to keep women safe was recommended.

Finally, the proper prevention of violence (starting with education in schools) to prosecution of offenders, was emphasised.

This section has summarised some of the major recommendations made by women participants in the four countries. More details of country – specific recommendations are elaborated in the national reports.

3.9 Good practice Examples

A brief outline of good practice examples given by women with disabilities is offered here and more details can be found in the national and comparative reports on Good Practice developed by this project.

Women drew attention to some services that offered a good understanding of what they needed. In particular, good mechanisms of assessment that took access requirements into account were valued, as were practitioners who were attentive and who looked at the person and the situation as a whole.

Emphasis was placed by many on the good attitude, knowledge and understanding of staff. The employment of women with disabilities in specialised services was viewed by many as a positive sign, as very helpful to women and in many instances indicative of an inclusive employment approach. However, it was not considered automatic that a woman with disabilities would have a supportive approach to other women. A good attitude was deemed more important in some instances than identity and it was essential that employment of women with disabilities was not carried out in a tokenistic way. Women with disabilities emphasised the importance of safety and anonymity and the development of a non-judgemental and empathetic environment that allowed them to express their feelings, outline their experiences and that offered information and emotional support in everyday life. Organisations that were proactive in explaining about violence and acceptable behaviour were very

important to women with disabilities who were experiencing ill – treatment. Groups where women with disabilities were treated with respect - some mentioned self – defence classes and peer support groups as examples - were all settings where support and helpful advice were often received.

4. Research Findings: Service Providers

This section presents the findings from the second major element of the study: research with specialised service providers to women who have experienced violence.

4.1 Defining Accessibility

Specialised service providers had more and less understanding about what accessibility entailed¹¹. Most thought of it in terms of a range of adjustments that might be made to buildings or facilities to accommodate women with particular impairments¹². Examples included adjustments to transport, changes to room layout, information and service provision in easy and sign language, and provision of additional assistance. A smaller number had a deeper understanding of accessibility that was more akin to the concept of universal design, or barrier-free environments.

Service provider interviewees highlighted some of the more difficult dilemmas faced in planning a responsive service. Most placed value of the idea of being open to all women regardless of their situations and they described difficulties in balancing different needs:

If you've got a deaf woman then how is she going to live in a refuge where everybody else is hearing? Okay, we can bring an interpreter in but that's very isolating for her and so there are those kinds of issues and how you deal with them. You know it's hard enough for somebody who doesn't speak any English but at least they can begin to learn English and we can help them to get to college to do classes and that kind of thing. (UK)

Basically, I think that accessibility is a utopian fantasy. I think what we are really able to achieve is a high level of reduction of barriers. For it's obvious that solutions that make things easier for one woman make things incredibly more difficult for another. So really achieving the basic idea, with all women coming and feeling comfortable and getting everything they need, might become relatively difficult. (Germany)

¹¹ The term 'barrier-free' was used in the research and it was a concept that was fairly well understood in all countries. German and Austrian service providers were more familiar with the concept, compared with the UK, where many had not heard of the term. In the UK service providers sometimes found it easier to identify what barriers were rather than to identify what a barrier-free environment might look like.

¹² Accessibility is described in Article 9 of the UN CRPD. The measures described by participants are largely in line with this.

In all countries there were similar concerns about equitable treatment and how this was possible in relation to the different requirements women might have. The desirability of an overly simplistic approach to accessibility was questioned.

These more nuanced approaches contrast with some answers given in the online surveys, where some respondents considered accessibility to mean the potential for adaptations to be made in response to requests from women with disabilities (sign language interpreters etc.).

Taken together the replies show a wide variation in understanding of accessibility.

4.2 Access at Micro Level (institution / organisation)

Service providers were asked a series of questions about the participation of women with disabilities and particularly about specific groups of women. The aim was to find out whether some groups of women with disabilities experience easier or worse access than others. The replies from all countries are provided in Table 7 below.

It is important to note again that the figures presented below are not representative in a directly comparable sense. Caution is needed because of the different numbers of responses and the very low numbers of interviews in Iceland.

In all countries service providers estimated that on average¹³ a third of women using their services had impairments and women with mental health conditions were the group most frequently reported.¹⁴ In many ways this is not surprising given the effects of violence on women's mental health but it may also reflect the degree to which women with other kinds of impairments experienced difficulties accessing services.

¹³ Mean scores: Austria: 35.9, Germany: 29.0, Iceland: 32.8, UK: 33.5.

¹⁴ For the purposes of comparison, the following rates are reported: Austria 25% Germany 25% Iceland 25% UK 19%, although it should also be noted that Germany and the UK, with higher populations reported much higher actual incidences of 97% and 95% respectively.

Figure 7: Service Providers' Reports of Accessibility by Impairment and Country

	Austria (N=60)			Germany (N=363)			Iceland (N=10)			United Kingdom (N=41)		
	Totally accessible	Partially accessible	Not accessible	Totally accessible	Partially accessible	Not accessible	Totally accessible	Partially accessible	Not accessible	Totally accessible	Partially accessible	Not accessible
Wheelchair users	44.2%	30.8%	25.0%	9.3%	32.6%	58.1%	40.0%	50.0%	10.0%	46.3%	41.5%	12.2%
Women with other mobility restrictions	46.0%	36.0%	18.0%	9.6%	42.7%	47.8%	66.7%	33.3%	0.0%	46.3%	48.8%	4.9%
Blind or visually impaired	0.0%	51.9%	48.1%	0.3%	8.2%	91.5%	10.0%	70.0%	20.0%	2.4%	39.0%	48.6%
Deaf or hearing impaired	13.5%	73.0%	13.5%	2.0%	66.1%	31.9%	10.0%	80.0%	10.0%	12.2%	65.8%	22.0%
Women with mental health problems	48.1%	50.0%	1.9%	27.1%	69.0%	3.9%	50.0%	50.0%	0.0%	70.7%	29.3%	0.0%
Women with learning disabilities	13.5%	67.3%	19.2%	9.1%	68.3%	22.7%	40.0%	60.0%	0.0%	34.1%	53.7%	12.2%
Women who live in residential institutions	13.7%	35.3%	51.0%	6.2%	43.1%	50.7%	40.0%	50.0%	10.0%	29.3%	24.4%	46.3%

Note: Data from Austria, Germany and the UK shows the outcomes of only women's refuges, women's counselling centres, women's emergency hotline and intervention centres for women who have experienced violence.

From the figures in Table 7, it is clear that accessibility levels are low. In particular, the inaccessibility of services for women with disabilities in Germany stands out. This figure is much lower than other countries, even though full accessibility is by no means the norm for other countries either.

It is not clear why professionals in Germany rated their own organisations as “not accessible” to women with disabilities. Accessibility may be particularly low in Germany or it is possible that there is a higher expectation or standard of what accessibility means. It may be significant that intense discussion of the topic was taking place at the time of the survey. In this regard, the low accessibility rate may reflect the work overload of the staff in the current German support system and the fear of further work if responsibilities and costs for full and free access are handed down to the support system (instead of resources being made available by political decision makers)¹⁵. Nevertheless, the lower rates in Germany may also reflect a lower engagement in trying to reach women with disabilities.

The survey asked open questions about the development of specific services for women who are wheelchair users and participants gave examples of measures that has been put into place. Many replies referred to measures such putting ramps in place or the possibility of meeting a woman in her own home. It appeared that service providers were not in general familiar with meanings of accessibility for example as given in the CRPD.

Low access levels of services for women with sensory impairments are noticeable. However it needs to be emphasised that in all countries there is particularly poor performance in this area. Marginally more represented but still disproportionately absent are women with intellectual disabilities.

Service providers were also asked about whether they extended services to women living in institutions. The highest figure here was for Iceland, followed by the UK, with Austria and again Germany showing a very low level of engagement.

¹⁵ Advice provided by German project partners (see Appendix 1).

Service providers were asked about the kinds of measures they had taken to ensure accessibility. Those most commonly described were counselling for women with mental health conditions (70 – 80% for all countries) and in easy language for women with intellectual disabilities and women with chronic ill-health (around 60 - 70%). Other measures that were mentioned more often were partial accessibility of rooms for women with physical impairments, the provision of legal advice (although it was not stated how this might have been adapted for women with disabilities or was something routinely provided) and assistance that could be given through email.

Perhaps unsurprisingly, given the points made above, adjustments had least frequently been made in relation to women with sensory impairments. The lowest percentages (between 0.1 and 4%) were given for alterations such as the introduction of Braille signage and the use of lights for doorbells and guidance systems for blind women. Given the relatively low cost of such changes, compared with other measures such as the provision of training or larger changes to buildings there is a question about why this should be so.

Service providers were also asked about planned changes to improve accessibility and the online survey gave examples of the kinds of adjustments and developments that service providers might have been considering. The most frequently identified measures were the development of a more accessible web site and information (Austria 33%, Germany 18%, Iceland 26% and UK 17%) and improved counselling support for women with physical disabilities and for chronically ill women. Overall however, the planned number of changes remained small, with an average of 2-3 out of 19 mentioned by respondents. Fewest improvements were planned for women with sensory impairments, although the UK had a slightly higher percentage at around 10% compared with around 1% for Germany and Austria and none for Iceland.

4.3 Access at Macro Level (regional / national level)

Service providers were asked whether support provision at regional level was adequate and all considered it to be insufficient (Austria 80.3%, Germany 94.7%, Iceland 100%, and UK 80%). The shortcomings described spanned all areas of provision, including for example, accessible information and materials for women,

aspects of building design (their own services and those of others), education and training, counselling and outreach services. It is of concern that some service providers mentioned the need for more places in institutions, such as mental health facilities, indicating that they may well have unaware of the dangers that women with disabilities may face in institutions.

4.4 Challenges of Implementing Accessibility

In all countries a number of common themes emerged regarding challenges in implementing accessibility. There were also differences in the difficulties perceived and the extent to which these were considered to be surmountable. Therefore, after a brief synopsis of commonalities, the different perspectives of service providers in each of the countries is discussed.

All four countries spoke about accessibility measures being limited by lack of funds. All said that services experienced lack of capacity that has been a continuing problem in most countries (see for example WAVE reports¹⁶ on service provision) and were therefore in the position of having to be selective in terms of the women that they turned away. Most services operated with an ethos of equal treatment for women; nevertheless selection was a necessity and from the evidence provided above, it was clear that women with disabilities were often screened out in one way or another.

Service providers in Germany expressed the highest degree of scepticism about the possibility of including women with disabilities. Large scale and costly adaptations were felt to be likely to be needed as well as more staff, making it “impossible” to include women with disabilities. It was also stated that more administration and bureaucracy would be involved although it was not clear why. Some providers felt that non-disabled users of shelters would be unlikely to accept women with disabilities and there was an assumption that women with disabilities would not be eligible for a service because they would not be able to meet the requirement that women should be able to care for themselves. On the contrary the view was expressed that women would need medical and nursing care. While there was an

¹⁶ Women Against Violence Europe (WAVE) <http://www.wave-network.org/content/wave-publications>

acknowledgement that staff lacked education and awareness, there was a considerable degree of scepticism about the possibility of including women with disabilities in their services, while recommending that society more generally needed to become more inclusive.

A different overall perspective was taken by UK services. Rather than emphasising the difficulties of including women with disabilities as service users, they mainly discussed the reasons why women with disabilities did not get to their services in the first place. Barriers felt to be important included the need women with disabilities have for care and personal assistance, views on the sanctity of marriage, especially in some catholic communities (Northern Ireland), the cost of interpreters, and other reasons echoed in the accounts of women themselves. A few service providers were open about the reality of turning women with disabilities away, for example from a refuge, because they knew they would face a lot of difficulties finding accessible housing or securing support from other service providers who should have responsibility for this. In turn, funding contracts they worked to emphasised payment for throughput of women through the service rather than individualised support.

In Austria, service providers also emphasised external factors, especially the need for an adequate policy framework in order to implement accessibility, with 80% judging current access to be inadequate. Specialised support as part of a network of provision was emphasised, with access to doctors' surgeries, public offices, police stations and courts needed. As well as the federal structure of Austria, participants felt poor service provision in rural areas to be problematic. Overall, service providers judged accessibility to require a lot of funding, staff and time, none of which were available. Accessibility was seen by many as something that was not achievable, and this reduced the motivation to actively effect changes. In this respect there are similarities with the situation in Germany.

Icelandic service providers emphasised lack of understanding in society and also prejudiced attitudes in society. They also spoke of the reluctance of women with disabilities experiencing violence to come forward. Funding shortages were again described, with the suggestion that these made alterations to service provision not possible.

Apparent in all accounts are the difficulties experienced by service providers faced with making difficult decisions in situations where they have limited funds. The accounts given in national reports back up and give further explanations for the lack of use of services by women with disabilities reported in the previous section.

4.5 Public Relations and Access to Information

Most organisations, apart from those that were specifically concerned with offering assistance to women with disabilities, stated that they did not seek to carry out publicity work with women with disabilities experiencing violence. Some service providers explicitly stated that this was because of concerns that additional work would be generated.

Most organisations emphasised the importance of having accessible information and there were some examples of good practice in this regard. However some websites were reported to have out of date information: service providers explained that due to limited funding, other matters such as direct service provision had been given priority.

Other reasons given for this lack of engagement were concerns about a lack of perceived professional expertise and a reliance on relationships with staff working in disability services. There was therefore very little recognition of the violence that takes place in institutional services, although exceptions existed.

A notable exception to the generally muted approach to public relations work was where organisations developed outreach services. Although service development is not the same thing as PR work, it was very marked that in all cases these were reported to be taken up by women with disabilities, even when not specifically aimed at them.

4.6 Co-operation and Networking

A large proportion of organisations had contact with other groups and collaborated with them in various ways. Contacts identified in the survey included health care organisations, counselling services and other organisations that were in the same or similar sector. Positive working relationships between agencies facilitated the referral of clients between services. Positive effects were reported from co-operation, including development of joint plans, mutual support and exchange of expertise.

Openness and improved awareness were reported by some, enabling the development of individualised solutions to women's problems in some instances. In each of the countries a small number of organisations worked across the divide and aimed to assist women with disabilities directly. However these were few and far between and often identified more strongly with one group or the other.

The number of contacts fell for services for disabled people (a third) and for DPOs (a fifth), especially for refuges, helplines etc. A proactive approach and mainly good working relationships characterised relationships between agencies in Iceland, with some mentioning awareness raising events that they had organised together. However, often there was not much contact between violence against women services and DPOs reported. Although women with disabilities experience violence from a number of sources, hate crime and institutional violence were largely treated as DPO responsibilities and domestic violence that of women's services. DPOs were generally described by participants as male dominated and lacking an understanding of the gendered nature of violence.

Some relationships were less effective, for example where they did not lead to any tangible benefits for women experiencing violence, such as women with more 'severe' impairments. Relationships between agencies were made more difficult in the UK by the competition for and shortage of resources. With less money available, statutory services were often unwilling to provide personal assistance that might be needed when women left a violent partner who had also provided assistance with daily living.

Social services, adult services are a big obstacle, there are good examples as well, but if we're sent a woman who needs personal care, my god I have a battle, a fight on my hands to get a carer in, paid by social services, adult services to shower the lady three times a day, to help her with the shopping, we are domestic violence professionals, DV workers, we are not personal carers, because I'm not qualified for that. (UK)

This service provider admitted that due to these issues she had turned women with disabilities away from the refuge she worked in. In a similar way, systems of funding put obstacles in the way of women with disabilities using support services who needed to move area to flee violence, because systems of support could not be

moved but had to be re-negotiated from the beginning again. As shown in the quote above, this was not easy to do.

Good co-operation existed therefore but there was notably room for improvement in relationships between specialised services and DPOs and in some instances with services that women with disabilities needed when escaping from violence. A considerable degree of fragmentation was therefore evident.

4.7 Future Prospects and Suggestions for Measures to be Taken

Lack of finance was emphasised in all countries. Long term funding in particular was deemed necessary so that future plans for facilities and ongoing staff training could be put in place. Diversity of information was also mentioned as in need of funding.

Two participants advocated the development of (albeit well situated in urban areas) separate refuges for women with disabilities, which would have special facilities and staff. The debate about integrated or separate provision was most marked in Germany.

In Austria and Iceland service providers recommended the following issues for development: more help overall for women with disabilities, training for staff, improved publicity, more funding and political will, better co-operation with organisations of and organisations for disabled people and peer counselling. Other recommendations put forward were the employment of a counsellor with experience of working with women with disabilities and improving physical access for women who were wheelchair users.

In the UK, where services overall were subject to wide-ranging funding cuts, there were few priorities mentioned for the future, other than finding ways to compete with non-specialised services, such as large generic providers of social housing. However the three issues that ranked most highly were barrier – free website material (14.7%), disability equality training for staff (12.7%) and barrier-free rooms for wheelchair access (7.8%). The low levels here are indicative of the degree to which services felt unable to recommend developments for the future other than remaining in existence.

For all countries it is noticeable that very few mentioned plans for accessibility in relation to where the most problems existed, such as development of services for

women with sensory impairments. This suggests that the knowledge of some service providers at least may be limited to more visible and well known disability issues.

4.8 Summary: Overall Experiences of Service Providers

Service providers were generally aware of the problems with violence faced by women with disabilities. In all countries they spoke of the greater risks and increased problems getting help. However they also emphasised the need for women to make their own decisions to approach support services, which was seen as an essential step for women in turning their backs on violence. The small number of women with disabilities approaching them for help was used as a justification for not improving the accessibility of services. As pointed out in the German national report, this could set up a vicious circle that prevents improvements to accessibility.

5. Conclusion

The seriousness of the violence faced by women with disabilities was made very clear by participants. The violence took many forms, was often experienced over the life course in different places and from different perpetrators. Serious and devastating violence took place where people lived and was associated with those who women were close to: partners, spouses and family members. Violence was also closely associated with living in institutions and with carers, whether paid to assist or informal family carers. The high prevalence of sexual violence in childhood was marked and is cause for concern.

Additional issues were particularly important for women with disabilities, compared to women without disabilities. The incidence of impairment – related violence needs to be recognised, where violence is directed towards women's perceived areas of weakness, with the intention of causing damage. Second, the existence of abusive care needs greater recognition. Perpetrators were not always recognised by other people as abusers but thought of as caring helpers, a situation that could be very dangerous for women with disabilities. Fear of losing a source of support for daily living could also be one of many factors conspiring to prevent women from leaving situations of violence.

Consequences of violence in causing impairments could be very severe. The effects of violence on mental health were catastrophic, but violence was a major cause of other physical and cognitive impairments as well.

Women with disabilities often did not have access to proper help, for two reasons. First, they often did not have access to specialised women's services, as has been explained in this report. Apart from physical access problems, many workers did not feel it was up to them to meet the needs of women with disabilities, or they did not know how to do so. Second, the support offered by specialised women's services was well attuned to the situation of women without disabilities experiencing domestic violence. For women with disabilities the type of support offered did not always meet their needs, because many experienced violence from several different sources. For example, women experiencing violence in institutions or the victimisation of neighbours might not be recognised as needing help or offered it. Indeed, in some instances the collaboration of specialised service providers with organisations for people with disabilities, rather than DPOs, could put women at increased risk if they sought help

Therefore a pressing need for women with disabilities is for safe spaces where their experiences would be recognised for what they were and where women can receive practical and emotional help. Where women with disabilities need assistance with everyday living, opportunities for accountable personal assistance need to be developed and made available.

Achieving this might be made possible through greater collaboration between specialised women's services and DPOs. The reality in most of the countries however is that a gulf exists between the two sectors and women with disabilities often receive no help from either party. DPOs lack recognition of gender-based aspects of violence and specialised services are inaccessible to women with disabilities. Nevertheless, in the gap between these, there are just a few organisations in each country specifically concerned with addressing the needs of women with disabilities who have experienced violence. Their existence is important in that it addresses the needs of women with disabilities experiencing violence

across a range of different areas and is highly valued as such. This work needs supporting (see the Good Practice reports developed as part of this project).

As emphasised in national reports, a political response is needed. Including 'disability' in mainstream services (improving accessibility in services for all women) and targeted approaches (assistance specifically directed at women with disabilities) are necessary. Sufficient funding needs to be made available to specialised services to tackle the problem with its associated emotional, human and financial costs.

National reports also highlight the need for further investigation into access to justice for women with disabilities. There are indications from all the countries that problems exist in this area but information on the precise nature of them is still patchy.

Some specific actions are emphasised with regard to specialised services for women experiencing violence. Improved orientation and training for staff, the development of access to facilities, as well as services such as outreach measures are all recommended. Prevention also remains a key strategy for all countries, with the establishment of programmes for an early age that enhance equality and respect for all. It is emphasised that only by undermining the conditions through which inequalities can arise that violence against women with disabilities can be eliminated.

Finally it needs to be restated that this complex and multi-faceted problem inevitably has attracted many recommendations from all countries. There is a need to implement these. Ways of ensuring that recommendations are acted on need to be developed at the various legal, political, service and individual levels.

6. Bibliography

Kelly, L (1988) *Surviving Sexual Violence* Cambridge: Polity

Schrötle, M. , Hornberg, C. , Glammeier, S. et al. *Life Situations of and Pressures on Disabled Women in Germany*. Short Version (2013): [online] URL: <http://www.bmfsfj.de/BMFSFJ/Service/Publikationen/publikationsliste,did=201652.html> (07.06.2014)

Appendix 1: Full List of Project Partners

AUSTRIA

Ludwig Boltzmann Association - Institute of Human Rights (BIM) – project management. Sabine Mandl and Claudia Sprenger

<http://bim.lbg.ac.at/en>

NINLIL (Counselling for Women with Learning Difficulties who have experienced Violence). Lisa Udl

<http://www.ninlil.at/index.html>

aum. cultural and social research. Anna Schachner and Oliver Koenig

<http://www.queraum.org/index.php?lang=de>

GERMANY

University of Giessen – Monika Schröttle, Kathrin Vogt and Janina Rosemeier

<http://www.uni-giessen.de/cms/fbz/genderstudies>

ICELAND

University of Iceland - Rannveig Traustadóttir and Hrafnhildur Snæfríðar- og Gunnarsdóttir

<http://english.hi.is/>

UNITED KINGDOM

University of Leeds - Sarah Woodin and Glasgow University – Sonali Shah and Lito Tsitsou

<http://disability-studies.leeds.ac.uk/>

<http://www.gla.ac.uk/researchinstitutes/healthwellbeing/>

