

SILENT VOICES: WOMEN WITH DISABILITIES AND FAMILY AND DOMESTIC VIOLENCE

A joint project of People with Disabilities (WA) Inc., the Ethnic Disability Advocacy Centre and the Centre for Social Research, Edith Cowan University.

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INTRODUCTION

Family and domestic violence is widespread and complex. It is a major issue which results in substantial personal, social, financial and health related costs. Considerable research has been conducted on the problem of family and domestic violence in Australia under the Commonwealth and State/Territories domestic violence prevention initiative *Partnerships Against Domestic Violence*. Researchers have studied causes of domestic violence, its effects on victims, and the effectiveness of various types of interventions with perpetrators and victims. However, there has been very little research on domestic violence against women with disabilities.

The risk for abuse that women with disabilities face, the direct and indirect effects of abuse on their health, and their barriers to seeking help remain largely undocumented. In addition, information about the experiences of abuse that women with disabilities face across cultures, disability types, and locales is extremely limited. This lack of information is problematic because existing knowledge indicates that women with disabilities experience violence and abuse at similar or higher rates than non-disabled women (Nosek, Howland & Hughes, 2001). Furthermore, the absence of attention to this issue from both disability and domestic violence researchers, has contributed to the “invisibility” of the victimisation of women with disabilities.

Like women, men with disabilities also experience violence and abuse. However, it is important to attend to the significance of both gender and disability status when examining this critical issue. Meanings associated with gender roles such as wife and mother and the well-documented effects of gender discrimination in society significantly influence the abuse experienced by women with disabilities. Being a woman with a disability has been described variously as a “double jeopardy” (Hutchinson, Beechley, Foester & Fowke, 1992), as “two strikes” (Hanna & Rogtovsky, 1991) and as having an “added layer of oppression” (Boyle, Rioux, Ticoll & WightFelske, 1998). These metaphors speak powerfully of the experiences of simultaneous discrimination through both having a disability and being women, and they convey to some degree the discrimination that such women experience.

Although the abuse experienced by women with disabilities is often identical to the abuse experienced by non-disabled women, there are forms of abuse that are unique to women with disabilities that may place them at additional risk. Because some women with disabilities depend on others to meet basic health or social needs, actions that may not be considered abuse for non-disabled women may be extremely harmful for women with disabilities.

The gravity of this problem requires that scholars, policy makers and service providers learn about its complex nature. Providing quality care to abused women with disabilities depends on this.

The project in context

This research project arose as a result of the widespread experience of women with disabilities, disability and community agencies and the paucity of relevant literature in family and domestic violence.

Since the mid 1990s a number of initiatives on family and domestic violence have occurred at State and Commonwealth levels in Australia. For example, in 1996 the Domestic Violence Prevention Unit located in the Women's Policy Office, developed an Integrated Resource Plan for Domestic Violence Services. The Domestic Violence Prevention Unit undertook a report outlining the outcomes of the 1995 Action Plan and further Action Plans on Family and Domestic Violence and an Aboriginal Family Violence Strategy. To date no research work has been undertaken specifically on domestic violence against women with disabilities.

In 1997, Women with Disabilities Australia secured funding from the Commonwealth Office of the Status of Women to undertake projects in the area of improving access to women's refuges and violence services for women with disabilities. These projects have been detailed in two Women with Disabilities Australia reports entitled *More than Just a Ramp – a Guide for Women's Refuges to Develop Disability Discrimination Act Action Plans*; and *Woorarra Women's Refuge Action Plan*. However, at the time of writing it appears that the Action Plan still has not been implemented due to lack of government funding.

Again in 1997, Women with Disabilities Australia successfully applied to the Commonwealth Office of the Status of Women for funding to run a *National Women with Disabilities and Violence Workshop*. This workshop had come about in response to the expressed needs of women with disabilities in Australia, as well as the apparent lack of research and other work in Australia on the issue of violence against women with disabilities. The workshop was the first of its kind in this country and was unique in that it was planned, organised, attended and run by, women with disabilities. Obtaining data on the prevalence of violence against women with disabilities was identified as the primary knowledge gap.

In 1998 Women with Disabilities Australia responded to the Consultations on the National Initiatives of the Partnerships Against Domestic Violence Strategy, strongly recommending that women with disabilities be included as a separate target group in the Community Education/Awareness Strategy research. To date the only outcome has been a suite of products developed and used in a community awareness campaign and in the same year, the Department of Families, Youth and Community Care in Queensland commissioned a project to

research and design information resources and strategies for women with disability about domestic violence (Mims & Associates, 1998).

In 1999, the Office of the Status of Women held national consultations on domestic violence issues for women with disabilities. As it was identified that there was a significant gap in knowledge, a Working Party of relevant disability and domestic violence groups in Western Australia was formed. The aims of this Working Party were to initiate inter-agency discussion, raise community awareness and advocate for improved accessibility to services for women with disability who experienced domestic violence. The Working Party included representatives from People with Disabilities (WA), the Ethnic Disability Advocacy Centre, Domestic Violence Resource Centre, Transcultural Psychiatry Unit of Royal Perth Hospital, Women with Disabilities Western Australia, and Women's Health Care House.

The Western Australian Working Party convened a forum in May 2000 where fifty community organisation representatives and consumers were in attendance. The overarching objective "was to establish, from a broad perspective, a greater understanding of the relevant issues concerning domestic violence and disability, identify needs and explore realistic recommendations for viable future action" (Domestic Violence & Disability Working Party (WA), 2000, p. 1). In highlighting the gaps in knowledge about the plight of women with a disability who are in a domestic violence situation, the forum recommended that research be undertaken.

Accordingly, this project was developed in response to the many calls for research into these issues. The objectives for the research were to:

- Document the nature and extent of family and domestic violence against women with disabilities who have accessed services in Western Australia.
- Identify whether the needs of women with disabilities are being adequately addressed by relevant services.

Community based research team

The research was a collaborative undertaking by several key community organizations in Western Australia, the first of which is **People With Disabilities (WA) Inc.** (PWD) the peak consumer agency that represents and advocates for the rights, needs and equity of all Western Australians with disabilities. PWD (WA) represents people across all disabilities - sensory, intellectual, psychiatric and physical.

The second agency, **The Ethnic Disability Advocacy Centre Inc.** (EDAC), was established in 1995 with joint funding from the Department of Family and Community Services and the State Disability Services Commission. It is the only community based advocacy agency in Western Australia for people with

disabilities and their families/carers, from culturally and linguistically diverse backgrounds. The main objective of EDAC is to protect their rights of access to appropriate community services through individual and systemic advocacy activities.

The **Edith Cowan University Centre for Social Research** primarily provided this collaboration with research leadership. The Centre and University have an established record of engagement with the community. The University is a major provider of human service professional education and training as well as being a provider of rigorous, applied research into social issues. Dr. Judith Cockram was the principal researcher on the project.

Two other agencies were involved with representatives offering on-going advice to the research project through the **Project Reference Committee**.

The **People 1st Programme** (PIP) is affiliated with the Family Planning Association in Western Australia. It was developed in 1994 as a unique programme offering a range of services intended to be dynamically responsive to the requests and needs of people with a learning/developmental or intellectual disability. It offers metropolitan, rural and regional services. In 1999 the quality of these services and activities was acknowledged, when PIP was named the Western Australian and a National Winner of the *Australian Violence Prevention Awards*.

Women's Health Care Association is the auspicing body of Women's Health Care House and Perth Women's Centre, with funding accountability to the Health Department of WA, the Commonwealth Government, and the WA Drug Abuse Strategy Office. Women's Health Care House was established in 1979 to provide a generalist women's health service to women, including clinical, domestic violence, education, counselling, information, culturally and linguistically diverse support services, and advocacy programmes.

Representatives of these groups made up the **Project Reference Committee**, **which** also comprised representatives from the Disability Services Commission and Communicare as well as two independent community representatives.

Defining Disability

Disability The definition adopted by The United Nations Declaration on the Rights of Disabled Persons, is used here. "...the term 'disabled person' means any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities."

For the purposes of this research, the term disability will encompass physical, sensory or mental impairments, or a combination of impairments. These are defined as follows:

Physical disability resulting from injury (eg. spinal cord injury, amputation); chronic disease (eg. multiple sclerosis, rheumatoid arthritis), or congenital conditions (eg. cerebral palsy, muscular dystrophy); sensory impairments consisting of hearing or visual impairments; and mental impairments comprising developmental conditions (eg. intellectual disability), cognitive impairment (eg. traumatic brain injury), or psychiatric disability.

Defining family and domestic violence

The Partnerships Against Domestic Violence Statement of Principles agreed by the Australian Heads of Government at the 1997 National Domestic Violence Summit defined domestic violence as:

... an abuse of power perpetrated mainly (but not only) by men against women both in a relationship or after separation. It occurs when one partner attempts physically or psychologically to dominate and control the other.

Recent definitions have attempted to extend this definition beyond 'couples' to provide a more inclusive description of domestic violence. This expanded definition includes violence which occurs in same sex and transgender relationships, sibling violence, child abuse as well as abuse of parents by adolescents or adult children, abuse of older family members by non partner family members and abuse within kinship relationships.

The Australian Public Health Association employs a comprehensive definition of domestic violence, outlining examples of abusive behaviour: (Australian Public Health Association, 1990).

Physical abuse, causing pain and injury; denial of sleep, warmth or nutrition; denial of needed medical care; sexual assault; violence to property or animals; disablement; and murder:

Verbal abuse, in private or in public, designed to humiliate, degrade, demean, intimidate, subjugate, including the threat of physical violence:

Economic abuse, including deprivation of basic necessities, seizure of income or assets, unreasonable denial of the means necessary for participation in social life; and

Social abuse, through isolation, control of all social activity, deprivation of liberty, or the deliberate creation of unreasonable dependence.

However, other forms of abuse that are equally important and often affect women with disabilities include: emotional and psychological abuse, threats against third parties (such as children) or threats to withdraw services of care.

It should also be recognised that 'domestic' situations for many women with disabilities are broader than the traditional understandings of what constitutes 'domestic'. There are many domestic situations in which women with disabilities live, such as community based group homes, residential institutions, boarding houses, transition houses. For example, a woman living in a group home or residential facility can experience domestic violence from other residents, carers and/or service providers. It is important that provision be made to cater for women with disabilities in all their various domestic situations.

How common is domestic violence in Australia?

Most studies on domestic violence can only ever approximate the extent of the issue. Statistical information can be difficult to obtain, as domestic violence is often under-reported. According to Bagshaw and Chung (2000, p.1).

We will never really know how much domestic violence exists in the community. This is because social sanctions prevent open discussion of the issue, and because the problem shows itself in various ways.

An estimate of the magnitude of the problem can be obtained from public records (police reports, hospital records, applications for protection orders, lists of refuge positions, and spousal homicides), clinical samples and community surveys. Although public records have inherent bias in their non-random selection and under-reporting of samples, they do show that women are the main victims of domestic violence:

- Based on Australian Bureau of Statistics (ABS) information from the mid-1990s, it was estimated that one quarter of the adult female population had experienced domestic violence at sometime in their lifetime. (McLennan, 1996)
- Evidence of the prevalence of domestic violence may also be found among requests for assistance to the Crisis Care Unit. In the 1990s, the numbers of violence restraining orders issued and health workers' reports of women seeking treatment as a result of injuries caused by domestic violence was approximately 10 per cent. On average, more than 600 violence restraining orders were issued in Western Australia every month. In 1996-97, more than half of all homicides in the

State were the result of a domestic violence incident. (WPDO, Building on Success: Government Two-Year Plan for Women, 1999-2001).

- Police figures reveal that women are over eight times more likely to be victims than males; (Ferrante, Morgan, Indermaur & Harding, 1995).
- Crime surveys show that a third of all assaults on women are by partners, whereas the number of assaults on men by their partners is too small to produce reliable estimates. (Ferrante, Morgan, Indermaur & Harding, 1996).
- Victorian public hospital figures show that 1.3% of women and 0.14% of men admitted to emergency departments are there as a result of partner-inflicted injury. (Sherrard, Ozanne-Smith, Brumen et. al., 1994).
- Each year, more than 20,000 women in Australia seek shelter in women's refuges and take out protection orders. (Alexander, 1993).
- A recent review in Western Australia showed that the incidence per 100,000 adult women of injury from domestic violence varied according to the source of public records used: 1.6 (police-recorded homicides), 129.2 (hospital admissions data), 183.5 (recorded crime), and 248.1 (restraining order data). (Ferrante, Morgan, Indermaur & Harding, 1996)
- In Australian survey research, women are three times more likely than men to experience an episode of physical violence by their partners. (Roberts, O'Toole, Lawrence, & Raphael, 1994; de Vries Robbe, March & Vinen, et.al. 1996).
- Domestic violence rates vary depending on the definition used (Hegarty. & Roberts, 1998) and whether the data are from community crime victim surveys (Ferrante, Morgan, Indermaur & Harding, 1996; Women's Policy Unit, 1992) or prevalence studies in clinical samples (Hegarty, 1999), or community samples (McClennan, 1996). Clinical studies in emergency departments and antenatal clinics indicate that between 19.3% and 25.0% of women will be subjected to domestic violence over their lifetime. Surveys of women attending general practice in Australia reveal varying partner abuse rates of 8.0% and 28% in a 12-month period.

- In economic terms, funding for family and domestic violence has changed significantly over the past twenty years. In 2001, the Department of Community Development, the Western Australian government department with the greatest identified commitment to the issue of family and domestic violence, allocated over \$12 million to non-government domestic violence services, of which \$10 million was for crisis accommodation (FCS Annual Report, 2000/2001). A fifth of all funding to non-government services provided by the Department of Community Development targets family and domestic violence (FCS Annual Report, 1997/1998). In addition, since 1997 the Federal Government has committed \$50 million to the Partnerships Against Domestic Violence initiative.

As a large number of cases remain under-reported, and as definitions of domestic violence are changed to become more inclusive and reflect the varied nature of intimate relationships, it is expected that the incidence of domestic violence and relevant reporting rates will be significantly higher than those cited above.

RESEARCH METHODOLOGY

The project incorporated an applied methodology, with research being undertaken using methods that maximised the relevance and on-going value of findings. Quantitative and qualitative methods were employed to gather information from agency workers. Qualitative methods were utilised with women with disabilities who have experienced family and domestic violence.

In addition, a review of the most recent published research in the area of disability and domestic violence was conducted and an annotated bibliography compiled. It is intended that the annotated bibliography of recent research, which is provided in Appendix 1, will provide a knowledge and information resource for agencies and organisations working in the areas of women, disability and family and domestic violence.

QUANTITATIVE DATA

A questionnaire was mailed to 231 disability, domestic violence, community and government organisations in Western Australia that may have had contact with women with disabilities who had experienced family and domestic violence. As many organisations and individuals make extensive use of electronic communications, the questionnaire was also made available on the Internet. Instructions were included in the postal surveys on how to access and complete the survey online.

In addition, ACROD (the National Industry Association for Disability Services), Western Australian Division, distributed the survey to over 360 agencies and organisations through their own email system.

Covering instructions outlined how to access the survey document attached to email. It could be printed, completed and returned by post or completed and returned by email. Information on how to access the survey online was also included. Assurances of confidentiality were given.

Agencies may have received the questionnaire through more than one source. In trying to reach as many agencies as possible it was hoped that any level of saturation would encourage a greater level of response.

A total of 107 completed questionnaires were returned (79 by post, 15 via the Internet, 7 by fax and 6 were emailed). Of these, 35 agencies reported they did not keep records relating to a women's disability or had not had any contact with women with disabilities who had experienced family and domestic violence over the two years preceding the research. The remaining 72 agencies reported they had women in the target group accessing their services in the past two years.

The questionnaire responses provided information on:

- agency's primary service;
- types of services the agency offered to women with disabilities who had experience family or domestic violence;
- accessibility of the service for women with disabilities;
- number of women with disabilities who had experienced family or domestic violence accessing the service in the last two years;
- number of women who had acquired a disability as a result of abuse, and the number who had a history of abuse before the onset of the disability;
- number of women from a non-English speaking or indigenous background;
- type of violence that the women experienced;
- perpetrator of the violence;
- estimated period of time that the women had experienced violence;
- types of interventions that had occurred and level of satisfaction with these interventions;
- number of women who had children who were involved in the process of intervention and
- what would help them to respond more effectively to the needs of women with disabilities who experienced family and domestic violence.

QUALITATIVE DATA

Agencies were invited to participate more fully in the research by way of undertaking a semi-structured interview. A list of agency representatives willing to be interviewed about their involvement with women with disabilities who had experienced family and domestic violence was compiled from the returned

questionnaires. Thirty-one interviews were conducted either face to face or by telephone. Nine interviewees were from domestic violence services including refuges, 9 from disability services, 5 women's health workers, 4 from family support services, and a representative from Western Australian Police Services, and a sexual assault referral centre. A lawyer and a psychologist who have extensive experience in the area also participated in the interviews.

Another list comprised agencies (including many on the first list) willing to put the research team in touch with women they believed would agree to a personal interview. The agency made the initial contact with the client and the principal researcher then approached those women who consented to participate. However, only three of the women came from this source. Some agencies had also included information about the research in their newsletters and community radio also included details in their community bulletins. This meant that most of the women who participated self referred.

Profile of the women interviewed

Thirty-two face-to-face interviews were conducted with the women by the principal researcher. The women who participated in the study came from a wide variety of backgrounds and circumstances. All of the women lived in the metropolitan area of Perth. Three women were from non-English speaking background, and three were indigenous women. The range of disability included fifteen women with physical disabilities that resulted from injury, chronic disease or congenital conditions, 8 women with an intellectual disability or cognitive impairment, 7 women with psychiatric disability and 2 with a sensory disability. Women's age ranged from 22 to 61. All had significant histories of family and domestic violence, in some cases within several relationships. Over one half of the women had experienced childhood abuse.

It was recognised that the researchers were asking a great deal from the women in the way of time and co-operation. Many of the women were at a stage in their lives when they had every reason to exclude 'others' altogether in order to concentrate on the process of rebuilding their futures. Many women, however, welcomed the opportunity to participate in the hope that their stories would help other women in similar circumstances. The researcher was vigilant in addressing issues of confidentiality and anonymity, continually clarified the aims and purpose of the research and the security of the data. Assurances were given that no identifying information would be used in research.

As a central concern of this research was to give voice to women's experiences of and reactions to domestic violence, qualitative research methods were used to explore the women's subjective accounts of violence in their lives. Specific questions to each informant were phrased informally often over a cup of coffee. The naturalism of unstructured interviewing creates the illusion that the interview is a 'conversation' (Oakley, 1981): one in which an informant can initiate questions and elaborate answers (without prompting) just as much as the

interviewer. Interviews covered all topics the research was concerned about, either raised by the woman herself, or introduced by the researcher. The conversational nature of the interviews facilitated both more and careful listening and the ability to return to past issues and events. It also helped the researcher to notice and check any apparent contradictions. Although all interviews covered the same ground, the women were able to introduce and emphasise experiences in the discussion that were important to them.

The Project Reference Committee established a set of “Guidelines for Referral and Support” for interviewing individual women to ensure that they were supported appropriately throughout the research process. This is provided in Appendix 2.

LITERATURE REVIEW

In 1998 The Australian Bureau of Statistics survey revealed that 19% of Australians – or 3.6 million people - have a disability. Overall, about half are male and half female. Eighty seven per cent of these people experience specific restrictions in core activities such as self-care, mobility, communication or their ability to participate in work or schooling because of their disability.

The website of the Crime Research Centre in Western Australia (<http://www.law.ecel.uwa.edu.au/crc/>) provides reports on rates of crime and domestic violence in Western Australia. However, a search reveals there are no documents available that relate to women with disabilities.

A search into published reports and journal articles on the topic of women with disabilities who have experienced family and domestic violence, also reveals the lack of relevant research that has been undertaken in this area. In particular there is a paucity of research undertaken on the extent and nature of family and domestic violence and women with disabilities.

What has been determined from some of the overseas research conducted in recent years is that women with physical disabilities are at similar or greater risk of abuse than other women and that their unique experiences of abuse require specialised services (Gilson, Cramer et al., 2001; Gilson, DePoy, & Cramer, 2001). Hassounch-Phillips & Curry (2002) also found that not only do women with disabilities experience abuse at similar or higher rates than women in general, they are at greater risk from multiple offenders.

It is also suspected that 'intimate partner violence' is a common and serious problem for women with intellectual disabilities. Women with intellectual disabilities interviewed by Carlson described being physically abused by an intimate partner, often repeatedly and severely enough to require medical attention. They also described being threatened with severe harm, controlled, insulted, and having their property taken or destroyed (Carlson, 1998).

An American study found that 40% of women who sought help had become disabled due to the abuse they suffered (Gilson, Cramer et al., 2001). These same researchers, in another study, found that women who are abused by an intimate partner are at greater risk of being disabled or suffering an illness that affects their activities of daily living (Gilson, DePoy et al., 2001). They also experience worse consequences than non-disabled women, for example, greater levels of poverty, social isolation, discrimination, stereotyping, low self-esteem, increased mental and physical health problems, depression and suicide (Curry et al., 2001; Gilson, DePoy et al., 2001).

Women with disabilities tend to experience abuse for longer periods of time and have fewer escape options because of their greater economic dependence, their need for assistance, environmental barriers and social isolation (Centre for Research on Women with Disabilities, 1999; Payne, 1994).

Another US study on violence against people with disabilities found that the majority of victims were women. However, the majority of reports they received did not come from the women themselves. The researchers suggested that the reasons for this non-disclosure were that the women were fearful no one would help them, they would be forced to move or they would lose their caregiver. This study also found that 60% of the alleged abusers were caregivers, with 40% of abuse occurring inside the family home (White, 1995).

Gilson, Cramer and DePoy (2001), found that women with disabilities are often over-protected by their relatives and carers. They are taught to comply with the requests and demands of others. This over-protection and compliance training may leave women ill-equipped to handle an abusive relationship and may in fact, make them more vulnerable to abuse.

Scerha presented a paper to the National Domestic Violence Forum, Canberra in 1996. She spoke of the myths that make women with disabilities invisible to society, such as women with disabilities are “childlike, passive, helpless, somewhat sad human beings” while other myths create an image of “frightening, dangerous and asexual creatures who are best avoided” (Scerha, 1996). Other researchers write about the myth created around women with disabilities that says that no one would ever abuse a woman with a disability (Young, Nosek, Howland, Chanpong, & Rintala, 1997).

Chenoweth explores some of these myths as well as the paradoxes they present, through the stories of women with disabilities themselves, their mothers and other workers. For example, the paradox that women with disabilities, although having little voice, are overprotected, segregated, and taught to be compliant; and that women with disabilities are seen simultaneously as asexual and yet promiscuous. These paradoxes increase the incidence of abuse and violence rather than prevent it (Chenoweth, 1996).

Other researchers have studied violence against women with disabilities within the broader contexts of culture, politics and disability itself. Disability already positions women at great disadvantage in the social context and the impact of poverty, isolation and discrimination are all increased when a woman with a disability experiences domestic violence (Curry et al., 2001). A Canadian study explores the experiences of Canadian Aboriginal women within the context of, for example, culture, the Christianisation of indigenous religion, Western medicine, gender, sexuality, alcohol and abuse. The paper includes personal stories that demonstrate the complexity of life as an indigenous woman with a disability, living in a society that is still struggling to come to terms with

generations of colonialism (Francis, 1992). The parallels for indigenous Australian women with a disability are obvious.

Cultural values and religious beliefs can also militate against recognition of violence. If the beliefs and practices of a cultural or religious group devalue women and confine them to stereotyped and subservient roles, they can be made more vulnerable to domestic violence and accept it as an inevitable aspect of being a woman (Buchmueller, 1996). If a woman from these backgrounds also has a disability she will be doubly disadvantaged.

Ryan evaluates the status of women with disabilities in a political context, in matters of equity and access (both physical and attitudinal), self-determination and the achievement of leadership position in the community. She argues that the burden of poverty prevents women with disabilities from interacting in the community (Ryan, 2002). She outlines a number of strategies, from local to federal government, to address the inequities experienced by women with disabilities.

One of the issues to emerge from the literature (Nosek, 1999) is that women with disabilities often do not report instances of abuse to their doctor for a number of reasons, including, fear of retribution, feelings of shame or believing she deserved the abuse.

Another paper poses questions a health professional might ask in order to identify women with disabilities who are victims of abuse (Diaz-Olavarrieta, Campbell, Garcia de la Cadena, Paz, & E Villa, 1999). The authors highlight the reluctance of doctors to talk about suspected abuse with their patients because of a lack of training in the area of abuse. The article concludes with a sobering reminder that abuse can be fatal and that patients who have experienced abuse should be responded to as seriously as if they had a heart condition. Another study comes to the same conclusion, calling for the same attention that is given to people with physiological disorders to be given to people with psychiatric disorders (McMullen O'Brien, 2002).

Focht-New (1997), writes that people with disabilities are at risk of misdiagnosis of serious illnesses because their ways of communicating may be misunderstood. Gestures and behaviours may be assumed to be signs of temper or anxiety rather than calls for help. The author describes the institutionalisation and the dehumanisation and labelling of people with disabilities that increases their vulnerability to abuse and points to prevention as a key element in assessment, intervention and treatment.

Gilson, DePoy and Cramer (2001), claim that there has been a misapplication to women with disabilities of theory, policy and practice that was developed to address abuse in non-disabled populations. Because women with disabilities experience greater risks and worse complications from domestic violence, existing strategies are inadequate. The researchers propose a model of abuse

assessment specifically tailored to meet the needs of women with disabilities who have experienced domestic violence, and stress the importance of keeping statistics on incidences of domestic violence experienced by women with disabilities.

One of the first projects in Australia to formally link the areas of 'disability' and 'violence' was a study, which considered how women with disabilities who are subjected to violence, access necessary support services and processes (Cattalini, 1993). This project was part of a range of research commissioned by the National Committee on Violence Against Women. Consultations with service providers and groups of women revealed that support and legal services generally have failed to respond adequately to women with disabilities who are subjected to violence.

In more practical terms, the Australian "It's Not OK – It's Violence" information kit has been developed to inform women with disabilities of their rights and options if violence occurs (Partnerships Against Domestic Violence, 2000) and the US-based website Claiming Our Bodies Internet Resource Kit has a good deal of information online for women with disabilities, including information on abuse, rights, articles and personal stories (Doe, O'Toole, & Kafer, 1999).

Summary

The literature presented here largely reflects a general overview of the issues that may arise for women with disabilities who experience family and domestic violence. There is little evidence in Australia of the extent and nature of family and domestic violence amongst women with disabilities who access services. It is the intention of this project to go some way toward redressing what is seen as a serious gap in the disability and family and domestic violence research literature.

FINDINGS

AGENCY RESPONSES TO THE QUESTIONNAIRE DESCRIPTIVE DATA

The following data summarises descriptive data sought from agencies that had provided services to women with disabilities who had experienced family and domestic violence.

Primary service provided by agencies

Table 1 shows that the primary service for 33 agencies (31 per cent), was disability services; 15 (14 per cent) provided domestic violence services (including refuges) a further 15 agencies (14 per cent) were community health service providers, 14 agencies (13 per cent) provided crisis services (for example, accommodation and sexual assault) and 11 agencies (10 per cent) provided family support services.

There were 9 responses from police service domestic violence units and 4 from public hospitals. Other service providers to respond were 2 agencies where the primary service was legal services, 2 phone counselling services, 1 counselling service and 1 in-home support service.

Table 1: Primary service provided by agency

Number of Agencies	%	Service
33	31	Disability services
15	14	Domestic Violence services including refuges
14	13	Crisis services, eg. Accommodation, sexual assault
15	14	Community health service
11	10	Family support services
9	8	Police Services domestic violence units
4	4	Public hospitals
		Other
2	2	Legal services
2	2	Phone counselling
1	1	Counselling
1	1	In-home support services
107	100	

Types of services offered to women with disabilities experiencing family and domestic violence

Many agencies reported that they provided more than one type of service (see Table 2). In total, 82 agencies (77 per cent) provided information and 79 (74 per cent) provided referral to other agencies. Support services were provided by 64 agencies (60 per cent) and 47 (44 per cent) provided counselling services.

Thirty-six agencies (34 per cent) provided legal and/or advocacy services and 30 agencies (28 per cent) provided accommodation. Twenty-two agencies (21 per cent) provided friendship and 25 (23 per cent) provided family/welfare services. Twenty-three agencies (21 per cent) provided task assistance and 10 agencies (9 per cent) provided other services including psychiatric assessment.

Table 2: Types of services offered to women with disabilities experiencing family and domestic violence

Number of Respondents	%	Type of Service Provided
82	77	Information
79	74	Referral to other agencies
64	60	Support
47	44	Counselling services
36	34	Legal/advocacy
30	28	Education
29	27	Accommodation
22	21	Friendship
25	23	Family/welfare services
23	21	Task assistance
10	9	Other including psychiatric assessment

Table 3 shows that 76 agencies (71 per cent) reported that they had accessible toilets, with 61 agencies (57 per cent) providing ramps. Fifty-two agencies (49 per cent) provided interpreting services and 22 agencies (21 per cent) provided information in other forms, for example, Braille. It can also be seen that 17 agencies (16 per cent) provided TTY machines and 3 provided other services such as email and audiotapes.

Table 3: Accessibility of services and premises to women with disabilities

Number of Respondent Agencies	%	Facility
76	71	Accessible toilets
61	57	Ramps
52	49	Interpreting services
22	21	Information in other forms eg Braille
17	16	TTY machines
3	3	Other including: email, audio tapes

Of the 107 agencies that responded to the questionnaire, 72 reported that an estimated 709 women with disabilities who had experienced domestic violence had accessed their service in the two years preceding the research. Of these 709 women, 270 (38%) have a disability that resulted as a consequence of acts of family and domestic violence against them.

One hundred and forty five (20 per cent) of the women were from a non-English speaking background and 201 (28 per cent) of the women were from an indigenous background.

An estimated 397, (or 56 per cent) of the women had children who were involved in the process of intervention.

Primary type of disability

Many agency respondents reported that the women had more than one type of disability.

Table 4 shows that psychiatric disability was the most prevalent disability reported, with an estimated 391 women (or 55 per cent), being identified as having this type of disability; 230 women (thirty two per cent) had a physical disability; 210 or thirty percent of women were identified as having an intellectual disability; and 115 (or 16 per cent) of women had a neurological disability. Agencies also reported that an estimated 75 women (10 per cent) had sensory disabilities.

Table 4: Primary type of disability

Type of Disability	%	Estimated number of women
Psychiatric	55	391
Physical	32	230
Intellectual	30	210
Neurological (including Acquired Brain Injury)	16	115
Sensory (including deafness and blindness)	10	75

Types of violence experienced by women with disabilities

Agencies reported that many women with disabilities experienced more than one type of violence (see Table 5). It was estimated that 513 (72 per cent) of the women experienced emotional violence. Social violence was experienced by an estimated 395 (55 per cent) of women and sexual violence by an estimated 360 (58 per cent) of women.

Three hundred and fifty five (50 per cent) of the women experienced physical violence and financial violence was experienced by an estimated 325 (46 per cent) of women. Two hundred and seventy five (39 per cent) of women had experienced stalking; 230 women (32 per cent) had experienced threats made to their children and an estimated 205 (29 per cent) of women endured threats to withdraw care. One hundred and ninety women (27 per cent) had been involved in discriminatory practices and spiritual violence was experienced by an estimated 70 (9 per cent) of women.

Table 5: Types of violence experienced by women with disabilities

Type of violence	%	Estimated number of women
Emotional eg threats, harassment, constant put downs, insults	72	513
Social eg controlling access to family, friends and phone calls, removing or controlling communication aids	55	395
Sexual eg vaginal, oral & anal rape, being forced to take part in other sexual acts that the woman does not want to, sexual harassment	58	360
Physical eg kicking, hitting, choking, cigarette burns, using weapons	50	355
Financial eg no input in decisions re income, not having access to money for personal use, not allowed to have own bank account, not allowed to purchase items for children	46	325
Stalking eg constantly followed, watched in a threatening manner	39	275
Threats to third parties eg. children	32	230

Threats to withdraw care as punishment or a means of control	29	205
Discriminatory practices eg withholding or forcing medicine, removing wheelchair or battery from wheelchair, criticisms relating directly to woman's disability	27	190
Spiritual deprivation eg being prevented from or forced to participate in religious or spiritual practices, being told God made a mistake	9	70

Perpetrator of violence

Table 6 below describes the perpetrator of violence. Agencies reported that 309 (43 per cent) of women with disabilities who accessed services through Western Australian agencies experienced violence against them by their male spouse or live-in partner. Eighty women (11 per cent) experienced violence by a female spouse or partner. Parents were responsible for violence against an estimated 105 (15 per cent) of women and other relatives accounted for violence against an estimated 60 women (8 per cent). Children were identified as the perpetrators of violence against an estimated 55 women (7 per cent) and other males eg neighbours, were responsible for violence against an estimated 45 (6 per cent) of the women. Thirty women (4 per cent) experienced violence from carers; 15 (2 per cent) from workmates and the same number of women experienced violence where health professionals were the perpetrators of violence. Ten women (1 per cent) had experienced violence by housemates and male clergy was responsible for violence against 5 women.

Table 6: Perpetrator of violence

Perpetrator	%	Estimated number of women
Spouse/partner-male	43	309
Spouse/partner/female	11	80
Parent	15	105
Relative other	8	60
Child	7	55
Other eg neighbour	6	45
Carer	4	30
Workmate	2	15
Health professional	2	15
Housemate	1	10
Clergy	1	5

Period of time women with disabilities experienced family and domestic violence

Two hundred and forty four (34 per cent) of the women had experienced family and domestic violence over a period of 1 to 2 years. An estimated 110 (16 per cent) of women experienced violence for a period of up to 6 months and an estimated 105 (15 per cent) of women experienced violence for a period 6 months up to 1 year. Two years to up to 4 years was estimated for 30 (4 per cent) of women and 4 years to up to 6 years was estimated for 95 (14 per cent) of women. The numbers rise again with an estimated 165 (23 per cent) of women experiencing family and domestic violence for more than six years (see Table 7 below).

Table 7: Period of time women experienced violence

Period of time	%	Estimated number of women
Up to 6 months	34	204
6 months up to 1 year	16	110
1 year up to 2 years	15	105
2 years up to 4 years	4	30
4 years up to 6 years	14	95
More than 6 years	23	165

Types of interventions

Many agencies reported that a range of interventions had been utilised for women with disabilities who had experienced family and domestic violence. Often a combination of interventions was undertaken for a client.

Table 8 shows that 46 agencies (64 per cent) reported that they provided support or information; 42 (58 per cent) provided a referral to another agency while 37 agencies (51 per cent) utilised advocacy as an intervention.

Thirty-six agencies (50 per cent) provided counselling, while 29 agencies (40 per cent) referred women to a refuge; 24 agencies (33 per cent) had contacted police, and the same number of agencies assisted the women to obtain a restraining order. Twenty agencies (29 per cent) provided other legal assistance; 18 agencies (25 per cent) utilised medical interventions and 18 agencies contacted the victim's family or friends. Eight agencies (11 per cent) reported that women declined interventions.

Table 8: Types of interventions

Number of respondent agencies	%	Type of Intervention
46	64	Support or information
42	58	Referral to another agency
37	51	Advocacy
36	50	Counselling
29	40	Moved to a refuge
24	33	Contacted police
24	33	Obtained a restraining order
20	28	Other legal assistance
18	25	Medical
18	25	Contacted family or friends

Agency levels of satisfaction with the effectiveness of interventions currently undertaken by agency

Table 9 shows that 32 agencies (44 per cent) reported various levels of satisfaction with the interventions undertaken by them. However 42 agencies (56 per cent) were dissatisfied with the effectiveness of these interventions.

Table 9: Levels of satisfaction with the effectiveness of interventions

Number of Respondent Agencies	%	Level of Satisfaction
22	31	Satisfied
7	24	Very satisfied
3	4	Completely satisfied
32	44	
22	35	Somewhat dissatisfied
18	11	Completely dissatisfied
40	56	

Agency levels of satisfaction with the adequacy of service to address the needs of women with disabilities

Forty-seven agencies (66 per cent) reported dissatisfaction with the adequacy of their service to address the needs of women with disabilities experiencing family and domestic violence. Only 25 agencies (34 per cent) reported that they were satisfied in this regard.

Table 10: Level of satisfaction with service adequacy to address needs

Number of Respondent Agencies	%	Level of satisfaction
41	58	Somewhat dissatisfied
6	8	Completely dissatisfied
47	66	
6	9	Satisfied
11	14	Very satisfied
8	11	Completely satisfied
25	34	

Agency level of satisfaction that clients made positive changes

Forty-four agencies (61 per cent) reported levels of satisfaction that their clients had been able to make positive changes in their lives since their interventions occurred. However, over one third of all agencies (39 per cent) reported levels of dissatisfaction (see Table 11).

Table 11: Agency level of satisfaction that clients made positive changes

Number of Respondent Agencies	%	Level of satisfaction
29	40	Satisfied
11	15	Very satisfied
4	6	Completely satisfied
44	61	
25	36	Somewhat dissatisfied
3	3	Completely dissatisfied
28	38	

What Agencies say they need to respond more effectively

Many agencies reported needs in more than one area (see Table 12). Responses indicate a high level of concern for the issues facing agencies when women with disabilities who experience family and domestic violence access their services.

A greater availability of services was cited by 90 per cent of agencies. A further 72 per cent believed that there was a need for improved communication and coordination between agencies and almost two thirds of agencies (63 per cent) believed that more funding was needed in order for them to respond more effectively. More Government and public awareness was cited as areas of need for 60 per cent of respondent agencies. Over one half of all respondent agencies reported a need for more training in disability issues and domestic violence issues.

Table 12: What agencies need to respond more effectively

Number of Respondent Agencies	%	Need
65	90	Greater availability of services
52	72	Improved communication and co-ordination between services
45	63	More funding
43	60	More government / public awareness
41	57	More training in area of disability
39	54	More training in area of domestic violence
7	10	More training in the use of aids
15	21	*Other

***Other areas of need:**

Fifteen agencies (21 per cent) cited additional areas of need:

- Specialised counselling services for women with disabilities .
- Earlier intervention and education in protective behaviours and relationships to shift the attitudes of women themselves.
- The needs of children of women with a disability experiencing domestic violence.
- Recognition of the increasing prevalence of financial abuse experienced by women with disabilities.
- More government assistance.
- Understanding the difficulties in speaking out experienced by women with disabilities (especially older women) in small towns, where support services may be in short supply.
- More supports to keep women safe.
- Recognition of the basic human and legal rights of women with disabilities to make their own choices.
- Awareness and understanding of cross-cultural issues as they affect women with disabilities.
- Services and assistance structured to empower women to make changes for themselves.
- More awareness that many women with disabilities are subjected to predatory behaviour because of their vulnerabilities.
- More funding for education programmes.
- More “Open talk” is needed on the nature of the so-called “non-violent” issues of family and domestic violence affecting women with disabilities.

SERVICE WORKERS TALK ABOUT THEIR INVOLVEMENT WITH WOMEN WITH DISABILITIES WHO HAVE EXPERIENCED FAMILY AND DOMESTIC VIOLENCE

Most of the agency representatives interviewed, expressed strong views about the issues that arose in relation to women with disabilities who had been subject to family and domestic violence. The combined experience of many years of working life and intimate contact with women with disabilities is reflected in these observations. There was a great deal of frustration with a human service system that many workers see as failing one of the most vulnerable groups in our society.

Service workers pointed out that although some forms of abuse are common to all women, other types of abuse are unique to woman with disabilities because of the limitations that the disability itself presents. Their disabilities may place them at additional risk, and the barriers to ending the abuse can be much greater than for women without disability. This is evidenced by their inability in many instances to speak up for themselves and the failure of many of those around them to listen when they do try to disclose the abuse.

“Invisibility” or “unobvious” disabilities was mentioned many times by service workers. There was a deep concern that community workers, be they be health workers, or police are not equipped to recognise other than the obvious physical disabilities. In one domestic violence worker’s experience, this was particularly so where women with a psychiatric disability were also affected by alcohol.

It can be hard to “see” the disability if they are drunk, especially if the disability is psychiatric or other unobvious disabilities.

There was equal concern that health workers are not educated to recognise “unobvious” abuse such as emotional, psychological or financial abuse, dealing only with the physical injuries, which are apparent. This was particularly difficult for women with disabilities who often experienced these types of abuse, when they wanted legal redress, as an experienced lawyer observed:

The law works to the detriment of women who experience family and domestic violence through its imposition of a narrow ‘legal’ definition of violence to domestic violence. Women however, experience domestic violence as a range of both physical and non-physical acts. By extension, law’s narrow definition of domestic violence disqualifies experiences of women that fall outside physical violence. Non-legal knowledge such as everyday experiences of non-physical domestic violence are considered suspect and/or secondary and of little interest to law. Personal experiences of violence must be translated into a legal form in order to become ‘legal’ issues: ongoing domestic violence, for example, needs to be represented as a series of seemingly unrelated individual assaults to ‘fit’ the legal paradigm. Subjugating women’s knowledge, therefore, calls into question law’s most

fundamental claims to fairness and impartiality. Of course this is the case for all women, but it can be particularly so for women with disabilities.

Domestic violence workers had also observed that women with disabilities were often fearful of government intervention in their families, in particular the fear that they could lose their children if welfare agencies and social services became involved. This often added to the already low self-esteem that many of the women experience, and the perception that they had no option but to stay in an abusive relationship. Many of the women they had had contact with suffered high levels of stress and often lacked support that lead to problems of dependence and powerlessness. In addition because women with disabilities are more likely to be low-income, unemployed and socially isolated, they are especially vulnerable to the increased risk of poverty, social withdrawal, and repeated victimisation.

However, a number of refuge workers reported that they were aware that they did not receive nearly as many referrals for women with disabilities as they would expect, but they were reluctant to raise awareness and formally promote their services for these women “because in many instances we are just not sure we can provide them”.

Interventions by service providers

Several domestic violence workers reported that when they did become involved, it was observed that it was not primarily whether a particular intervention worked or not, but that the women themselves, through lack of their own understanding or through lack of support from agencies and families, often failed to make the changes needed to escape the abusive situation. It was their experience that women with disabilities often lacked the confidence, support, opportunity, skills or knowledge to be able to withstand the pressure from abusive partners to stay in the relationship.

A common response was that interventions also failed when the worker could not follow the women up because their partner, who is usually the abuser, isolated them. “If a woman relies on him for care, it can be especially hard to break a woman’s reliance on him”. One disability worker went on to say that there were limits to services intervening if partners were resistant to intervention. If women have difficulty getting to a phone or out of the house, this prevented them even having access to services in the first place. As this disability worker put it:

There is a multiplicity of discriminations against women with disabilities. It’s hard enough to access services anyway, but with restricted mobility, mental comprehension or speech impairments of some victims, it is even harder. I have had experience with many women who are extra reliant on

their partners and fear having nowhere to go and no one to look after them should they leave.

Women's health workers also cited lack of understanding on the part of some emergency workers as a reason why interventions can fail. One women's health worker provided an example of a woman who had a disability that impaired her ability to communicate. She was treated as drunk in the emergency room of a hospital, and kept waiting for treatment for hours. "She gave up on the violence issues and returned home before she got the help that she needed".

A domestic violence worker from a regional centre stressed the importance of cross-cultural awareness and understanding when they were called upon to intervene:

Service workers supporting women who live in communities other than mainstream Australia would benefit from a greater awareness and understanding of cultural issues relative to their situation which influence the reporting of violence and the management of disability. Violence often goes unreported in certain communities because of the pressure on a woman not to go outside the family, to strangers, for help. Many of the women believe if they report the abuse they will be punished or shunned by their families and community for doing so. So victims need to feel safe in reporting. The woman needs to know that her story will be believed and acted upon. If it is not, she must return to the abusive situation with him knowing that she has spoken out. This makes it even more dangerous for her.

A psychologist, who had worked with a number of women with disability experiencing domestic violence, spoke forcefully of current practices that place the onus on women to leave the family home in a domestic violence situation:

We must deal with domestic violence in a totally different way and remove the male or offender while the abuse is being investigated. Until we grasp this fact nothing will change. It's appalling that we require women and children to leave the home. We wouldn't need women's refuges if the offender was made to leave (as in child sexual abuse cases). The women and children are disconnected from their familiar surroundings and life. The onus is on the woman to prove the offence and she is given little protection. For example, one woman with a disability who I currently see, experienced her partner breaching a Restraining Order 50 times – what can she do? Where is her protection? Of course this can happen to any women, but it is especially painful for women with disabilities. It's appalling that the system treats women like this. This is a critical issue and we need to change this quickly.

Issues that arise for women from different disability groups

Service workers pointed out that there could be particular issues that arise for women with different types of disability, as well as difficulties for agencies when these women access their services.

Many of the refuge workers stressed the impact that women presenting with psychiatric disability had on workers. They pointed out that increasingly refuges are seeing women with the fewest resources, i.e. low-income women, women from indigenous background, women from culturally diverse backgrounds, and women who had been multiply victimised as children and as adults. These are women who have experienced greater adversity throughout their lives, and who may be more vulnerable to the mental health consequences of abuse. A common response was that further service provision was critical to assist domestic violence workers to support women with psychiatric disability.

Women with mental illness have the most impact on staff. The illness affects their behaviour and they are incredibly hard to work with. Often we can't even manage to get their story. We find that our interventions are usually unproductive or that we can give only minimal assistance. This really affects many refuge workers, because we try so hard to work with these women, to assist them to make some changes. Many of these women feel so trapped. They become easy targets for their partners. The men see how vulnerable these women are. And it is my experience that the police or even some health workers do not believe them. It then gets very difficult for them to speak up. Even if they report the violence to the police, there is no follow through when restraining orders are made, so it doesn't stop the violence. And with mounting stresses associated with domestic violence they are likely to continually become unwell which throws them right back into their illness and so the cycle is perpetuated. A big problem for us is that we find that these women are a very transient group and they seem to just wander off. A number of them become known around the refuges and because of their behaviour many refuges just won't take them, so they just drift back to violent relationships.

Refuge workers also commented on the difficulties for other women in the communal setting if a woman's behaviour was erratic and became a disruptive influence within the refuge.

It can become very difficult for other women in a communal setting. After hours when we are not here we have to always think of how the woman's behaviour impacts on the other women and children. We often have to call in the psychiatric team, if we have problems but we usually don't get any assistance from them. So all that is often left for us is to call the police to help control the situation.

The nature of the abuse was something many service workers made reference to. Not all abusers are physically violent or even deliberate in their day-to-day abusive behaviours. Yet abuse has far-reaching consequences no matter the form it takes. A mental health worker had this to say:

... There was another older woman who had a psychiatric disability. She was in a wheelchair when I met her. Her husband was controlling but not physically violent. We worked with her for a while and eventually she actually left the wheelchair. She was a victim of the emotional wearing down which was much more subtle than if he had bashed her. She suffered a loss of self-esteem and confidence. She was not physically disabled, but emotionally. It still put her in a wheelchair.

Social isolation was identified as particularly troubling for many women with disabilities, as illustrated by an example given by a family support worker

I recently assisted a couple that had Acquired Brain Injury. The woman was also blind. Over time, the man had isolated his wife from her family, her carer and all outside contact except for the one phone call he permitted her to make each week. He then left her with her parents for four weeks. That is when they realised their daughter had been abused. She was ill and afraid, covered in burns and bruises. Because of her disability she did not understand what had been going on and she was so dependant on her husband. The woman's parents were devastated. Neighbours had been concerned but had done nothing. The caseworker said, they were known to disability services but it appears nobody had been checking on them; if they had her situation might have been discovered."

A women's mental health worker spoke of a woman who had been overlooked by community services. Even though someone had obviously assisted her with initial medical care and with obtaining a wheelchair, little else had been put in place for ongoing support.

I met her 5 years after her boyfriend had bashed her, putting her in the wheelchair. She was afraid, immobile and bored at home, and he continued to abuse her. No one had bothered to see about support services or disability services for her. I explored respite services and activities for her. Once she became involved, her situation radically changed. She pressed charges and he is now in jail. We worked out a plan of action regarding transport options and activities. Fear had kept her inside the house, isolated and alone. She must have slipped through the net. I can't imagine what she has gone through for so many years.

A number of women's health workers believed that factors such as dependence on carers increased the vulnerability of many women with mental impairments to

experiencing abuse. This was mirrored in one woman's experience when she had to rely on another person for her care.

I had a client, a young woman 19 years old who suffered frontal lobe damage and a broken pelvis in an accident. After an operation in hospital, a man she lived with sexually assaulted her. She was taken out of the hospital into the car park and raped by this same man and this wasn't the first time she was abused. She was cognitively impaired and felt powerless to say no, even more reluctant to file a report because she was so dependant on him to take care of her. When she did speak about it, her mother didn't believe her. She was discharged from hospital and no charges were laid against the man.

This young woman suffered severe psychological problems and had to deal with multiple issues, such as loss of trust and loss of control. She eventually ended that relationship but her next one was emotionally abusive.

Refuge workers also reported particular problems they experienced when a woman with physical disabilities who had been subject to violence needed to access their service.

We had an older woman referred to us last week who had a physical disability and they didn't inform us of the level of care that she needed. We are just not equipped to provide 24-hour care for women who need medication, bathing, assistance with meals and toileting and we will refuse to take women because we cannot meet our duty-of-care commitments. Through domestic violence, this woman had lost her arms and her home, but we were not able to provide the care that she needed. I know it must seem to some people that refuges just don't want to know. We feel very bad about that but we are just not equipped to provide that level of personal care.

A long-term community health worker identified the nature of the relationship between a woman with an intellectual disability and an abusive partner as particularly problematic. Women with intellectual disabilities often lack insight into the nature of abusive relationships. She reported that she recently had a client with an intellectual disability "who couldn't see herself as a person who could manage or cope". This young woman was at the mercy of an abusive partner who talked her into believing that she was the problem. She was easily manipulated, and was convinced that the abuse she suffered was her fault.

Several health and family support workers described the "revolving door" situation that was evident with many women with an intellectual disability with whom they had had contact. Because of the lack of insight into abusive relationships, women with intellectual disability often fell back into these relationships, not understanding they could do anything about it or they may have relatives who support them staying in the relationship:

Perpetrators of violence look for vulnerable women to prey on. This places women, particularly those women with intellectual disability at great risk. In my experience they are more dependant than non-disabled women, not only experiencing abuse from abusive partners but from well-meaning relatives who believe they are doing the right thing when they stay in the relationship.

As one disability worker observed:

Sometimes things done in the woman's 'best interests' deny their basic legal and human right. Many women with an intellectual disability have been denied control over their bodies, particularly in relation to decisions about sexuality and contraception and others may have exercised total control over their finances. In many instances they have few opportunities for social contact and community participation but if they do end up in a violent relationship, which many of them do because they are so vulnerable, it is very difficult for us to work with them to break the cycle.

A number of refuge workers commented on the marked difference of advocating for women with intellectual disabilities compared to other women.

It is really very difficult for many of us to work with women with intellectual disabilities. The amount of repetition you have to use, the time it takes, and having to accompany them to almost everything is extremely difficult. It is far more time consuming and we are already stretched. We have to take on a much more directive role than we would normally take which means we are always in danger of overstepping the mark and becoming more controlling than we like to be. It is particularly difficult if there are children involved. We spend so much our time monitoring them to make sure the woman has bathed their child, fed them etc. Really this group of women are very hard to serve; it just sometimes becomes too hard and we often find that it is just too difficult to take them.

Communication was also identified as an area of deep concern amongst refuge workers as illustrated by one worker's experience:

I had a young woman with an intellectual disability come into the refuge recently and I invited her to join a woman's group. This became a real challenge for all of us. I don't think she had any understanding what was going on and wouldn't contribute. It made the other women uncomfortable. The group process was just not suitable for her. I feared that I was constantly talking to her like a child, which I didn't like. She left the group; I didn't ask her to come back. I have been deeply concerned that I just don't have the skills to talk to these women. How do you explain issues of abuse when they just don't seem to have the skills to understand them?

Service workers were also concerned about ignorance on the part of police. A health worker provided an example of a woman with an intellectual disability who

contacted the police to report a man stalking her and asked for assistance: “She was not believed and the police treated her as paranoid”. This worker said that charges were often not proceeded with because the police do not see a woman with an intellectual disability as a credible witness.

A family support worker who had worked with a number of women with a physical disability who had been subject to domestic violence, believed that poverty severely restricts options for these women. Options often suggested for a non-disabled woman in a domestic violence situation, for example housing, are often not available or suitable for women with physical disabilities. In addition, they may experience unintentional but subtle abuse by health professionals. She believed that many women put on an act in order to receive necessary care – this worker called it the “Disability Dance” – being submissive, bright and chirpy for fear of being treated badly or denied support”.

A community health and domestic violence worker also observed this pattern amongst women with physical disabilities, saying:

Domestic violence is not their fault but they have learned not to say how things really are. They are made to feel stupid, as if they deserve it. Women with physical disabilities can learn to present themselves in a good light in order not to lose services and care, or not to be ridiculed. A woman who does this can be her own worst enemy.

Service workers talk about other workers’ responses to domestic violence

A common theme throughout many of the interviews was the lack of across service training for disability and domestic violence workers. This was reflected in one disability worker’s comments.

Many women with disabilities are much less able to avail themselves of help. They may be unable to speak up for themselves and don’t understand abuse – what it is, what it looks like and that it’s not all right. Even though there may be difficulties in communication for some women, it takes care and patience to explore the situation and find solutions. Women’s stories must be respected but I wouldn’t say that all staff are competent to make the necessary connections. More training is needed for staff in communicating the nature of abuse and delineating between abuse and other issues when disability is present.

These sentiments were echoed by domestic violence workers, with one worker commenting: “Special training would go some way towards levelling the ground and gaining equity for all clients”.

Concern was expressed about the ability and willingness of many disability service workers to understand and identify all the issues involved. One women’s health worker with many years experience in the area of domestic violence said

she believed there was a “disinclination” on the part of some disability workers to discuss domestic violence issues. It was her belief that disability workers often don’t see past the disability and were sometimes fearful of women speaking about a violent relationship “because they just don’t know how to assist them”. In this worker’s experience, disability workers often have a lack of understanding of the issues surrounding violence and lacked understanding of the women as victims.

Another women’s health worker reported that she had had experience with disability service workers who believed that the women who had been abused chose to stay where they were, but in many instances, she argued, they were just not presented with any other options. In a family support worker’s experience:

... there is often a ‘rescuer’ mentality among some disability workers who are overprotective, not wanting to see the scope of domestic violence. They also underestimated the abilities of the women to deal with the issues.

However, other service workers commented on “systemic faults which prevent women from making choices”, for example, under-resourced agencies and lack of services. Evidence of this came from a disability worker in a regional office who commented on a woman with intellectual disability who she knew was in a violent relationship:

To be honest we as a team were terrified that she might leave – we had to keep her there, support her where we could. We just didn’t know what we would do for her, there just aren’t enough services to put anything else in place for her.

When asked if she involved domestic violence services in these situations, she replied that “it is not something I immediately think of”.

A number of disability workers reported that due to the ongoing pressures of their own support work and lack of adequate funding, few have workers with energy for inter-agency work.

Domestic violence workers saw services as fragmented with a lack of communication between agencies that did not work in the best interests of the women. For example, there was often no one person to co-ordinate an individual woman’s case across services. Women were shuffled from agency to agency but information was not always shared. These workers felt it was important to get the “bigger picture” so a woman’s needs could best be met. A refuge worker said:

There is no one person to co-ordinate across services. I am often debriefing on a women's confusion at her treatment from multiple agencies.

In addition, refuge workers observed that disability services often believed that once a woman with a disability is in a refuge "they can back off". However, refuge workers believed that this was "an opportune time when some really good things could happen between support agencies" but in their experience this was rarely the case.

One health worker said women with disabilities are completely disempowered in their interactions with services that impacted on workers when acting for them in an advocacy role. For example, in emergency wards at large public hospitals, the level of attention women who experience domestic violence receive varies greatly. Unlike the private practice setting where access to the doctor is through a preset appointment time or 'wait-turn' basis, in the emergency ward access to the medical staff is based on the professional estimation of the severity of the patient's injuries. For many women experiencing domestic violence the wait for attention is long. One source of initial support for women with disabilities experiencing abuse in Western Australia has been the Sexual Assault Referral Centre. However, sexual assault workers reported that this initial support has now been withdrawn, with the centre adopting a policy that all women with disabilities who experience violence must go to a public hospital:

This means that these women are in a chaotic, frightening environment, and in many instances in my experience, they just don't stay. This creates enormous difficulties for us, as we are not in a position to guide the process and set up a therapeutic relationship at the outset, as has been the case in the past.

Service Workers interactions with government services

There was a level of frustration expressed by many service workers in their dealings with key government agencies such as Centrelink and Homeswest on behalf of their clients, and the barriers women with disabilities experienced when accessing these agencies. Problems with meeting deadlines and filling in forms, even understanding the Centrelink system can all present difficulties for people with disabilities. One worker spoke of her experiences with women with disabilities who, in trying to escape domestic violence, had asked Centrelink for a crisis payment but because there were no children involved, they were not eligible to receive assistance. Without money to actually get away, they felt they had no choice but to return to their home, where the abuse was occurring.

Another commented on the long waiting lists for accommodation that were of particular concern if a woman with disabilities was experiencing abuse. A

disability worker spoke strongly about problems she had encountered with Homeswest when advocating for her clients saying:

Rhetoric is all “yes, we do all we can” but in practice it doesn’t happen. Women with disabilities are marginalised and not treated with equity. I deal with Homeswest in an advocacy role. Clients with disabilities, who can’t process information, get into debt because they haven’t been able to meet form filling and deadline requirements. Those who are immobile can’t get to meetings on time, or some don’t understand the system. It’s the biggest agency that deals with housing for people with disability yet it’s structured to the mainstream. And when a woman with a disability experiences domestic violence she needs all the sensitivity and assistance she can get.

Keeping Records

Many of the service workers interviewed reported that their agencies had collected statistics for this project informally from knowledge and case notes from workers in their agencies. They did not keep formal records of disability because it was not part of their funding requirements.

One disability worker said that although they must report injuries, there is no requirement to record any domestic violence/disability link. A domestic violence worker saw “no advantage” in keeping statistics on disability. Some service workers objected to the keeping of statistics on the basis that they reject the idea of labelling women and putting them into a category that carries with it negative stereotypes and implications. A number pointed out that many of these women, who are striving for equality and equity, although seen by others as having a disability, reject the label as disabling in itself. Notwithstanding these objections, service workers did agree that keeping formal statistics on disability and domestic violence would assist them not only to give a clearer picture of the extent of the problem, but also to assist them in policy making to meet the needs of these women.

WOMAN WITH DISABILITIES TALK ABOUT THEIR EXPERIENCES WITH FAMILY AND DOMESTIC VIOLENCE

Thirty-one women with a disability shared their experiences, primarily focussing on exploring in some depth women's stories about coping and dealing with domestic violence. The women's recounting was sometimes harrowing and difficult, especially for those women who had also experienced childhood abuse, but by the time of the interview most were establishing independent lives for themselves and were much more aware of coercive techniques used by their abusers. For some women the interviews provided the opportunity for them to reflect on their own lives and draw new conclusions about past events. This, they said assisted in the re-establishment of their lives. They were keen to convey a message to other women with disability experiencing domestic violence. In particular they were concerned that these women should not blame themselves or 'put up' with the abuse, but should realise their own strengths and capabilities and be confident that they could escape the violence.

The similarity of women's accounts was striking, but while the same issues may have been confronted, often different decisions may have been made. Responses were never directly challenged, as it was important for individual women to recount their 'truths'. Women were interviewed in women's refuges, at their homes at the researcher's home and workplace and in coffee shops.

The women reported experiencing many different types of abuse including physical assault, threats of assault, sexual assault as well as verbal, emotional, social and financial forms of abuse. Most women said the domestic violence started in one form or another relatively early in their relationship. Many of the women reported that the disability itself was often used as a target of the abuse. For example, one woman with a psychiatric disability was told by her partner that she did not recall events accurately because of her illness. Here, the partner used the woman's illness to suggest she was making up abusive events that had actually happened.

A number of women described negative images of their own body that had led to feelings of low self-esteem. The women were not free from the influence of the media when it came to thoughts of what is desirable or not in a woman's body and made comparisons. They observed that disability is seen as a "deficit" and the "ideal" imposed was far from their reach. For some, this message had become ingrained, and a comparison established between the standards of beauty and the image the women had of themselves. These women also reported that the perpetrator believed that the women should be grateful that they were in a relationship with them despite their disability.

By far the majority of women interviewed had separated from their abusers. Only 6 were still living with the perpetrator.

A number of themes emerged with respect to participants' experiences of family and domestic violence, including coping with the abuse; barriers to responding to abuse and issues relating to community services, the police and the courts.

Coping with the abuse

The women reported using a number of ways of coping with the abuse perpetrated against them. The particular strategies used included trying to change the abuser's behaviour; trying to make things more agreeable for the abuser; becoming more compliant and in many instances, withdrawing. For some of the women, involving themselves in activities they enjoyed for example painting, was a way of coping or dealing with abusive incidents.

However for the vast majority, the ultimate solution was eventually to leave the abuser. Most women said there was a defining event that helped them to make the decision to leave the relationship. For some women, this involved reaching a stage where they held grave fears for their physical safety or that of their children. For a number of women it was a growing acceptance of their own self-worth that was the catalyst that assisted them to take action to deal with the abuse. Leaving was a very difficult experience for many of the women, especially when they had few family or social supports, or dependant children. Leaving also placed some of the women at increased physical risk.

Barriers to responding to abuse

Many of the women described living their lives in a world that devalues and discriminates against people with disabilities and women. The women frequently spoke of ways that societal attitudes toward people with disabilities, foster abuse and neglect. One woman said:

People who are devalued as cripples and burdens and inferior will be abused. If you respect somebody, you are not going to kick her. You are not going to leave her and not help her to get up. You are not going to hit her. Even though you might feel frustrated about the whole situation sometimes, you are going to take care of that person.

Individuals from marginalised groups will often resist mistreatment but may inadvertently succumb to internalisation of oppressive assumptions. Many of the women blamed themselves and expected less for themselves in the context of the real difficulties they found themselves in. Several of the women reported weighing the pros and cons of a relationship that turned abusive, which is very similar to the way women without disabilities respond to abuse. Included in the equation for some women were factors such as the lack of care available or losing custody of children because of not being able to manage.

For the majority of women fear was the major deterrent to the women telling anyone about the violence; fear for their own physical safety or that of their children and fear that no one would believe them or not take them seriously. But the biggest fear was the fear of being alone, and in many instances the belief that they would never enter into another relationship if they left.

A number of the women talked about their fear of being alone superseding their fear of being assaulted:

It's not that I am stupid or enjoy physical pain, but pain is a feeling, and I sometimes felt that bad feelings are better than having none at all. I used to dissociate myself from the parts of my body that were being assaulted. This was not unfamiliar to me. From birth I had to shut off my feelings as medical people probed and generally caused constant pain in the name of helping me.

Issues relating to community services, the police and the courts

A wide range of formal services was approached (but mostly only after the women had left), including general practitioners, personal counsellors, relationship counsellors, psychologists, disability services and mental health services, solicitors, family support services, crisis centres and women's health care clinics. The various service-providers approached reflected the women's primary motivation for seeking help at that point in time. This finding highlights the importance of service providers having the ability to recognise both the indicators of disability and of abusive relationships and also, where necessary, to pursue the matter further if they suspect abuse has occurred but the woman needs some encouragement to talk about it openly. The response of others to some of the women's eventual disclosure was often significant in determining the women's subsequent help-seeking behaviour. At worst, a poor negative response deterred or delayed the women from seeking help from elsewhere.

Although a number of women interviewed did seek help from domestic violence services, most did not. The main reasons the women gave for not using these services was the belief that these services would not assist them. Lack of knowledge of services, or of how to access them, was another significant factor. Some of the women had strong reservations about approaching domestic violence crisis services for assistance and a number of women who had had contact reported being so distressed with their experiences that they would not be comfortable using the service again. Several of the women commented that they were not aware or did not feel entitled to call on domestic violence services. This was mainly because of their belief that there was a low level of access and awareness of their needs within these services.

The majority of women had also not involved the police or law courts. The major barrier to the women was the belief that because police services and the courts see domestic violence as secondary to public violence, personnel in these institutions trivialised women's experiences in insensitive and intimidating stereotypical ways. In addition many of the women believed that these institutions were often unaware and untrained in issues related to disability and may not understand the nature of the abuse they were experiencing. Women with psychiatric disability were particularly afraid to report violence to the police because of their negative past experiences with police services.

One participant discussed her assumption that police typically regard violence against a woman with disability within the "medical model" of disability, which describes the difficulties of people with disability in society as stemming only from the person's limitations, rather than from the social context of discrimination. A number of women reflected that if women with disability are not ultimately valued by society as worthy citizens, then violent mistreatment against them might seem less worthy of criminal prosecution.

The following stories are from a selection of women interviewed to highlight experiences of women with disability who are subject to family and domestic violence.

Ann's story

I really don't know what it is about women with disabilities. It's like we are putting up psychic signals. We grow up thinking we are worth nothing. It's like thump me because we are no good. These silent signals are always around us. I met a man some years ago who was a good Christian man; he didn't drink which was really good, as I had grown up with a father who was always drunk. Eventually though he did start to drink and used to say to me, it makes me look good in the eyes of god to marry and take care of a cripple. He used to say to his best man's wife how much he had to help me, even though I was running the business. He was constantly denying any of my capabilities; he belittled me about my slowness, which did sometimes create difficulties. This went on for years, it was dreadful for me, and I felt ill all the time, totally worthless. I eventually couldn't stand it any more when he started to take out his anger on the children. I was disgusted with him and his drunkenness. There weren't any services where I lived, and I didn't know where to turn, but I did eventually find the strength to go.

Seven years later I met another man – he used to stalk me then I started to feel sorry for him. My parents thought he was great, they kept saying you need a man to look after you. I felt so pressured by my parents that I eventually married him. He started to try all sorts of things – he got a car I couldn't drive so he had complete control over me. He insisted on doing everything, he took away my independence. I was feeling so cloistered, he even insisted he come shopping

with me. He said I was a cripple and I couldn't do anything, look what I am doing for you, you should be grateful.

He became violent to my daughter and then me. I thought I was going to die. I was so vulnerable. He would take my wheelchair away from me so I couldn't get up from the floor. I was absolutely terrified of him. My parents left us alone. Anyway I couldn't really tell them what was happening, as they wouldn't have believed me. He abused me for years. He really believed he was owed everything because he cared for me, but he took my independence and nearly my life.

Then I started to paint and I got a friend to take me to get my pension back. She took me to a lawyer. He started to lose control over me and one day I came home and he was gone. I cannot understand why I am attracted to people who abuse me. I couldn't talk about any of this to anyone, but then what else did I have to compare it with? I mean I had few role models with whom to measure myself with. Perhaps it is because of my longing to feel intimacy with another person, I engage in unhealthy and even lethal activity, rather than shut off from human contact.

Rebecca's story

I was married for 12 years but we were together for 17 years. My teenage years were devastating. I really believed that no one would ever love me. No matter who came along I would have grabbed them. My parent's didn't approve but after 2 years we moved in together. The abuse was immediate and progressed from controlling and emotional behaviour like not turning up when he was supposed to and leaving me on my own to eventually the most horrific physical abuse. My palsy affects my speech, making it slower than normal and sometimes slurred. I will never forget when he told me not to laugh loudly as I sounded so ridiculous, so for years I never laughed again. I had to be conscious of everything I did. He used to say if I wanted to, I could get your neck and snap it. But I remember justifying anything he did; I couldn't bear the thought of having no one in my life.

All this made me change my behaviour so I could avoid physical abuse. Some days I don't know how I did it. I would gain some power and strength and then the powerlessness was back again. I hid it all. I tried to leave several times, I went to friends on weekends but I always went back. I just didn't see any alternative. His alcohol intake increased markedly. The worst nights were Sunday. He used to drink all weekend. He would never come out as a family. I would take the children out and on the way home say, just be really good. I saw this as a way of at least having a chance of avoiding his violence. One Sunday night he went berserk. I couldn't keep the children in the bedroom; it was dreadful. I eventually got them in the car and went to my brother's house. He rang Crisis Care. Crisis Care sent me to a refuge. I don't remember too much of

my experience there. I had a 2 year old who didn't sleep or eat, so I didn't sleep. I stayed six days but most of it is a blur. I remember being very intimidated by the refuge, I remember the refuge worker saying this is only your first time you will be back.

I rang my husband after three days knowing he would be a mess; I exposed myself to all the stuff he constantly said after he was violent. I didn't want to be responsible for ruining his life. I couldn't live with the guilt. He did get some counselling but he really didn't want to hear. It got progressively worse, and then I knew if I didn't keep going this would be my life. Along the way I would build pieces of knowledge, friends would give me tips, they must have suspected something terrible was happening, but I couldn't talk about it. I remember when I had my last baby a social worker came to visit me and left me some literature. I wouldn't acknowledge it and I put it in the bin. I wasn't really conscious how I built my strength. I just lived for him passing out on a Sunday night. But I remember even on the last terrifying occasion when he abused me over a three or four hour period and pushed me down the stairs, even then I was justifying his actions. A huge influence on me to eventually leave was my daughter begging me to go. The other trigger was my younger daughter who never took her eyes off the television, even when she was surrounded by all the violence.

My neighbour did call the police after the last violent episode but there has been no follow up, it would have helped to have some sense that someone was following up my case. On this last occasion I was absolutely at his mercy. I was physically dry reaching; I didn't want to be raped, which I knew was a distinct possibility. When I called the call centre the police told me that the receptionist had told them that it sounded like I was drunk. They said that if they hadn't have known me from a previous occasion they wouldn't have hurried. I remember being very grateful for the first time in my life that I had a disability. I got a restraining order and this was the beginning of a long frightening period of my life, I was terrified he would come back. The first twelve months was absolute survival. I sometimes wonder how I came through it.

I believe the big difference for a woman with a disability experiencing domestic violence is that people just don't believe you. They still have this underlying assumption that the able bodied partner is wonderful taking on a person with a disability. In my case it fed his ego. I was astounded by people who didn't believe my fear when I eventually told them. They believed I was overacting. I remember the disbelief of some of my neighbours and one saying he wouldn't do that, he has done so much for you for so many years. All the lifestyle improvements I advocated for myself, but the perception was he had done it all. But the biggest problem was the emotional consequences of the abuse. If you are in an intense emotional experience you are already on the backfoot, you are not presenting yourself in the best light. Every part of your disability increases because of your anxiety. The increased effects and pure exhaustion make it very difficult to share your experience. When I did seek help, people assumed the symptoms were related to my disability rather than believing that there were

other causes such as abuse. This is an enormous barrier for women with disabilities when they need services to assist them.

Elizabeth's story

I am 27 years old and I was born with cerebral palsy. I lived with my family in a farming community but I left home at 17 after finishing school when I realised that the small town in which the family were living could not offer me any future.

I lived in terror all of my years at home. I was severely bullied at school, on a number of occasions being pushed down flights of steps by other students. I told teachers but nothing happened. The response from my mother was they treat you like that because you are obnoxious. My father said I was bullied at school, so get over it.

I suffered emotional abuse and neglect all of my life. Family members mostly ignored me. I remember being a voracious reader and finding a corner to sit and read. I can hardly remember the last 20 years because I was so exhausted. There was no recognition of my disability and the family offered no support. There were no handrails to assist with shower and toileting and nothing available to assist with my mobility. My mother and father did carry out physiotherapy exercises with me but I believe that these were only done because they couldn't accept the way I was. They always paid great attention to my defects. My mother was always very critical: don't swing your arms, lift up your feet, you look so undignified.

In my early 20s I tried to get assistance from my parents for a scooter to assist with my mobility. I was also having a lot of falls and asked them for help for an alarm to ring if I was in trouble. But my parents put up so many barriers that I couldn't continue discussions with them. After one of my falls a doctor referred me to a hospital clinic and arranged for government funding for me to obtain a scooter.

I believe my family has always ignored me or used me. To justify my existence I have always over compensated. With friends at school I ran errands for them, spent hours listening to them about their relationships. I often felt such anger, as I couldn't get any man to even look at me. For many years I was just dying inside. I felt I did not exist.

My experiences with my family have had a huge effect on me. The only physical contact was to make me walk better. I would come home from school all my school life crying, I would have nightmares and wet the bed until I was 16. My parents were wilfully ignorant. The isolation was horrendous. I had to learn how to have a proper conversation. I remember bailing up visitors telling them jokes; it was the only way I knew how to converse. My mother now says you were often a happy child.

But the worst thing was I didn't feel safe around them. I was permanently terrified. Whenever I went out they left me to struggle. I had to crawl backwards down steps; they just left me to manage. I remember one time on holiday they took a picture of me coming backwards down the stairs on a windy day and my dress blew up; they thought it very funny.

When I was 13 we had a teacher at school talking about puberty. My mother made me go up to her afterwards and ask her whether cerebral palsy had any effect on menstruation but the teacher didn't know. My mother took me to a male doctor – I had to go through an internal examination to see if I was normal. No body explained to me why this examination was to take place. I was terrified. I asked my mother many years later why she insisted on this examination but she didn't tell me why. She just said I knew if I told you, you wouldn't go.

I have only had contact with services over the last three years. However, my experiences with disability services have been so troublesome that I don't trust them. I felt that the service providers were so difficult about my physical needs that I could never get to a stage where I felt comfortable to talk about family abuse. I am now seeing a counsellor and that seems to be helping me.

I live independently and have some home help. I don't believe there will be reconciliation with my family. This is often hard, as I don't have anyone else. I don't have anyone to remember my birthday. I now live with a double isolation, my disability and breaking up with my family. And I have to try to come to terms with the years of abuse. My family really didn't have to do much to support me, but withdrawing and ignoring me was so dangerous. I am often astounded that I came out of it in one piece

Nicole's story

I am 35 years old and I am blind. I live at home with my parents. I entered into a relationship with a man who I met a couple of years ago. I fell in love and it was magic at first but I soon knew I loved him a lot more than he did me, I just gave too much. About three months into the relationship I found that he was constantly putting me down, telling me I couldn't do anything. I remember we went for a holiday and he said you can't go down that track, you can't see, he really hurt me. He started to spend time with his friends, but he couldn't make time for me. He was always nice to outsiders, but increasingly abusive to me. If I made him a sandwich I often had to ask him if I had cut it correctly, but he was forever critical, it made such a difference that I wasn't sighted. He expected a lot more of me than what was possible for me. I tried to do a lot at home and asked him to check things, but he refused. Everything became such a big issue to the point if I couldn't get something I just wouldn't ask him to help me and I went without. He was critical of things I couldn't do, even though he knew it was hard for me. He made me feel so useless, so put down. He never made plans – if he

didn't have much on he called, but if he did he just didn't. I know I chased him. I would have done anything to keep him. I know he was seeing another woman and I felt so used, I was at his beck and call. I relied on him emotionally more than he relied on me. I constantly dwell on the negative side, it is so hard, what did he really want out of me?

I became very bitter, I didn't go to work, and I had a nervous breakdown. But I know that it is finished now, I will never have another relationship. I tried so hard to hang on to him. My self-esteem just went down so low; I didn't want to meet people. I went out eventually but I am very wary. I think emotional abuse is worse than physical abuse. I really hated the ongoing put-downs. It gets you down and your self-confidence in coping with your life is virtually non-existent. The physical violence, I think you can eventually get over, but the psychological scars resulting from emotional violence are ever present. They have stayed with me for so long. It is just so damaging and the worst part is that I know I hung onto the relationship because I was so scared that I might not ever have another.

He was used to being around people who weren't sighted so it wasn't as if I was anyone different from his experiences, but if I were sighted he wouldn't have done this to me. I know I have got to rely on people. I ask for help that isn't a problem for me. But if I asked him for help then he was negative and resented me. I used to feel so vulnerable, I never trusted him, and I really didn't know if he would leave me to fend for myself. I bottled a lot of my feelings up, but I eventually did do an anger management course to get rid of my anger and meditation helps me too.

Marie's story

My name is Marie and I am 42. I don't understand things very well and I often need help. I have been in this refuge for a week. People have come to see me from disability services and someone from the family support place, but mostly they don't come back. I was living with my husband and he became so cruel to me, he hit me and raped me. He said I was useless and he couldn't stand me. He sold our house last year and I had nowhere to live.

I found another man but he gambled and lost all the money. He had my pension put in his account so I had no money. He also started to hit me. I remember the last time he bashed me really badly and I went to a refuge. I had to take my two children with me. I was so scared. But I hated it in the refuge so I called him after two days and went back. I couldn't look after the children on my own. My boyfriend locks me in everyday when he goes to work. I was hungry, my children were hungry; there was no food, I had no money anyway. I even had no underclothes, and I had to wear his underpants. I don't like living with him now, but I am so frightened of being alone. So now I am back in this refuge, I hate it, the refuge workers are always on at me to feed my children, look after them to

stop them from going crazy. I don't know where I am going to go when I leave here.

Amanda's story

I am 31 and I have bi-polar disorder. I come from a family of 8. We came here from Turkey ten years ago. I was brought up in a home where there was physical and sexual violence against my mother and all my brothers and sisters. My father was the most violent man; he used cricket bats, pieces of wood, rubber hoses and punched us in the head. My older brother also sexually abused me.

I met my husband when I was 13 and was with him for 16 years. I got pregnant when I was 15 and had my first child. My husband was also from Turkey and under our culture our husbands make all the decisions, I had to do everything he told me to. My husband was violent for years. His verbal and demeaning abuse was bad enough – for years I lived with three words that never left me 'crazy ugly bitch'. He had so many ways of controlling me; he would throw everything at me, and threatened to kill me many times. He once held my head up by the hair as I cradled my daughter and pressed a kitchen carving knife to the back of my neck. He was drunk most of the time and he would choke me to the point where I would pass out.

The abuse started gradually but the violence increased, with one argument ending in my head being smashed against a pole. I didn't go to a hospital; I just took some Panadol and tried to sleep. I never had any money, I couldn't drive and I didn't have any friends. My family lived in the country; anyway I am sure I wouldn't have told them. I stayed with him through it all just because I thought my daughter deserved a mum and a dad.

I was getting my medication from my doctor; I don't know if he knew I was involved in domestic violence, he never asked me so I never talked about it. Once I had had enough and I called the police. They came after about an hour, but when my husband saw them he said she's crazy look at the medication she takes, and they left. I never called them again.

Last year, I don't know why this time was different; I took my daughter and left when he was at work. I walked to the hospital and they helped me. I kept inside, the horror of my childhood and the awful violence I experienced by this man until I had left. I buried the pain and the anger away deep inside of me where I thought no one could ever find it. I was so exhausted when I eventually had some counselling, I really didn't know how I was going to survive. When you have been so abused as a child I am sure you have a tendency to pick an abusive partner. That is what I did, and I am equally sure that this is also the reason I have a mental disorder. We are conditioned to put up with hell. We don't even realise that our adult relationships are mirroring our childhood

experiences. I thought that it was normal to live like that, to be punished all my life. Being locked in the house, having no money and being raped is not normal. It has been years of pain, torment and hell.

When I was in court to obtain a restraining order I had to sit there and tell this judge, who had a smirk on his face, everything that had happened to me and some of it was just so bad, it was hell. I had to prove that I needed a violence restraining order. And it was like because I had a mental illness, it was my fault. I will have to carry these experiences with me my whole life as well as try to live with my bi-polar.

FINDINGS: SUMMARY AND CONCLUDING COMMENTS

Of these 107 agencies that responded to the questionnaire, 72 agencies reported that they had provided services to an estimated 709 women with disabilities who had been subject to family and domestic violence in the two years preceding the research. Two hundred and seventy women or 38 per cent had acquired a disability as a result of the abuse.

Twenty per cent of the women were from a culturally and linguistically diverse background, while 28 per cent of women were from an Indigenous background.

Fifty six per cent of the women had children who were involved in the process of intervention.

Primary Types of disability

Many agencies reported that the women who accessed their services had more than one type of disability. Psychiatric disability was the most prevalent disability reported, accounting for 55 per cent of the women. Physical disabilities accounted for an estimated 32 per cent of women; 30 per cent were identified as having an intellectual disability; 16 per cent a neurological disability and 10 per cent had sensory disabilities.

Type and duration of violence

The women experienced multiple types of violence. Agencies reported that one half of the women experienced 3-4 types of violence and an estimated 24 per cent experienced 5 or more types of violence. Seventy two per cent of women experienced emotional abuse; social violence was experienced by an estimated 55 per cent of women and sexual violence by an estimated 58 per cent of women. One half of the women experienced physical violence and financial abuse was experienced by an estimated 46 per cent of woman.

Women with disabilities also experienced violence for lengthy periods. Twenty three per cent of the women experienced family and domestic violence for more than 6 years and 18 per cent up to four years.

Perpetrator of violence

Forty three per cent of the women had experienced abuse by a male spouse or partner while the perpetrator for 11 per cent of the women was by a female spouse or partner. Parents were responsible for abuse against an estimated 15 per cent of the women and other relatives accounted for abuse against 8 per cent of the women.

Services

Responses indicate that agencies provided more than one type of service to women with disabilities who had been subject to family and domestic violence. Services ranged from information (77 per cent), support (60 per cent), counselling (44 per cent) and legal services (34 per cent).

Thirty per cent of agencies did not provide accessible toilets for people with disabilities. In addition, 43 per cent of premises did not provide ramp access for people who used wheel chairs.

Interventions

Most agencies provided multiple services and also utilised a combination of interventions as required. Fifty eight per cent of agencies used referral to other agencies as part of their intervention strategy. However, over one half (56 per cent) of respondent agencies were dissatisfied with the effectiveness of these interventions and two thirds of all agencies reported dissatisfaction with the level of services they could provide for women with disabilities experiencing family and domestic violence. On the other hand, sixty per cent of agencies reported levels of satisfaction that their clients had been able to make positive changes in their lives since their interventions occurred.

Agency needs

There was a growing awareness among service workers of the need to address the traumatic effects of domestic violence against women with disabilities. However, many service workers reported that they were already struggling with limited resources, which meant that they often felt unprepared to respond to the complex needs of the women they serve. Evidence of this lay in the dissatisfaction with the effectiveness of their intervention and dissatisfaction with the level of services they could provide.

Agencies identified areas of need to assist them to respond more effectively. A greater availability of services was cited by 90 per cent of all agencies. Seventy two per cent believed that there was a need for improved communication and coordination between agencies, and almost two thirds of agencies reported that their funding was not sufficient to enable them respond more effectively. More government and public awareness were cited as areas of need by 60 per cent of respondent agencies. Over half of all respondent agencies needed more training in disability issues *and* domestic violence issues.

For each disability type different dynamics of abuse come into play. Nevertheless, there are certain commonalities, which exist across disability groups, and particular attention must be paid to identifying vulnerability factors that are disability-related as opposed to those factors experienced by all women, which increase their susceptibility to entering and remaining in abusive relationships. These include dependency on others for care; denial of human rights that results in perceptions of powerlessness; less risk of discovery as

perceived by the perpetrator; difficulty of being believed; economic dependence; social isolation; increased risk of manipulation; increased risk of poverty and social withdrawal and the whittling away of self-esteem associated with having a disability as a precursor to abuse.

For women with psychiatric disabilities a number of key themes emerged in the interviews with domestic violence, family support and mental health workers. Refuge workers talked about the frustration of unproductive interventions and the impact this had on staff when trying to support this group of women. They also pointed out the considerable difficulties they, and other women and children had in managing a woman's behaviour in the communal setting if the behaviour became erratic and a disruptive influence. There was an increasing awareness of the need for other services that would support them to address the concerns of women with psychiatric disabilities when they are subject to domestic violence. Increasingly, refuges are seeing women with the fewest resources, who have been multiply victimised as children and as adults. These are women who have experienced greater adversity throughout their lives, and who may be more vulnerable to the mental health consequences of abuse. This was evidenced by many of the women interviewed who shared their stories of childhood abuse. Moreover, psychiatric disability is still highly stigmatised and is frequently used against victims of domestic violence in child custody decisions by abusers as well as by the legal and child welfare systems.

For women with physical disabilities, limitations in physically escaping violent situations, increased dependency on others for care, and difficulties in accessing the level of care needed in domestic violence services were common themes presented by community workers and the women themselves. In addition, poverty severely restricts options for these women. Options often suggested for a non-disabled woman in a domestic violence situation, for example housing, are often not suitable for women with physical disabilities.

Women's health, domestic violence and family support workers identified the nature of the relationship between a woman with an intellectual disability and an abusive partner as particularly problematic and described the "revolving door" situation which was evident for many of these women. It was their belief that many women with intellectual disability with whom they had had contact, lacked insight into the nature of abusive relationships, and this lack of insight meant that these women often fell back into these relationships time and again. Often communication between the woman and themselves was a difficult issue for them to manage making it hard for service workers to work with this group of women to break the cycle. A number of refuge workers reported that they found this group of women "hard to serve" and often found that it was "sometimes just too difficult to take them".

The majority of the women who participated in this study experienced violence perpetrated by their partner, often repeatedly and severe enough to require medical attention. Many of the women described being threatened with, or

experiencing, severe physical or sexual harm. Other women experienced verbal, emotional, social and financial forms of abuse and neglect. The emotional abuse often took the form of being isolated from contact with others. The women said that it was not uncommon for their disability to be used as a controlling or dehumanising factor.

Agencies reported that nearly three quarters of the women who had accessed their services experienced emotional violence. A key to understanding the phenomenon of emotional violence against women with disabilities is in the image society has of them as well as how they see themselves. Some of society's negative images and myths regarding women with disabilities increased the women's risk of being emotionally abused in their intimate relationships. These images and myths included:

Women with a disability are not able to give or participate equally in an intimate relationship - often the disability gets used as a basis for inequity in the relationship.

Women with a disability are child-like and dependent – the abusive partner perpetuates this by encouraging others to speak to him rather than her and his control may be disguised as “caring support”.

Women with a disability are a burden to her partner and family, always needing/taking. This is typified by statements such as “She has a disability, she can't do anything”

The woman's partner is a martyr or hero for being in a relationship with a woman who has a disability - illustrated by comments: “He wouldn't do that, he is wonderful for taking on a person with a disability”.

Confusing feelings were distinct for many of the women in the study, particularly where intimate partners exercised violence. Many of the women described feelings of low self-esteem and negative images of their own body. The women were not free from the influence of the language of advertising when it came to what is desirable or not in a woman's body and made comparisons. Disability is seen as a “deficit” and the “ideal” imposed was far from reach. This message became ingrained and influenced negatively the perception some of the women had of their bodies. A comparison was established between the standards of beauty and the image the women had of themselves, which in turn led to a lowering of their self-esteem. For a number of women, this was given credence when their partner believed that they should be grateful for the relationship, despite their disability.

At the same time, as a result of the perception others have of disability, the traditional roles assigned to women are neglected or limited. Not being able to fit into the mould, many of the women ended up seeing their disability as something negative because among other things, it reduced their possibilities of having

another relationship. Consequently fear became a major deterrent to the women leaving. Some women talked about their fear of being alone superseding their fear of being assaulted.

CONCLUSIONS AND IMPLICATIONS

Family and domestic violence against women is acknowledged as a pervasive and serious problem. It is a violation of trust and an abuse of power in a relationship where a woman should have the right to absolute safety. Women with disabilities are especially vulnerable to victimisation and the barriers to ending the abuse can be much greater than for women without disability. However, to date there has been limited research on domestic violence against women with disabilities.

Accordingly, this project was developed in response to the many calls in Western Australia to overcome the knowledge gaps in the area. The objectives for the research were to document the nature and extent of family and domestic violence against women with disabilities who have accessed services in Western Australia, and identify whether the needs of these women are being adequately addressed by relevant services in that state.

Women with disabilities face the silence of double oppression. As women and as individuals with disability they experience numerous inequities and injustices. At the root of this double discrimination are sexism and ableism, which set standards for “women” and “normal” that exclude, devalue and marginalise women with disabilities. Even though many women with disabilities living in the community today experience new freedoms, rights and responsibilities, they continue to confront cultural stereotypes and discriminatory practices. Of prime concern, is that double discrimination perpetuates violence against women with disabilities, justifying that violence on the basis of their devalued status in society. In addition, for perpetrators, it is even easier to put women with disabilities into a state of uncertainty and to assign guilt and responsibility to them.

Over the past two decades in Australia, people with disabilities, families and allies have established a solid record of advocacy promoting the basic human and civil rights of people with disabilities. These developments combined with the feminist movement have enabled the issue of violence against women to emerge, and provide a strong foundation from which to develop strategies to decrease abuse against women with disabilities. Community work practitioners can draw upon this foundation to enhance their work with this vulnerable group of women.

A major goal should be for domestic violence and disability services to bridge the philosophical and service delivery gaps between the domestic violence and disability communities and to provide some of the practice, policy, and training resources necessary to enhance and speed these efforts.

It is critical that domestic violence workers receive training and background information on the disability rights movement, significant legislation, research about violence against women with disabilities and current communication and

education “best practices” for the delivery of service for people with disabilities. Taking the necessary time to obtain accurate information will assist understanding disability issues. It will also enhance communication, therapeutic and advocacy skills, enabling domestic violence agencies to interact more effectively with women who have disabilities. This information should be integrated into individual professional practice and agency programmatic systems and physical structures.

Disability service providers must educate themselves about the nature of domestic violence generally, and specifically about violence against women with disabilities. They need to determine how they will incorporate this information and understanding into the delivery of their services. They must honestly examine the degree to which their own personal biases and professional behaviours may support the root causes of this violence at an unconscious or conscious level towards the women with whom they work. These workers need to cooperate with domestic violence programs to expand their knowledge about the services these programs provide. It is critical for disability workers to advocate with domestic violence specialists for accessible crisis services for women with disabilities who have been victimised.

Whenever possible, disability workers should team with domestic violence workers and activists to promote the empowerment of women with disabilities who have been abused. Asking questions about abuse and addressing issues of abuse as part of a routine protocol while working with women with disabilities, the service worker can provide the necessary resources and support to help the woman break the cycle of violence in her life. It is also essential that all professionals, families and women with disabilities advocate for increased program funding and legislation that advances the rights of women with disabilities who experience domestic violence.

It appears that crimes of violence against women with disabilities are often not reported. This follows the trend in reporting personal crimes of violence generally. Reasons given by the women include attitudinal barriers among the police in recognising violence against women as a crime and a lack of understanding about disability issues.

For those women who do contact the police, identification of disability is often problematic. In fact it is only recently in Western Australia where there has been a mechanism to report disability status in the record-keeping systems of the police. Although indication of disability in crime statistics is better than no indication, it is acknowledged that it will take considerable effort to establish feasible reporting systems. As it stands, identification clearly puts a burden of labelling on police officers. This means that it is likely that only the most obvious disabilities such as wheelchair use, blindness, deafness, or amputation would be correctly classified, Police officers should have access to specific training to be able to recognise the wide variety of disabilities, especially the less visible ones

such as psychiatric disability, intellectual disability or milder forms of cerebral palsy.

A significant number of women with disability who have experienced family and domestic violence are accessing community services in Western Australia. However, these services need to work together to break a long tradition of silence about violence experienced by this vulnerable group of women. Double discrimination against women with disabilities is a complex systemic and personal problem. Women's refuges have become central services for women escaping violence. They are known to believe what women say about their experiences of violence, they support women's decisions and work for the maintenance of women's rights. Yet, many are failing in their support of women with disabilities.

Procedures on how to deal with violence against women with disabilities need urgent action. More attention needs to be given to appropriate staffing within relevant community agencies to address the complex needs and the devastating effects of family and domestic violence against women with disabilities. Sensitive coordinated disability, mental health and community supports that provide access to refuges, affordable and appropriate housing and counselling is critical. Funding bodies should also require agencies to keep records of women with disabilities who experience family and domestic violence.

Women with disabilities require the same level of attention that is being dedicated to non-disabled women who experience family and domestic violence. Women with disabilities are often victimised by society. It is imperative that all community agencies take responsibility to assist in preventing further victimisation and work with women with disabilities to understand their rights. They must take steps within their own agencies to overcome the barriers and stop the silence that currently exists for this vulnerable group of women.

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APPENDIX 1

Introduction' and 'Guidelines for Referral and Support' for interviewing individual women in stage two of the research project on Women with Disabilities and Family and Domestic Violence.

The purpose of these guidelines is to ensure individual women who participate in the research project are supported appropriately throughout the research process.

The goal is to enable the research team, in responding to women with a disability, who have or are experiencing Family Violence.

The underlying assumption is that participation in the research may raise complex issues for women, emotionally and socially. This may result in emotional trauma immediately or in the future, as memories are re-ignited. It may initiate fear of retribution from a carer.

To ensure a safe environment a number of Principles are articulated below plus an outline of procedural matters to guide the interview process.

Principles:

- Confidentiality and Privacy. Research participants must have a clear understanding and knowledge how these two principles apply to their participation in the project. Where assistance in communicating with participants is required, care needs to be taken to re-enforce confidentiality.
- Informed Consent. Women must only participate in the research on a basis of informed consent. This means the researchers describing the purpose and methodology and potential outcomes. Plus, the potential for the research process to raise emotional responses. Informed Consent also entails the researchers checking with the woman prior to the commencement of, and during the interview, that she is comfortable to continue.
- Personal Support. Acknowledging to the participants that talking about experiences of violence and abuse can be emotionally disturbing or create flashbacks that reignite memories either during the research or later. Giving reassurance that there are systems of support in the community and that this can be outside the field of Disability services.
- Provision of knowledge and understanding on the issue of family and domestic violence. Participants may have limited understanding of the parameters of the issue and may not identify varying forms of behaviour as abuse. Likewise it may be culturally or socially difficult for them to announce some forms of violence for example sexual abuse or assault.

- Provision of information. The researchers have a role in ensuring participants have information about appropriate and relevant support services for the future.
- Allowing sufficient time. The researchers may find participants will require varying periods of time. Some may need hours to explore their own story, the issues involved and a re-assessment of how those issues were dealt with at the time.
- Debriefing for researchers. Interviews of this nature can raise anxiety and/or distress to varying levels for the interviewer. It is essential they have access to a debriefing process between interviews as required. Members of the Reference committee with relevant expertise could be utilised.

Within the interview a number of procedures need to be followed: -

Interview process:

Introduction. At the commencement of the interview the researcher needs to provide a statement of what the research entails and why it is being done. For example "...to gain insight into the incidence of family and domestic violence against women who have a disability". This introduction should also include a statement about confidentiality and how the information gathered, will be used.

The researcher needs to provide an outline of what is commonly regarded as abusive or violent behaviours. For example the behaviours listed in question 9 of the questionnaire could be talked through and spoken of, but not limited to, as behaviours most often reported by women.

It will also facilitate the interview if the researchers state that the common understanding of family and domestic violence is where abuse and violence occurs where one person in the relationship consistently dominates the other person, uses fear inducing behaviours to control the other and to determine what must happen in the relationship. Within the parameters of the definition it is generally understood that family and domestic violence is not about people who have equal power in the relationship or where both may consistently or sporadically use violence and abuse to determine outcomes. Family and domestic violence is not a family argument.

Further, that family and domestic violence often occurs after the relationship has ended (the individuals have separated). It can mean one member will pursue the fear inducing behaviour to enforce a reunion. Alternatively the enforcement may be manipulative behaviours such as promises or the wine and roses treatment.

The researchers also need to acknowledge to participants that talking about their experiences during the interview may raise complex and emotional responses. The researchers should provide relevant information about the support options available, for example - Women's groups, Outreach services - and explain how to contact them. The participants should also be given the information in a relevant format, which includes the names and telephone numbers of service providers to access support (See below).

Services Available:

- **Domestic Violence Advocacy service Joondalup.** This free service is for women in the northern suburbs. A woman can self refer. She will be offered information and support. She can enter a women's group run locally. Paulette is the Administrator who will answer phone calls.
The phone number is 9300 1022.
- **Outreach service of Nardine Wimmin's Refuge.** This free service is for women across the metropolitan area, in the community (not residing in a refuge), who need support and information on domestic violence. The Outreach service has women's groups during the year. It is run by two women job sharing – Karen or Gillian.
The phone number is 9470 3628.
- **Women's Health Care House. Aberdeen Street Northbridge.** The Domestic Violence worker, Eloise Magalizza, offers individual free counselling to women. Also provides women's groups and ongoing support to women in the community.
The phone number is 9227 8122.
- **Multicultural Women's Advocacy Service.** A support service for women of non-English speaking backgrounds and access to ethnic workers. The Coordinator is Fauziah Varusay.
The phone number is 9328 1200
- **Relationships Australia Incorporated.** This agency has a number of offices in metropolitan Perth. Contact to the local office can be made via the 1300 number where the receptionist will make an appointment. They offer counselling on a fee basis for individuals or couples on any life matters including domestic violence. They run women and men's groups relating to domestic violence.
The phone number is 1300 364 277

- **Centrecare Marriage and Family Service.** This agency provides individual counselling on all relationship matters, including domestic violence. A sliding scale of fees is normally charged. If the fee is not affordable and the counselling is for domestic violence, women can request a fee reduction. In such cases a reduction or waiver will normally be granted. Centrecare also provide free support groups for women who have experienced domestic violence. Contact the Client Liaison Officer (currently Kathryn).
The phone number is 9325 6644
- **Kinway Relationship Counselling and Education Services.** This agency provides individual counselling on domestic violence. A sliding scale of fees is normally charged, however if unaffordable can be reduced. Groups for women victims of domestic violence are also available – a donation is requested. Contact Sheena Edwards.
The phone number is 9263 2050
- **Family Helpline, Department of Community Development.** This government department runs a number of crisis phone lines. They state that a person can gain some telephone counselling by ringing the Family Helpline. It is a 24-hour service and free. It is necessary that a person make it clear they wish to talk about domestic violence. This helpline is also the after business hours contact number for Disability Services Commission and has listing of all the residents of DSC accommodation services in the event of harm, confusion or injury.
The phone number is 9223 1100.

Crisis Care Unit is a special unit within the department for any emergencies after business hours. If you ring during business hours you will be put through to the local office of the department.
The phone number is 9223 1111.
- **Domestic Violence Helpline** for men. The Department of Community Development. This is a phone service and is available for short consultation by phone to men who want to talk to someone when they fear they may be or have been abusive or violent towards a family member.
The phone number is 1800 000 599.
- **Domestic Violence Children’s Counselling service.** This is specifically for children who may have directly experienced violence within the family or have witnessed violence and abuse. It is a free counselling service. Appointments are necessary.
The phone number is 9328 1888.
- **The Domestic Violence Legal Unit.** This is part of the Legal Aid Commission. It provides legal information on rights and means of gaining

Restraining Orders by phone or appointment and has a duty Lawyer at the Perth court. For regional and country women who experience difficulties in gaining access to a lawyer, the Unit will assist. The Coordinator is Nawdy Roussetty.

The phone number is 9261 6254.

- **Women's Information Service.** This is part of the Office of Women's Policy and is a general information phone service and can provide information on a range of women's services.
The phone number is 9264 1900.
- **The People 1st Programme (PIP),** offers educational services for people with an intellectual disability, for parents, family members and for services providers. Protective and human relationships and self-esteem education are a major aspect of one-to-one services we provide. PIP also offers counselling services to complement education where appropriate. Educational fees are \$40 per annum for people 18 years and over. The Manager is Ruth Keszia Whiteside
The phone number is 9227 641

Appendix 2

SELECT ANNOTATED BIBLIOGRAPHY

This annotated bibliography focuses on the most recent articles and papers published in journals and on the Internet, together with some other key writings. Internet addresses were current at the time of publication but can change at any time.

Due to copyright laws, most online journal articles are only accessible through a licensed institution. If you are unable to access any of them, they can be viewed by visiting an Edith Cowan University library in Western Australia and logging in as a guest on a "Sunray" terminal. Printing is not available from these computers. For further information on this, please contact an ECU library near you on 134328. Access may also be possible through other university libraries.

Australian Bureau of Statistics. (1999). *ABS survey shows one Australian in five has a disability.* Australian Bureau of Statistics Media Release. Retrieved 25th March, 2003, from the World Wide Web: <http://www.abs.gov.au/ausstats/abs@.nsf/0/81A21B2987D05D49CA2568A90013631F?Open&Highlight=0,disability>

AUSTRALIA: Statistical information from a survey in 1998 shows that 19% of Australians – or 3.6 million people - have a disability. Of these, 87% experienced specific restrictions in core activities, such as self-care, mobility or communication, or in their ability to participate in schooling or employment.

These statistics point to the need for services and support, not only for those with a disability but also for those who provide care.

Cattalini, H. (1993). *Access to services for women with disabilities who are subjected to violence. Report to the Department of Prime Minister and Cabinet, Office of the Status of Women, National Committee on Violence Against Women: Canberra: Australian Government Publishing Service.*

AUSTRALIA: This study is about how women with disabilities who are subjected to violence access necessary support services and processes. The study looks at access issues, appropriateness of service, service philosophy, community attitudes, support services, police services and legal services. Consultations with service providers and groups of women revealed that support and legal services generally have failed to respond adequately to women with disabilities who are subjected to violence.

Chenoweth, L. (1996, Dec 1996). *Violence and Women With Disabilities: Silence and Paradox* [Online]. *Violence Against Women* 2(4) Dec 1996. Retrieved, from the World Wide Web: April 1, 2003, from Proquest Database.

AUSTRALIA: Women with disabilities experience marginalisation and exclusion, which makes them “more vulnerable to violence and abuse than other women”. The silence of their lived experience means that the violence in their lives is largely invisible. This article explores the notions of certain paradoxes through the stories of women with disabilities themselves, their mothers and other workers. For example, women with disabilities, although having little voice, are overprotected, segregated, and taught to be compliant; and that women with disabilities are seen simultaneously as asexual and yet promiscuous. These paradoxes increase the incidence of abuse and violence rather than prevent it. It also examines several Australian enquiries into violence.

**Curry, M. A., Hassounch-Phillips, D., & Johnston-Silverberg, A. (2001). *Abuse of Women With Disabilities: An Ecological Model and Review* [Online Journal: *Violence Against Women* 7(1)]. Retrieved 28 Aug, 2002, from the World Wide Web:
<http://proquest.umi.com/pqdweb?TS=1030505137&RQT=309&CC=2&Did=00000065097249&Mtd=17&Fmt=3>**

USA: This study examines the problem of abuse against women with disabilities within the social context of disability itself. Women with disabilities may experience greater levels of poverty, social isolation, discrimination, stereotyping, low self-esteem, increased health problems, depression and suicide than non-disabled women who experience abuse. The researchers assert that the prevalence of abuse among women with disabilities is unknown. In addition, the multiple types of victimization have not been described but are known to include more than physical and sexual abuse.

This lack of knowledge and attention to the issues has contributed to the invisibility of the victimization of women with disabilities.

**Diaz-Olavarrieta, C., Campbell, J., Garcia de la Cadena, C., Paz, F., & E Villa, A. (1999). *Domestic Violence Against Patients With Chronic Neurologic Disorders* [Online Journal: *Archives of Neurology*, Chicago, June 1999. 56 (6) start page 681]. Retrieved 28 Aug 2002, from the World Wide Web:
<http://proquest.umi.com/pqdweb?Did=00000042444175&Fmt=3&8Deli=1&Mtd=17&Idx=9&Sid=0&RQT=309&LDid=00000043077799&LSid=1&L=1>**

USA: This very short paper poses questions that a health professional might ask in order to identify women with disabilities who are victims of abuse. The

authors highlight the reluctance of physicians to broach the topic of abuse with patients for a number of reasons, including the lack of training in the area of abuse. Chronic or unexplained symptoms, the over-solicitous behaviour of domestic partners or other social factors may be an indication of abuse which doctors should be alert to. It concludes with a reminder that abuse can be fatal and that patients who have experienced abuse should be responded to as seriously as if they had, for example, a heart condition.

**Doe, T., O'Toole, C., & Kafer, A. (1999). *Claiming Our Bodies*. Disabled Women's Conference May 26 1999, Washington DC. Retrieved 20th March, 2003, from the World Wide Web:
<http://www.disabledwomen.net/claiming.htm>**

USA: This Internet resource kit has several articles written by women with disabilities (including "Claiming our bodies, claiming our lives", "Resistant Bodies: disability as sites of resistance" and "Ending Violence") on issues relevant to women with disabilities. The recounting of deeply personal experiences make for an excellent source of information for all people concerned about the quality of life of women with disabilities. It also includes a list of useful printed resources (many of which are not, however, available in Australia) and websites, which provide information and resources on a variety of issues.

Domestic Violence & Disability Working Party (WA). (2000). *Domestic Violence and Disability: A Neglected Combination* (Report from Forum held November 2000).

AUSTRALIA: This Western Australian report states many government documents have been written on domestic violence but these have had little impact on those with a disability. The report particularly highlights the situation of migrant and refugee women with a disability. This group may have special needs due to low English proficiency and limited social or family support. The report calls for collaboration between "all parties" (for example, in the areas of policing, multiculturalism and disability) to meet the needs of women with disabilities.

Elman, R. A. (1997, Jun 1997). *Disability Pornography: The Fetishization of Women's Vulnerabilities* [Online]. *Violence Against Women* 3(3) June 1997. Retrieved, from the World Wide Web: April 1, 2003, from Proquest Database.

USA: This article critically explores various pornographic media that sexualise and ridicule women and girls whose disabilities make them especially vulnerable to sexual abuse and how this pornography contributes to the second-class safety and status of not only women with disabilities, but all women.

**Focht-New, V., (MSN, RN). (1997). *Beyond Abuse: Treatment Approaches for People with Disabilities*. 1(2) [Online]. Retrieved, from the World Wide Web: Access date 24th March, 2003.
www.quuxuum.org/~greg/journal/focht_new.html**

USA: This article uses case studies to highlight evidence that people with disabilities are at risk of misdiagnosis of serious illnesses because their ways of communicating may be misunderstood. Gestures and behaviours may be assumed to be signs of temper or anxiety rather than as calls for help, especially in those with disabilities that impair communication. The author sees prevention as a key element in assessment, intervention and treatment, citing research that indicates 90% of abuse does not result in treatment for the individual.

Institutionalisation and the dehumanisation and labelling of people with disabilities increase their vulnerability to abuse. Focht-New suggests that by creating societal, familial and organisational cultures that focus on learning and competence, people with disabilities can be supported in advocating for themselves rather than being victimised by a system that devalues them.

**Francis, J. (1992). *Voices in the Wilderness: Aboriginal Women and Disabilities*. National Aboriginal Network on Disability, Ottawa. Retrieved 18 March 2003, from the World Wide Web:
www.schoolnet.ca/aboroginal/disabl6/acknow-e.html**

CANADA: This article comes out of a conference run by Canadian Aboriginal women, and examines the lives of Canadian Aboriginal women with disabilities within the context of, for example, culture, the Christianisation of indigenous religion, Western medicine, gender, self-image, sexuality, alcohol and abuse. It includes personal recollections that demonstrate the complexity of life as an indigenous woman with a disability, living in a society that is still struggling to come to terms with generations of colonialism. Parallels to Australian indigenous life are striking and point to many issues in common to both countries.

Recommendations include the convening of a national symposium on Aboriginal people with disability which is consumer focused and driven, a video project to document the personal experiences of those with disabilities and a national directory of services available to Aboriginal people with disabilities.

Frohman, C. (1999). *Violence Against Women With Disabilities*. Dickson, ACT: Women With Disabilities Australia. National Women With Disabilities and Violence Workshop, Melbourne, February 1998.

AUSTRALIA: This is a report on the proceedings of a 2-day "National Women With Disabilities and Violence Workshop" in Melbourne, held in February 1998. The workshop linked women together for the first time in order to develop a strategic plan of action against violence against women with disability in

Australia. A range of workshops was conducted on the first day, focussing on gender, disability and violence.

Day 2 workshops focussed on identifying gaps in knowledge and service provision; and developing strategies to meet those gaps in the areas of education, service, information, research, social action and networking. This report is a very comprehensive account of the weekend activities, with useful information on what the participants see as priorities for the next 5-10 years. The report includes a state-by-state list of some key service organisations as well as key Internet sites.

Gilson, S. F., Cramer, E. P., & DePoy, E. (2001). Redefining Abuse of Women with Disabilities: A Paradox of Limitation and Expansion. *AFFILIA*, 16(2), 220-235.

USA: This study found that although disabled and non-disabled women face the same forms of abuse, disabled women have unique experiences that require specialised services. One US statistic reveals that 40% of women seeking help had become disabled due to the abuse they suffered. Disabled women are more likely to be victims of sexual abuse than non-disabled women.

Women with disabilities are often over-protected by their relatives and carers and are taught to comply with the requests and demands of others. This over-protection and compliance training may leave women ill equipped to handle an abusive relationship. The article points out the lack of information in the area and calls for future research to include, amongst other criteria, the type and onset of the disability.

Gilson, S. F., DePoy, E., & Cramer, E. P. (2001). Linking the Assessment of Self-Reported Functional Capacity With Abuse Experiences of Women With Disabilities. *Violence Against Women*, 7(4), 418-431.

USA: The authors state that research indicates that women with disabilities are abused at similar or greater rates than women without disabilities; that women who are abused by an intimate partner are at greater risk of being disabled or suffering an illness that affects their activities of daily living; that women with disabilities experience more and unique forms of abuse than other women; and that women with disabilities experience significantly worse consequences in areas of mental and physical health. They point to the misapplication to disabled women of theory, policy and practice developed to address abuse in non-disabled populations.

They propose a model of abuse assessment for women with disabilities composed of three elements. Firstly, there is the traditional assessment that encompasses the unique forms of abuse experienced by women with disabilities. The second element is a comprehensive functional assessment of an individual's disability through self-reporting and self-rating. Thirdly, that attention is given to

heterogeneity with regard to cultural sensitivity, structure of reporting and the nature of disability.

Hassounch-Phillips, D., & Curry, M. A. (2002). Abuse of Women With Disabilities: State of the Science. *Rehabilitation Counseling Bulletin*, 45(2), 96-104.

USA: This article points to the lack of information concerning women with disabilities and domestic violence. The authors conducted a critique of previous research, reaching several conclusions, which include (p. 102) the observation that women with disabilities are at greater risk of abuse from multiple offenders, and that a feminist perspective is valuable in this area of research. It points out some flaws in the methodologies and theoretical development of past research, including a lack of detail, which could impact upon the trustworthiness of the research. Finally, the authors call for the conduct of “more rigorous and comprehensive research” (p. 103), which they see as essential to the promotion of the health and safety of women with disabilities.

Impact. (2000). *Feature Issue on Violence Against Women with Developmental or Other Disabilities* [Online]. The Institute on Community Integration (UCEDD), The Research and Training Center on Community Living, College of Education and Human Development, University of Minnesota, Volume 13, No. 3. Retrieved 17 March 2003, from the World Wide Web:<http://ici.umn.edu/products/impact/133/default.html>

USA: This is a series of articles in a special edition of the journal *Impact*, published in hard copy and online, which investigate abuse against people with disabilities. Articles include the personal account of a woman who experienced abuse in various ways at the hands of friends and strangers alike, to the investigation of issues such as the power imbalance between caregivers and care-giving agencies that supports overt and subtle violence against individuals with disabilities.

Another article looks at the many “faces of violence” against women with developmental disabilities, highlighting the high rates of women with disabilities who are victims of homicide. Another focuses on the double impact of discrimination faced by women with disabilities because of their gender and disability, and calls for the silence that surrounds violence against women with disabilities to be broken. From disability services to attitudes of sexism and ableism, the author calls for changes in education and policies to empower women who have been the most marginalised.

The website profiles seven programmes in the US and also has a link to resources on violence and women with disabilities. This is a very useful and informative collection of articles that, although referring to American institutions

and conditions, seeks to shed light on problems also faced by women with disabilities in Australia.

**McMullen O'Brien, S. (2002). *Staying Alive: A Client With Chronic Mental Illness in an Environment of Domestic Violence* [Online Journal: *Holistic Nursing Practice* 16 (3) , pp. 16-23]. Retrieved 5 Sept, 2002, from the World Wide Web:
<http://proquest.umi.com/pqdweb?Did=00000012202783&Fmt=3&Deli=1&Mtd=1&Idx=18&Sid=1&RQT=309>**

USA: This is the case study of a young African American single mother with chronic mental illness. Her complex needs, combined with the effects of serious mental illness and the impact of abuse as a child and spousal domestic violence, could not be adequately addressed by the local mental health and human service system. She also needed “sensitive, coordinated, mental health community support that provided affordable housing, legal counselling, sheltered employment, social service consultation, and financial assistance”. The author points to the victimisation of mental health patients by a “fragmented, stigmatised health care system” and calls for the same attention that is given to people with physiological disorders to be given to people with mental health disorders.

MIMS & Associates. (1998). *Domestic Violence and Women with Disability Project (Report)*. Brisbane: Department of Families, Youth & Community Care, Queensland.

AUSTRALIA: This report from Queensland acknowledges the slowness of Australian authorities to respond to violence against women with disabilities; the myths that have hindered meaningful responses; and the lack of information available to women in this situation.

The report includes women’s stories, evaluations of agency resources, and an assessment of the information required to address the problems. It makes 11 recommendations to address the identified problems, ranging from education for individuals, agencies and government, resources in print and non-print formats for women with disabilities and the development of government strategies.

**Nosek, M. A., Ph.D, & Howland, C. A., MPH. (1998). *Abuse and Women With Disabilities*. US Department of Justice, Office of Justice Programs. Retrieved 18 March 2003, from the World Wide Web:
www.vaw.umn.edu/Vawnet/disab.htm**

USA: The study brings together relevant statistics and information, finding, for example that “there have been virtually no studies that examine the existence, feasibility or effectiveness of abuse interventions for women with disabilities”. Architectural inaccessibility, lack of services and inability of emergency accommodation services to cater for women who need daily help or medication

are mentioned, along with other special needs of women with disabilities which need to be catered for.

Recommendations for research and programme development include making all emergency shelters accessible and integrated for women with disabilities; keeping statistics on the number of women with disabilities who access crisis and other services; training of domestic violence workers in disability issues and training of disability workers in issues of domestic violence.

Nosek, M. A., Ph.D. (1999). *Guidelines for Physicians on the Abuse of Women of Disabilities* [Online]. Centre for Research on Women With Disabilities. Retrieved 20 March 2003, from the World Wide Web: http://www.bcm.tmc.edu/crowd/abuse_women/ABUGUIDE.htm

USA: Paragraphs in this document include

- Dispelling the Myth: No one would ever abuse a woman with a disability
- Why patients don't tell their doctors about abuse
- Reasons physicians don't ask about abuse, and
- What can physicians can do for an abused patient

Many useful points are made that can be helpful for anyone involved with women with disabilities. It forms part of a large website that offers valuable information on issues that affect women with disabilities who have experienced abuse.

Pane, L. (1994). *Emerging From the Shadows: A Report of the Status of Women with Disabilities Living in Australia*. Curtin, ACT, Australia: Women With Disabilities Australia.

AUSTRALIA: This report brings to light many issues facing women with disabilities, including the increased risk of abuse because of their dependency on others for care. It comments that although many "policies, strategies and legislation" have been put in place to protect the rights of people with disabilities, women with disabilities are still "categorised as a 'special interest' group...whose...experience is separated and marginalised". The report sets out strategies to address the lack of action in the many identified areas.

Partnerships Against Domestic Violence. (2000). *It's Not OK. It's Violence*. (Information Kit). Sydney: Commonwealth Office of the Status of Women. Available at <http://www.padv.dpmc.gov.au/publications/publicat.htm>

AUSTRALIA: This information kit includes a poster, booklet and handy telephone reference card intended to educate and inform women with disabilities about their rights and avenues for recourse. Nationwide phone numbers are listed.

Powers, L. E., Curry, M. A., Oschwald, M., & Maley, S. (2002). *Barriers and Strategies in Addressing Abuse: A Survey of Disabled Women's Experiences* [Online: *Journal of Rehabilitation* 68(1)]. Retrieved 24th March, 2003 from the World Wide Web: <http://proquest.umi.com/pqdweb?TS=1030603107&RQT=309&CC=2&Dtp=1&Did=000000110353866&Mtd=1&Fmt=4>

USA: Women with disabilities who have experienced abuse identify personal assistance services (PAS) providers as a “particular problem”. This study explores women’s experiences of PAS abuse, behaviours of personal assistance providers considered most harmful, barriers to responding to abuse and strategies perceived as most helpful for preventing or stopping abuse. The discussion indicates that rather than increasing professional monitoring and supervision of care, the most useful approach would involve “building women’s capacities” – through “information, validation and resources” – to understand abuse and have an input into their own carer situations. Further research is called for.

Ryan, C., & Women With Disabilities ACT. (2002). *An Inclusive Democracy? Paper presented at the Women's Constitutional Convention 2002 "Trust The Women"*.

AUSTRALIA: This paper evaluates the status of women with disabilities in Australia from a political viewpoint i.e. on matters of equity and access (both physical and attitudinal), self-determination, and the achievement of leadership positions in the community. The author says that the burden of poverty prevents women with disabilities from interacting in the community.

Ryan calls for a gender audit of all government programs and policies to reveal the discrepancies in the system; a rights based discrimination system rather than a complaints based system; an Access Action Plan in the political system; a constitutional Bill of Rights system; for government, business and the community to address inclusiveness and access concerns on a constant basis; whole of government access strategies; and grass roots level evaluation of access and egalitarian issues in local communities.

Scerha, M. (1996). *Women With Disabilities and Domestic Violence. Women with Disabilities Australia. Retrieved 20 September, 2001, from the World Wide Web: www.wwda.org.au/madge.htm*

This article explores the issues facing women with disabilities who have experienced family and domestic violence concerned with the accessing of information, resources and services. Scerha comments on not only the problems with accessing these things, but the lack of disability specific data collected in Australia that is both disability and gender specific.

The author discusses some of the myths concerning women with disabilities that make them invisible in a society that itself could be called disabled, in that it is itself blind and deaf to the needs of women with disabilities. She goes further to say “But that’s letting society off too easily though for, far from being disabled, our society is more appropriately described as ignorant, uncaring and in fact, disabling”. Reasons why high levels of domestic violence against women with disabilities have been unidentified are explored. In a world that values physical beauty so highly, the voices of women with disabilities who experience domestic violence have been mostly unheard. Ignorance, superstition, fear and neglect have isolated people with disabilities throughout history and even when women are able to speak out or seek help, the system they seek help from may further marginalise and victimise them. And when people are marginalised, they can be hidden, ignored, silenced and more easily targeted by perpetrators of violence.

Strahan, F. of Sage Consulting. (1997). *Woorarra Women’s Refuge Disability Action Plan 1997. Woorarra Women’s Refuge and Women With Disabilities Australia: Commonwealth Office of the Status of Women.*

AUSTRALIA: Working with one women’s refuge to develop a DDA Action Plan (*Disability Discrimination Act, 1992*), this project points to several issues affecting women with disabilities, for example, the lack of research, limited access to services and the lack of knowledge about domestic violence. A detailed report, it covers the research methodology, key findings, strategies, implementation and monitoring issues involved in the Action Plan that was developed. The Action Plan is meant as a model for all women’s refuges in Australia to better respond to the needs of women with disabilities who are experiencing domestic violence.

Swedlund, N. P. (2000). *A Exploratory Study on the Work of Independent Living Centers to Address Abuse of Women With Disabilities* [Online: *Journal of Rehabilitation* Oct-Dec, 2000]. Retrieved 4 September 2002, from the World Wide Web: www.findarticles.com/cf_0/m0825/4_66/68865438.print.jhtml

USA: This study “attempts to learn more about how ILCs are addressing the issue of abuse”. Major themes to emerge from this study include

- 1) The need for staff to recognise that abuse is a serious problem for women with disabilities.
- 2) Inadequate staffing levels hinder the ability to address abuse issues.
- 3) Utilisation of existing services rather than establishment of new ones seems the most effective approach
- 4) Greater inter-agency cooperation needed for effective abuse intervention, as with domestic violence issues.
- 5) Lack of accessibility of services to women with disabilities.

- 6) Although improvements have been made in abuse intervention in recent years, the needs of women with disabilities have often been ignored. Further research is called for.

White, N. (1995). *Society must realise that disabled are abused, too* [Online newspaper]. South Coast Today. Retrieved 24th March, 2003 from the World Wide Web: www.s-t.com/projects/DomVio/societymust.HTML

USA: This article is one of eleven published after a 6-month investigation into domestic violence in Bedford, Massachusetts and highlights some very important issues for people with disabilities. The state run Disabled Persons Protection Commission “fields more than 300 calls a month to its 24-hour hotline”. The article points to a reluctance in society to accept that abuse could happen to disabled people and the shortage of facilities that can accommodate disabled people fleeing situations of abuse.

The investigators found that of the 3,000 reports received in 1994, 60% of alleged abusers were caretakers and 40% of abuse occurred in private homes, most often by family members. The article also points out the added vulnerability of disabled people, although as abuse occurs across the board at about the same rates, disability is not a cause of abuse. The majority of victims are women and the majority of abuse reports do not come from victims themselves because they fear no one will help, they will be forced to move or they will lose their caretaker.

Whiteside, R. K., & Perry, D. (2001). *'Women', 'Dis'Ability and 'Us'*. Retrieved 25th March, 2003, from the World Wide Web: http://www.people1stprogramme.com.au/publications_and_resources.shtml

AUSTRALIA: This article, draws attention to the problems facing women with disabilities and how the current trends of politicising and valuing (or devaluing) the differences between human beings has not reduced the discrimination and disadvantage that many groups in society experience, “relating to things like sexual orientation, age, dis’ability, ethnicity, economic circumstances”. The authors point to an emergent ecological notion of ‘inter-dependence’ and the idea that ultimately what hurts one hurts us all. It is very sobering information which points out that women in general experience such abuses and discrimination at greater rates than men however women with disabilities are at even greater risk and experience greater levels of discrimination and abuse than women without disabilities.

Women With Disabilities Feminist Collective. (n.d.). *Women and Disability An Issue*. Victoria and South Australia: Women With Disabilities Feminist Collective.

AUSTRALIA: This small book brings together a collection of poems, stories and articles written by women with disabilities on issues such as family, children, work, violence, sexuality, belonging, the deafness of the medical community to their concerns and the “double disservice” (in the areas of physical attractiveness and charity) done to women with disabilities by the beauty quest.

Young, M. E., PhD., Nosek, M. A., PhD, Howland, C. A., MPH, Chanpong, M. S., & Rintala, D. H., PhD. (1997). Prevalence of Abuse of Women with Physical Disabilities. *Archives of Physical Medicine and Rehabilitation*, 78. (1997 Supplement), S34-S38.

USA: This study was a case-comparison of 439 women with physical disabilities and 421 without disabilities. Results revealed that women, whether disabled or not, experienced emotional, physical and sexual abuse “to the same extent” (p. S-37). However, women with disabilities were at greater risk of abuse from attendants or health care providers and experienced abuse for a longer duration. They may feel powerless to report or prevent the abuse because of the disability itself, lack of services, dependence or fear.

Problems occurring include: a belief that disabled people do not get abused; lack of education and understanding of carers; reluctance of victims to report abuse for fear that they will not be believed. Further research and a direct confrontation of the issues are called for to reduce the prevalence and consequences of abuse for women with disabilities.

WEBSITES

An enquiry at any Internet search engine will provide links to many websites around the world in the areas of disability and domestic violence. From government sites to online communities, from non-government agencies to support groups and individual stories, you can find information and support from just about any perspective. These are just a small sample and the links were active at the date of publication. Inclusion in this list does not imply endorsement of the content by the research team.

Australian Bureau of Statistics

<http://www.abs.gov.au/>

Statistical information on Australian life.

Australian Centre on Quality of Life

<http://www.deakin.edu.au/acqol/index.htm>

An extensive

Australian Disability Services, Abuse and Neglect Hotline

<http://www.disabilityhotline.org/help.html>

A site with information on what abuse is, contacts for when help is needed and how to go about reporting abuse.

Australian Domestic and Family Violence Clearing House

<http://www.austdvclearinghouse.unsw.edu.au/>

A comprehensive national resource on domestic and family violence issues with extensive links to other online resources.

Australian Human Rights & Equal Opportunity Commission – Disability Rights Homepage

http://www.hreoc.gov.au/disability_rights/index.html

News on HREOC projects, information on legislation, rights and responsibilities, and subject pages on disability and different areas of life, and a feedback link provide a wide range of information for anyone interested in equal opportunity.

Center for Research on Women with Disabilities

<http://www.bcm.tmc.edu/crowd/>

This research centre focuses on issues related to health, aging, civil rights, abuse, and independent living of women with disabilities. The website provides links to many useful resources, including current US research.

“Claiming our Bodies” Internet Resource Kit

<http://www.disabledwomen.net/claiming.htm>

This US based site has lots of information, articles, and links to websites on issues for women with disabilities on violence, sexuality, health and even a guide on using the Internet.

DAWN DisAbled Women's Network Ontario

<http://dawn.thot.net/> Resources for women in Canada plus information for women around the world.

disABILITY Information and Resources

<http://www.makoa.org/>

A compendium of links to many sites around the world.

Disability Social History Project

<http://www.disabilityhistory.org/index.html>

A fascinating site with information on a disability history timeline, accounts of famous (and not-so-famous) people with disabilities, links to other resources and projects around the world on disability.

Disabled Women on the Web

<http://www.disabledwomen.net/>

Still under construction, this site has lots of information, including a search facility and links to other sites.

Disability World

<http://www.disabilityworld.org/index.htm>

A bimonthly web-zine of international disability news and views, with pages of information on conferences, women, children, stories, access and technology, legislation around the world and lots of other links.

Domestic Violence and Incest Resource Centre

<http://www.dvirc.org.au/>

This Victorian website has information on all sorts of issues likely to be of interest to a diverse number of people. There is a link to an excellent Online Document Library, lists of support groups and discussion forums around Australia and information on research, training and education.

Freedom From Fear

<http://www.freedomfromfear.wa.gov.au/>

An initiative of the Western Australian government, supported by the Men's Domestic Violence Helpline.

I-Can Online

<http://www.icanonline.net/>

An online disability community with a positive and practical approach.

National Ethnic Disability Alliance (NEDA)

<http://www.neda.org.au/>

The National Ethnic Disability Alliance (NEDA) is Australia's national consumer-based peak body for people from a non-English speaking background (NESB) with disability, their families and carers.

The National Relay Service

<http://www.facs.gov.au/disability/ood/nrs.htm>

The website of The National Relay Service (NRS) which enables people who are deaf, or who have a hearing, speech or communication impairment, to use the mainstream telecommunications network in Australia.

National Women's Health Information Centre

<http://www.4women.gov>

Office of Women's Health, US Department of Health and Human Services
US: This American site has lots of information and resources.

North Queensland Domestic Violence Resource Centre

<http://cwpp.slq.qld.gov.au/nqdvrs/order.html>

Funded by the Queensland Department of Families, offering services and information to a large part of Queensland, including the Gulf of Carpentaria region.

NSW Women's Refuge Resource Centre

<http://www.wrrc.org.au/>

Central contact point and resource centre for the 55 women refuges in New South Wales. The information kit "It's Not Love, It's Violence" is available to download from this site.

Office for Women's Policy

<http://womenwa.communitydevelopment.wa.gov.au/default.asp>

Part of the Department for Community Development, this site provides information for women on events, projects and community engagement initiatives of the Western Australian state government.

Partnerships Against Domestic Violence

<http://www.padv.dpmc.gov.au/index.htm>

This is an Australia Commonwealth initiative aimed at preventing domestic violence. The website covers many issues including breaking the cycle, protecting those at risk, informing the community and developing good practice. Violence against children, Indigenous family violence, violence in rural areas and violence against women with disabilities are areas of interest.

People 1st Programme

<http://www.people1stprogramme.com.au/index.shtml>

You can view pages about PIP's Western Australian programmes for primary and secondary school children, find information for parents, and on women's health issues; links to articles and publications; even print out a "Helping hand" or find out how you can be a student volunteer.

Western Region Disability Network

<http://www.disabilityconnections.org.au/>

Information and services for people with disabilities in the Western region of Melbourne.

Wholewoman

<http://www.wholewoman.org.au/>

Information for women in Victoria, Australia, including a discussion board, how to use the Internet, local newsletters and publications, and a collection of women's stories and poems.

Women With Disabilities Australia (WWDA)

<http://www.wwda.org.au/>

This site includes links to research, publications for sale, government policies and legislation, and the status of women with disabilities in Australia, WWDA newsletters, poetry and a discussion group. Over 30 publications are available for purchase and online.

The Women's Refuge Group Inc. of WA

<http://www.space.net.au/~wrgofwa/index.htm>

Information on domestic violence issues and the services provided by the 38 refuges in Western Australia.