

# **Making the links**

## **Disabled women and domestic violence**

**Final report**

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**Ravi Thiara, Gill Hague, Pauline Magowan, Researchers**  
**Audrey Mullender, Research Consultant**

## Project note

Note: In this report, the two surveys of domestic violence and disability organisations which were conducted as part of the study are presented in an abbreviated form. They have already been reported fully. The initial project report was published by Women's Aid in 2007, and should be used for a comprehensive discussion of the issues arising.

**The initial project report:** Hague, G., Thiara, R. and McGowan, P. (2007), Making the Links: Disabled Women and Domestic Violence, published at [www.womensaid.org.uk](http://www.womensaid.org.uk), and also at: [www.bris.ac.uk/vawrg](http://www.bris.ac.uk/vawrg) and [www.warwick.ac.uk/shss/swell](http://www.warwick.ac.uk/shss/swell),

**Various papers are also available, for example:**

Hague, G., Thiara, R., Magowan, P. with Mullender, A. (2007) 'Making the Links: Disabled Women and Domestic Violence', *Safe: The domestic abuse quarterly*, 22, summer.

## Chapter 1: Introduction

This is the final report on the first ever national UK study of the needs of disabled women experiencing domestic violence and of the services available to meet these needs. For many years, Women's Aid, together with many disabled women activists and some disability organisations, has recognised the lack in the UK both of national research, and of systematic services and policies, on disability and domestic abuse. In attempting to address this issue, however, it proved very difficult over a long period in the 1990s and 2000s to raise any national funding at all, in either the academic or the policy fields.

After several years of effort, Women's Aid was finally able to secure funding in 2005, through the generous sponsorship of the Big Lottery Fund, to conduct this study on the needs of abused, disabled women, and on the effectiveness of services provided. The Violence Against Women Research Group at the University of Bristol and the Centre for the Study of Safety and Well-being at the University of Warwick were commissioned to conduct the research. Both of these UK research groups work on issues of gender violence within an activist and feminist frame, and attempt, whenever possible, to raise the voices and views of women survivors and their children.

### **1.1 A political issue: the social model versus the medical model**

Ways in which disability is defined and explained are highly contested between the medical model in which disabled people are viewed only in terms of impairments or medical conditions and assumed dependency, and the social model which argues that the problems experienced by disabled people, and disability itself, result from socially disabling attitudes and practices. In other words, disability is socially created. The study reported here embraces this latter model.

The social model acknowledges the existence of impairments that disabled people live with, but a clear distinction is drawn between impairment and disability. As defined by the Union of the Physically Impaired Against Segregation (UPIAS) in the UK, disability is:

The disadvantage or restriction of activity caused by contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities.

UPIAS (1976)

Thus, the theoretical basis of the study is grounded in an understanding that barriers caused by social attitudes to disability, and by a lack of commitment to the issue, have contributed to society's failure to take account of the needs of disabled people. It is this failure that is truly disabling, and not people's individual conditions (UPIAS, 1976; Shakespeare and Watson, 1997; Swain et al, 2004; Corker and Thomas, 2002).

Because of these disabling societal factors, it may be that we need to re-define what we mean by domestic violence in order to understand disabled women's experiences, the contexts in which intimate violence occurs and the behaviour of perpetrators (in both heterosexual and same sex situations), since the range of experiences that women have are likely to be particularly diverse and complex.

#### **a) Which words?**

It should be noted that the use of the term 'people with disabilities' is regarded as poor practice in the UK in the disabled people's movement, and increasingly across the board. However, it is generally, and widely, used in the different activist contexts of North America and Australasia, as can be seen in the non-UK literature referred to in this study. In the UK, 'disabled' is the word of choice – as used, for example, in the term: 'disabled women', rather than 'women with disabilities'.

Learning from the disabled people's movement and from disabled activists in this country, it has become good practice here always to use the term 'disability' in the singular (relating to the impact of a discriminating society, and not as a word to refer to the individual conditions or impairments that people may have).

In this project, we have used these terms throughout.

## 1.2 Aims of the research

The aims of this study were to:

- Develop further understandings of the needs of disabled women experiencing domestic violence.
- Investigate the scope of existing provision and identify what disabled abused women need from this provision.
- Identify gaps in assistance to disabled women experiencing abuse both within disability services and domestic violence services.
- Identify and examine examples of good practice and policy.
- Make recommendations for policy and for service development in the fields of community provision and health and social services to meet these identified needs.

Thus, our study aimed to produce research evidence and key recommendations with the aim of leading to:

- Practical improvements in both disability services and domestic violence services.
- Ideas for good practice in all sectors.
- Recommendations for input into the strategic agenda nationally and locally.

### a) What do we mean by domestic violence and who commits it

Domestic violence is understood in the study according to the definition used by Women's Aid, as follows:

Domestic violence is the physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and forms a pattern of coercive and controlling behaviour. This can include forced marriage and so-called 'honour' crimes.

Domestic violence may include a range of abusive behaviours, not all of which are in themselves inherently 'violent'.

Domestic violence perpetrators are most commonly men and those abused most commonly women, although abuse can also occur both the other way round and in same sex relationships (see Hester et al, 2007).

This research takes a woman-centred and activist approach, grounded in the long-standing and overwhelming evidence of the intimate abuse committed by men against women (Schechter, 1982; Dobash and Dobash, 1992; Hague and Malos, 2005). In the study, we included abuse against women by partners and ex-partners (mainly in heterosexual, but also in lesbian relationships). However, we also included abuse perpetrated by other individuals who have close relationships with disabled women, for instance, personal assistants/carers and family members. The research does not cover abuse that women may experience within institutions. Nevertheless, we recognise that violence also occurs in residential homes and hospitals, where it may be carried out by health, support workers and other professionals.

#### **b) Which women are included?**

The focus of the research is, thus, on the service needs of:

**Disabled women experiencing abuse from partners, ex-partners, other family members, or personal assistants (including paid and informal care workers).**

The study has made a particular effort to include disabled lesbians experiencing abuse and disabled women from black, minority ethnic and refugee (BMER) communities, especially including South Asian and African-Caribbean women.

We have focussed specifically on the experiences of women with physical and sensory impairments, including older women. We strongly recognise that abuse is a major issue for women with learning difficulties and with mental health issues. Unfortunately, we did not have the resources to do full justice to these issues in this research, and they

would require further comprehensive studies<sup>1</sup>. However, we recognise their importance and believe that funding must be raised to conduct further robust and comprehensive research on the needs of women in the UK with learning difficulties or mental health issues in the future. Women's Aid and the research team are committed to this endeavour.

Overall, then, the aim of this national study is to fill a major gap in existing knowledge in the UK by developing further understandings of the needs of abused disabled women; investigating the scope of existing provision in terms of strategic, policy and practice development; and identifying gaps within both domestic violence and disability services. The study draws on a growing view that the voices and perspectives of those who use services, in this case disabled women who have experienced intimate abuse, should inform the evaluation of these services and the development of best practice guidance (e.g. Dullea and Mullender, 1999; Hague, Mullender and Aris, 2003).

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<sup>1</sup> Women's Aid undertook a survey of provision for women experiencing domestic violence who also had mental health and substance use issues in 2002-3, and which included consultations and interviews with a small number of survivors. See Barron, 2004.

## **Chapter 2: What the previous literature tells us**

### **2.1 Overview of previous research: gaps and lacks**

Previous research and research overviews in the domestic violence field in the UK (e.g. Mullender and Hague, 2001) have revealed little in the way of literature on disability and domestic abuse. Even studies that have made a deliberate effort to give a 'voice' to abused women (e.g. Hague et al, 2003), and have consciously attempted to address disability, have not been able to encompass disabled women in any significant numbers, and this lack includes women in both heterosexual (the vast majority) and same sex relationships. The gaps in research mean that little evidence has been available to support service and policy development.

The few existing studies in the UK, though very welcome, have tended to be small. In some research on disabled women's lives, violence has emerged as one theme among several, but specific service needs have been identified (Depoy et al, 2003). Three small-scale studies in the 1990s explored disabled women's experiences of accessing service provision, primarily from service providers' perspectives and found a catalogue of failures and inadequacies in existing provision (see James-Hanman, 1994; Hill, 1995; Macleod and Cosgrove, 1995). Such UK studies have often been locally-based, operating in particular local authorities, for example, the recent local study carried out in the North East of England (Radford et al, 2006).

Internationally, studies and responses in other countries have been, and continue to be, of key importance and provide findings from which researchers, activists and practitioners in the UK can learn (see e.g. Chenoweth, 1997; Nosek and Howland, 1998; Dorian, 2001; Nosek et al, 2001; Garland-Thompson, 2005; Nosek et al, 2007). A EU-funded European study, for example, is currently nearing completion and will provide valuable findings.

Research and activism exploring disabled women's experiences of abuse in North America have been more advanced to date, compared to work (or lack of it) here. US research by Margaret Nosek and various colleagues have been key in this respect (see Nosek et al, 1997).

For example, Young, Nosek et al (1997) conducted nation-wide, large-scale research revealing inadequate service provision coupled with a

higher incidence of domestic abuse experienced by American disabled women, compared with non-disabled women. In a further example, the Canadian organisation of disabled women activists, DAWN, which has a variety of branches in different cities, works to promote the equality rights, inclusion and empowerment of disabled women and girls through education, advocacy, coalition-building and publications (DAWN. 2007), combining research with activist and practical initiatives.

In Australia, the research of Lesley Chenoweth and colleagues has been of importance. They have argued, for example, that disabled women are so devalued that they are 'invisibilised' and perceived as asexual, exposing them to grave risk of emotional, physical and sexual abuse. When such abuse happens, they are then likely to be ignored by both disability and gender violence support systems (Chenoweth, 1997).

In regard to practical responses by agencies in the UK, the small-scale research conducted so far has revealed a distressing lack within relevant agencies, strategic partnerships and inter-agency forums of dedicated service and policy development for disabled women who experience domestic violence (James-Hanman, 1994; Magowan, 2003; Radford, 2006). As a result, many domestic violence practitioners and support organisations have become increasingly aware of difficulties in meeting the needs of women coming to them for assistance. A lack of awareness of domestic violence in many, if not most, disability organisations has also been identified, despite the activities of disabled women activists. The study by Jill Radford and colleagues (Radford et al, 2006) has shown that, while many professionals and survivors of violence hope for greater service development in the future, currently they recognise both individual and agency limitations in making the connections between disability and domestic violence.

Barriers to effective intervention, identified in a variety of studies, include a low take-up of domestic violence services by abused, disabled women and low numbers of women disclosing abuse to disability organisations, failures of awareness-raising campaigns, and fear that services will be unsupportive of women's personal issues and inappropriate places in which to address them (Magowan, 2004; Radford et al, 2006).

Disabled women who do decide to leave home due to violence are likely to have more complex needs, for example for accessible accommodation and transport, assistance with personal care or sign language interpreters, and possibly for specialised emotional support (see Nosek

et al, 1998; 2001). Domestic violence support services may not be able to meet these various needs. Further, because of disabling social attitudes and lack of access or awareness, more general sources of protection used by non-disabled women (such as criminal justice and legal remedies) are often less available to disabled women. Thus they may be forced into the situation of having to endure abuse for longer before seeking help (Magowan, 2004).

The lack of evidence both from research, and from practice or policy responses, is compounded by the fact that previous studies have usually failed to include the experiences of lesbians, and disabled women from BME backgrounds (Vernon, 1997; 1998; Begum, 1992). A recent Australian study (Cockram, 2003) is one of the few that has included as a key component the experiences of women from minority ethnic groups. Margaret Nosek and her colleagues also conducted a recent study of disabled women in Texas, the majority of who were from minority groups (Nosek et al, 2006).

## **2.2 Findings from previous research: Isolation, vulnerability, and issues of power**

The seriousness of the gaps in existing knowledge and services is compounded by the suggestion, in the literature that does exist, that, in general, disabled women have particular reasons to fear violence and abuse, which non-disabled women may not face (Sobsey and Doe, 1991; Sobsey, 1994; Chenoweth, 1997). There may be specific issues of increased power and control over disabled women, especially by non-disabled abusers, multiplying the vulnerability and isolation that they may experience.

Perpetrators often use forms of abuse which make use of, and exploit, a woman's impairment or condition so that the violence experienced is compounded (see Macleod and Cosgrove 1995; Young et al 1995; Magowan 2004). Episodes and experiences of abuse have been found to be intensified among disabled women, and to be experienced over wider contexts and perpetrated by a greater number of significant others (Nosek 1997, Magowan 2004).

Magowan's small scale study, specifically of disabled women's experiences of abuse and the first of its type within the UK, explored how disability and women's increased vulnerability interacted with abusive episodes and relationships to give rise to new types of violence, and to more complex barriers to escape. Data from this study suggests that

more than 50 per cent of disabled women in the UK may have experienced domestic abuse during their lives (Magowan, 2003, 2004). There is also research evidence to suggest that disabled women, regardless of age, sexuality, ethnicity or class, are assaulted or raped at a rate at least twice that for non-disabled women (Disabled Women's Network, 1986; Sobsey and Doe, 1991; Magowan, 2003, 2004).

These findings are backed up by data from a sub-set drawn from the 1999 British Crime Survey (BCS), in which nearly twice as many disabled women were found to have experienced intimate violence compared to non-disabled women (Mirrlees-Black, 1999). The 2006 BCS also showed that having a limiting illness or disability was associated with all types of intimate violence (Jansson, 2007).

Abused disabled women experience additional barriers in situations where they are reliant on their abuser (often their partner) for personal assistance with daily, and perhaps, personal care tasks, making them more vulnerable and unsafe. The issue of control comes to the fore in this extremely painful personal context (Magowan, 2003, 2004). Finding out about support available, being able to access other people for help, and leaving an abusive relationship may be especially problematic for disabled women. There are further difficulties that they may experience in leaving their home if, for example, it has been specially adapted for them with aids and facilities, or if a care package of home-based community care services has been organised (see Cross, 1994; 1999), especially if the abuser was part of setting this up.

Where the woman's abuser is not her partner, there can still be very specific power and control issues. For example, the vulnerability, isolation and dependence which disabled women often experience are exacerbated when a paid personal assistant or carer is the perpetrator (see e.g. Saxton et al, 2001). Power and control issues between perpetrators and disabled women may be further accentuated by the attitudes of society to disability and by institutional and social barriers. Disbelief or voyeurism from agencies, family members and friends may also be a factor (Magowan, 2004).

### **2.3 Developments in service provision and policy**

At the same time as, but usually unrelated to, any formal research, key practical, training, policy and investigative work has been undertaken by

Greater London Action on Disability (GLAD)<sup>2</sup>, Scope, the UK Disabled People's Council (UKDPC, formerly the British Council of Disabled People) and the UK Disability Forum Women's Committee. This Women's Committee previously developed a useful website (with some input from Women's Aid and from disabled women activists and organisations) (see Ellis, 1995; UK Disability Forum, 2008). Disabled women consultants and trainers have also offered training and support services (see e.g. Magowan, 2005). Most of these training and policy developments and innovations, however, have been conducted without formalised research assistance or support. Some organisations have also started to develop good practice in this area – for example, the Leeds Inter-Agency Project (LIAP) (LIAP, 2007).

#### **2.4 Multiple disadvantage: increased risk but fewer services**

Overall, then, disabled women have been found often to experience greater hurt and damage at the hands of abusers, and this is likely to be increased even more if they are frail, ill or immobilised. The more severe impacts of the abuse are also due to the frequently more protracted duration of abusive episodes, attacks and relationships for disabled women (see Magowan, 2004), related to the paucity of appropriate and knowledgeable service provision. This situation can thus set up a vicious circle of abuse in which disabled women may become increasingly 'damaged' by intensified and extended abusive episodes and/or relationships, exacerbated by the lack of available help (Magowan 2004, 2005). Radford et al (2006) further propose the existence of a 'double stigma' and Vernon (1998) suggests 'compounded disadvantage' for disabled women from some minority communities (e.g. for some South Asian women) (see also Vernon and Swain, 2002).

Thus, gaps in services and barriers to effective provision are accompanied by the fact that the needs of abused disabled women in the UK and their isolation and vulnerability to abusers may be more pronounced. These inadequacies in provision apply to all disabled victims of domestic abuse, though lesbians and others experiencing same-sex abuse may be even more isolated and vulnerable.

In other words, in summary, substantially *less provision* than that available proportionally to non-disabled women is accompanied by a *greater need* for such focussed and specialist services. Disabled women

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<sup>2</sup> Not currently in existence.

therefore lose out *on both counts* (James-Hanman, 1994; Magowan 2003, 2004).

## **2.5 Women, disability and inequality**

A number of authors have added to ideas about the social model of disability in terms of women's experiences and gender. It is well documented that women's movements have in the past tended to ignore disabled women (see Fine & Asch, 1988; Chenoweth, 1997). Such analyses have now been further developed by theorists who have developed feminist-derived understandings of the 'embodiment' of women's impairment, compounded by differences in ethnicity, culture, class and sexuality (Crowe, 1996; Morris, 1996; Vernon and Swain, 2002). A recent paper (Mays, 2006) incorporates both disability and feminist theory to develop an explanation in which disabled women identified domestic violence as being a strongly gendered and further disabling experience. The article argues that feminist interpretations and disability theory, with their emphasis on gender relations, 'disablism' and poverty provide, if used together, an effective analytical tool for exploring the nature and consequences of violence against disabled women. On a wider global and post-colonial level, to give just one further example, a recent Special Edition of *Wagadu* (2007), the journal of trans-national women's studies, has developed intersecting gender and disability perspectives about globalisation and trans-national politics in regard to disabled women. These analyses build on intersectional approaches to understanding multiple systems of oppression similar to those developed by black feminists in the late 1980s and early 1990s.

## **Chapter 3: How the study was conducted**

This study was conducted over two and a half years from 2005 to 2008, and utilised a multi-method research strategy. An advisory group of disabled women consultants / activists was established and worked with the researchers throughout. The methodology included two stages.

### **3.1 Stage 1**

Methods included, in the first phase of the study: an initial focus group with disabled women to inform the design of the research; interviews with key professionals and activists in women's and disability organisations; a literature review and a background analysis of policy and legislation; and wide-ranging consultation with disabled abused women. This initial phase of work was followed by two national surveys of:

- a) Local Women's Aid and other domestic violence organisations;  
and
- b) Disabled people's organisations.

### **3.2 Stage 2**

In the second phase of the study, various sets of interviews were conducted. a) In-depth interviews were carried out with disabled women who have experienced violence to investigate their experiences both of abuse and of seeking help from services. b) Examples of good practice were then identified through interviews and case studies with organisations and individuals with particular good practice expertise. c) A further set of interviews was carried out with officers and agencies on the wider strategic framework in which services for disabled women and domestic violence are set.

For full details of the methodology, see the Appendix.

The findings of Stage 1 are reported in Chapters 4, 5 and 6. The findings of Stage 2 are reported in Chapters 7 and 8. Chapters 9, 10 and 11 relate to Stage 2 principally, but also draw on the whole study.

## **Chapter 4: The survey of domestic violence services**

(Please see Project Note on p. 7)

In Stage 1 of the study, two national surveys of services for disabled women experiencing abuse were conducted, one of domestic violence organisations and one of disability services and disabled people's organisations. In the case of the former, a survey was designed piloted and sent, with the help of Women's Aid, to all domestic violence organisations in England (342), offering refuge, outreach, and other forms of support to women experiencing domestic violence. These organisations were identified through Women's Aid lists and UKrefugesonline (which includes all local domestic violence services<sup>3</sup>.) After several follow-ups, the final number of responses numbered 133 and the response rate was almost 40 per cent.

The geographical location of responding organisations was spread throughout England. All of them assisted women and children experiencing domestic violence and some specialised in providing services, for example, for black and minority ethnic (BME) families or specifically for South Asian or African Caribbean women.

### **4.1 Provision and policies in domestic violence organisations**

#### **a) How many disabled women use domestic violence services?**

From available Women's Aid statistics, we were able to address the issue of how many disabled women use domestic violence services. Overall, Women's Aid and specialist domestic violence organisations in the UK offered services of different types to 131,245 women and 95,960 children in England in 2006. Women and children accessing specifically refuge-based services numbered 16,815 and 19,450 respectively. Of these women, extrapolation from the annual Women's Aid Census Day figures<sup>4</sup> revealed that approximately 1,170 were disabled women with physical and sensory impairments in 2006. This is a percentage of 7%.

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<sup>3</sup> All service details in the UKROL database are updated biannually; new services and changes to contacts are updated on an ongoing basis.

<sup>4</sup> Annual figures of disabled women using local domestic violence services can be extrapolated from the day count or 'census' undertaken by Women's Aid in November each year, and published as part of the Women's Aid Annual Survey at [www.womensaid.org.uk](http://www.womensaid.org.uk)

Eighty-seven per cent<sup>5</sup> of the domestic violence organisations surveyed in our study monitored referrals for disabled women coming to them. Seventy per cent routinely asked questions about disability to each woman being referred in order to best assist her. Some, however, did not do so, but said they were led instead (from a position of respect for the woman's autonomy) by what a woman wished to disclose. Others stressed that they offered a universal service open to all women. However, good practice now suggests that monitoring services for numbers of disabled women using them (and explaining to women why this is being done and offering support if required) is the only way to collect accurate information to assess need. Services which did not monitor said that the reasons were limitations on time and the fact that they were already overwhelmed by demands, often with only one or two over-stretched staff members.

### **b) Policies**

Ninety-nine percent of organisations had equal opportunity policies, but only 87% specifically included disability. This represents an anomaly which needs to be addressed, given the introduction of 1995 Disability Discrimination Act (DDA) compliance from September 2005, and the requirement to include disability within such policies. However, encouragingly several services were in the process of developing full disability policies or conducting disability assessment impacts and audits.

### **c) Services for disabled women**

Thirty-eight percent of organisations offered some form of specialist service to disabled women compared to 53% to BME women - a substantially lower figure for disability services, arguably illustrating a substantially lesser commitment. Of those providing services, these were primarily 'structural' (e.g. the provision of accessible accommodation, accessible transport, ramps, handrails, and so on) as opposed to 'attitudinal' (e.g. disability equality training), although some refuges were able to offer specialised emotional support.

It is generally regarded as good practice to offer women using domestic violence services the opportunity to work with a worker who shares their background or heritage, where possible, in order to maximise meaningful and well-informed support. While this does not of course guarantee a good service, it may enable a more understanding one. As regards

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<sup>5</sup> Percentages relate to the 294 refuge organisations giving any information on disabled facilities, and not to the total number of 350 organisations.

access to black and minority women, sixty-eight per cent of projects could offer this. In the case of disabled women, it may be particularly helpful to offer support from a worker who self-identifies as disabled, but the percentage of projects who could provide this was very low by comparison. Only 27% of organisations said that they could offer some form of access to disabled workers, and only three projects appeared actually to have disabled staff in post.

Twenty-seven percent of services made attempts to reach disabled women, through publicity, talks or local partnership working with disability organisations. The reasons given by the remainder for not doing so was also lack of resources.

#### **d) Accessibility**

Ninety-four percent were aware of the 1995 DDA (and the requirement for compliance from 2005) and were making attempts to meet it in terms of the accessibility of their properties. However, 76% stated that they were not yet compliant. Some projects had specially adapted accommodation or facilities, and a few (especially those in new-build properties) offered clear examples of best practice in meeting disabled women's needs, providing fully accessible housing (for example, a whole adapted apartment).

Accessibility also depends on being able to access personal assistance if necessary. Disabled women leaving their home area for a refuge may lose their care packages in doing so and hence their personal assistants (PAs). However, about 13% of refuges could provide, or otherwise access, temporary personal assistants to assist disabled women staying at the project. Several would offer accommodation to an existing PA who was able and willing to accompany a disabled woman to a refuge, although this would be expected to happen only rarely.

There was a wide range of adaptations in use, although most of these were in a minority of projects only. Many respondents did not provide any information at all about adaptations indicating that they probably had none available.

The following table shows the percentage of refuge projects offering different types of facilities to disabled women<sup>6</sup>.

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<sup>6</sup> Data from information collected for UKROL and relates to 294 out of the 350 organisations listed.

**Table 1**

Facility offered	Percentage <sup>3</sup> and number of projects	
Full wheelchair access	49%	n=144
Limited wheelchair access	47%	n=137
Some wheelchair services available	85%	n=250
Ground floor accommodation	60%	n=180
Ground floor services	68%	n=199
Accessible office	60%	n=177
Accessible playroom	46%	n=136
Adapted shower	48%	n=142
Adapted toilet	64%	n=188
Adapted minibus	4.7%	n=14
Alarm system	46%	n=135
Flashing lights / alarm system	12%	n=34
Lift	15%	n=44
Quick and ready fire exit	27%	n=80
Reachable light switches	53%	n=156
Reachable telephone	17%	n=49
Reachable electric sockets	52%	n=153
Services for visual impairment	17%	n=49

As these figures are all self-reported, they have the usual limitations of self-reported data. Therefore, it is not possible to estimate how comprehensive the facilities were in each project, and how effective they were in making it possible for disabled women to use the premises.

It was clear that, while there is still a long way to go and accessibility remains a severe problem in many local areas for disabled women seeking refuge, Women's Aid and other domestic violence organisations have improved their services in recent years, and effort and resources have been devoted to improving facilities.

#### **4.2 Attitudes and disability equality training**

Awareness, attitudes and understanding of disability and domestic violence were assessed by looking at the knowledge and attitudes displayed in the discursive parts of the survey, and at ways in which domestic violence organisations utilised disability equality training, and employed, engaged with, and learned from disabled women.

A fair number of survey responses indicated considerable awareness of the issues and understanding of disabled women's experiences of domestic violence. Several projects spoke movingly of the support they offered, the isolation and vulnerability of abused disabled women that they addressed, and the way that their counselling and support services attempted to meet the needs of traumatised disabled abuse survivors. A few had clearly taken on the issue in a whole-hearted way and were refreshing examples of good practice. Encouragingly, four organisations were employing specialist disability workers to advise on disability issues.

On the other hand, awareness of disability issues appeared to be low in the majority of organisations. While some structural changes had clearly taken place, as discussed above, this was far less clear in terms of attitudes - which, of course, underpin the impetus behind social and organisational change. It was clear that, in many cases, there were no measures in place to improve attitudes or knowledge. A number of responses indicated a lack of clear commitment to the issue, or of attempts to reach disabled women and involve them in the service.

Overall, the language used by many responding to the survey displayed a lack of awareness of disability issues, and unfamiliarity with the dynamics and implications of the social model.

However, fifty-nine per cent of projects did provide disability equality training, usually as part of core training. Agencies had accessed training of varying lengths (with 41% for a full day, 47% for only half a day, and 7% less than two hours). The training was also provided from a wide range of sources, sometimes of variable quality, despite attempts by Women's Aid to ensure good practice. The majority believed that such training would be best delivered by a disabled woman.

The overall recommendations from the surveys are that all organisations should offer good quality disability equality training and that it should be provided by respected organisations with expertise in this area, and preferably by disabled women. More guidance and direction from Women's Aid nationally was identified as desirable.

### **4.3 Gaps in services**

Overall across the country, domestic violence services for disabled women were patchy and sometimes minimal, very often despite the best of intentions. Responding service organisations identified problems that were difficult to deal with in accommodating and/or providing services for disabled women, including awkward stairs in properties; problematic old buildings; building regulation constraints; inaccessible rooms; no disability access/adaptations at all in some cases; no funding to improve properties; and widespread inability to comply properly with DDA accessibility regulations, often also due to absence of resources. Many organisations also interpreted disability access narrowly, solely in terms of wheelchair access. It should be noted that many domestic violence organisations do not own their own properties, and hence are reliant on other organisations to provide and modify the buildings in which their services operate.

A number of respondents articulated the need for, and lack of, thorough disability equality training within their organisations. They were often unsure as to how to address disability requirements, in terms both of practical issues, and of language and attitudes.

In general, the survey concluded that, until a wider and embedded shift regarding disability occurs at management level, as well as among front line workers, domestic violence services for disabled women are likely to remain inadequate, and gaps in provision unfilled.

The majority of specialist domestic violence organisations were able to liaise with disability organisations when required, although few had more

developed partnerships in place which they could draw on. Some organisations pointed out that they tended to find that disability organisations were not concerned with the issue or able to provide the type of inter-agency partnership that good practice requires.

#### **4.4 What organisations said they needed**

Interviewees identified a range of general needs for:

- More accessible refuge accommodation and other safe housing for disabled women so that abused, disabled women know there is somewhere to escape to.
- More outreach services
- Better publicity and advertising to improve the information available.
- More awareness of disabled women's needs in domestic violence services across the board, and the development of a deeper understanding of the impact of abuse on disabled women's lives.
- Clear and fully developed disability policies.
- Better partnership with disability organisations.
- Increased and high quality disability equality training across the board.

The main difficulty identified was lack of resources and funding, with projects often already stretched to the limit. There may be further funding difficulties for some domestic violence organisations in the future, as discussed in Chapter 10. However, on a general level, most organisations surveyed appeared not to have interacted with, taken advice from or otherwise involved disabled women in their work, inviting the question as to whether a lack of services leads to lack of disabled women coming forward which leads to a lack of services, and so on.

The study identified a need for attention to the needs of disabled women to be embedded at both operational and management levels as a core issue in domestic violence services in order to build on the good work already conducted in some projects.

## **Chapter 5: The survey of disability organisations**

(See Project Note on p.7)

In Stage 1 of our study, a survey of organisations of disabled people and other disability agencies in England was conducted, simultaneously with the domestic violence survey reported in the last chapter. By drawing on lists compiled by the UK Disabled People's Council and other national and local organisations, surveys were sent out to 348 disability organisations (of which 26 had to close during the survey process). After very lengthy follow-up, a total of 126 responses were received, giving a response rate of 39 per cent. However, 53 of these said simply that they did no work in this area, so substantive responses were received from only 73 organisations.

### **5.1 Provision and policies in disability organisations**

#### **a) How many disabled women experiencing domestic violence approached disability organisations?**

While domestic violence would not be directly relevant to the work of some disability organisations (e.g. those not offering advice or other relevant services or with a different and specific work brief), for most it is likely to be. All of them might be expected to have contact with disabled women experiencing domestic violence<sup>7</sup>. Therefore, offering basic information and referral to specialist domestic abuse services, monitoring and having domestic violence policies in place could be expected.

The majority of responding organisations of disabled people monitored general take-up of their services but, in the main, they did not specifically ask users of their services about domestic violence. Thus, it appeared in the study that very few abused women were approaching disability organisations for support.

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<sup>7</sup> Even those organisations that do not offer information and support (on any issue) are likely to have – a) employees and/or volunteers who may have experienced domestic violence; b) contact with others – e.g. through political campaigning, lobbying, etc - who may have experienced domestic violence. (It is, for example, recognised good practice for all businesses and other organisations to have domestic violence policies in relation to their staff – in the same way as disability should be included either in a separate disability policy (preferable) or explicitly recognised in their equal opportunities/diversity policies.)

Only four organisations monitored systematically for domestic violence and conducted routine inquiry about it, reporting a range of between one to eight women supported in the last year.

### **b) Policies**

Very few disability organisations that conducted relevant work had domestic violence policies. The main reasons given for this included lack of staff and funding capacity, and for some domestic violence being regarded as 'not appropriate' or as a necessary work focus. In some cases, dealing with domestic abuse was seen as part of wider vulnerable adults' policies, or was something that was automatically signposted to specialist agencies.

Only five per cent of disability organisations had domestic violence policies. All of these had been asked for help. This suggests either that, if an organisation has been approached for assistance with domestic violence, it is likely to view the issue as of increased importance and therefore to develop a policy, or that, if an organisation has a domestic violence policy already in place, then it is more likely to be approached for help. If the domestic violence policy includes routine enquiry, then this in itself is likely to highlight the issue and encourage women to approach the organisation for help and support

### **c. Provision for disabled women experiencing domestic violence**

Over three-quarters of responding organisations said that they had no provision at all for responding to disabled women experiencing abuse. Just 12 projects (10%) reported that they did offer such specialist provision which included, variously, basic advice and counselling, emergency/crisis care, outreach, and in some cases, housing services, referrals, signposting and a wider hate crimes advocacy service. None were able to provide longer-term support. Indeed, when approached for help, the majority of organisations referred abused women on. Only four disability organisations employed dedicated staff with domestic violence expertise.

## **5.2 Specialist domestic violence training and liaison with other organisations**

Only seven responding organisations (6%) had offered specialist domestic violence training to a range of staff and volunteers. The need for staff and management to undertake domestic violence training and to take on the issue was identified by the study as an issue for attention.

Just under a third of respondents liaised with other groups, when necessary, regarding disabled women experiencing domestic violence. Among the organisations mentioned as liaison partners were local Women's Aid and women's refuge organisations, domestic violence forums, housing associations and social services.

The majority of responding organisations were not members of their local domestic violence forums, with only three reporting that they were, and many not knowing that they existed.

### **5.3 Gaps in services**

Our survey clearly illustrated that very few disabled women are accessing support from organisations of disabled people for help with domestic violence issues. The relative lack of awareness about domestic abuse, as well as the lack of resources among disability services, meant that staff were not routinely asking about it and would often have been unable to deal with it if it had been disclosed; and consequently abused women would be unlikely to feel confident about disclosing their experiences.

Domestic violence was an issue that had not been addressed by many disability organisations, and was not regarded as a priority area of work or as something that was part of their remit. The large number of organisations which chose not to respond to the survey, or which said they did no work in this area, could perhaps be assumed to hold similar views.

Several organisations demonstrated little awareness of gender issues in general, or of violence against women as a specific matter of concern. Some had only male advocates, or only male staff altogether, and might therefore have been unlikely to be able to respond adequately to domestic violence.

Further, there was minimal domestic violence training, and this lack of training was linked to organisations not asking disabled women who were referred about abuse, so that the issue was effectively sidelined. There was also a general lack of relevant information about domestic abuse among staff in disabled people's organisations, and many of them were unaware of how to access or refer to specialist domestic violence services (including accessible refuge places). Several said that domestic violence did not come up in their work at all.

A minority of disability organisations stated there was no gap in their services as they always signposted to specialist domestic violence organisations and considered them the appropriate agencies for dealing with the issue. Several respondents, however, highlighted gaps and difficulties outside their own facilities that they experienced in terms of a lack of accessible refuges or domestic violence outreach services. These gaps in provision resulted, in their view, in greater dependence of disabled women on perpetrators and a lack of information about sources of help/advice. Inadequate care packages also tended to lead to women entering into dependent relationships, seen to be exacerbated further if they had dependent children.

#### **5.4 What organisations said they needed**

Generally, organisations of disabled people have to cover a very wide range of issues and are not single-issue agencies. They may also have extremely limited resources (or none whatsoever), making it very difficult for them to address domestic violence. As discussed above, they were likely (as far as could be judged from the results of the survey) to view domestic violence as not their business or – at best -- just one among a wide range of work areas.

The very few organisations that were embracing the issue felt that disabled people's organisations need to develop an improved awareness of domestic violence, to build links with existing domestic violence services, and to have the resources to recruit dedicated staff who could work on the issue. Training, information, financial resources, better multi-agency work and specialist posts were the principal areas of need identified. Respondents also stated that domestic violence organisations should develop more awareness of different types of impairments and of disability issues, and deeper understandings of the potential vulnerability and isolation that disabled women experience.

Given the small numbers involved in this survey, further research is needed to establish how widespread the issues raised are. However, the following needs were identified:

- More information available to disabled women about sources of help and advice in relation to domestic violence. Lack of information leaves disabled women vulnerable to abuse.

- Attention to abuse perpetrated by PAs, other carers and family members, issues which have been widely neglected.
- Many more accessible refuges, taking accessibility in its widest sense. The lack of such refuge spaces severely limits the options available for abused disabled women and was a specifically stated concern for most of the disability organisations concerned.

Also identified by respondents were the difficulties of having to move areas to escape violence because this may mean that women lose their care packages and PAs, and then have to start again to get a new package set up, making this a very difficult option. Direct payments may also have impacted negatively on some women, although for others they can result in them having greater control over their lives. It was suggested that further protocols should be developed with the Independent Living Fund and in terms of the new developments in the self-directed support agenda (which is expanding the direct payments system) to ensure that abused disabled women are indeed in independent control of payments made to them (in order to counteract dependence), but are provided with adequate professional support should difficulties arise.

## **Chapter 6: Summary and discussion of the surveys**

The shortage of resources in both the disability and the domestic violence sectors identified by the surveys means that disabled women are less likely than non-disabled women to access support and help when they need it, and this is likely to also play into fears of institutionalisation, if domestic violence is disclosed. Disabled women facing intimate violence are therefore placed in a distressing, desperate, and possibly life-threatening situation because of lack of services, limited means of escape, and insufficient information as to the options available.

### **6.1 Domestic violence organisations**

Our findings from both the surveys include the clearly evidenced need for more accessible domestic violence refuge and outreach services for disabled women, with increased facilities and adaptations. Women's Aid and other domestic violence organisations are attempting to take on the issue of disability and domestic abuse, and are making welcome attempts to ensure that services are indeed adapted and accessible. The present study is part of that initiative. However, provision remains very uneven across the country, and many domestic violence organisations have no facilities for disabled women at all.

A few domestic violence organisations have fully adapted premises, for example, a specialist bungalow (in one case), while others have made some modifications -- and some have nothing. It should be noted that, as well as such fully adapted refuge and outreach space, there is also a need for small-scale non-fixed adaptations, which might not be too costly to purchase for organisations on tight budgets, but which might make all the difference for disabled women using the service.

However, the major issue identified was lack of both resources and staff, so that taking on disability could be beyond the capability of the domestic violence organisation in question, in their own view. Many had only one or two staff and were already over-worked and over-stretched. Maintaining funding for even a very basic service was often as much as they could do. This situation may be made much worse by current funding initiatives, as noted above, and discussed in more detail in Chapter 10.

While structural changes had clearly taken place in some organisations, our survey also found that knowledge and attitudes have not always

developed to the same extent. More awareness of disabled women's needs and a deeper understanding of the impact of abuse on disabled women's lives, were needed in many domestic abuse projects, including an awareness of the social model of disability and of appropriate language. Organisations needed to know how to integrate services for disabled women into more 'mainstream' domestic violence provision, and how to take on disabled women's needs as an integral part of work done.

Several domestic violence organisations identified the need for a 'sea change' or a 'cultural shift' in attitudes to disability, so that attention to the issue is built into all service development and budgets. This would include clear and fully developed disability policies and increased, high quality disability equality training across the board. The findings of the surveys are that specific attempts to reach involve and provide for disabled women experiencing violence need to be prioritised and embedded in a systematic way, both in the operation of Women's Aid and other local domestic violence services in the UK and in their strategic management. Best practice would be for this to be done with the full involvement of disabled women themselves.

More guidance and direction from Women's Aid nationally was identified as potentially helpful in this respect. Building on recommendations such as these, policy and training development with support from Women's Aid on a coordinated and national basis in the UK could then be expected to lead to the required 'culture change' around making services for disabled women a core issue for domestic violence provision.

## **6. 2 Disability organisations**

Due often to lack of awareness, knowledge and resources, there was a serious lack of domestic violence services in disability organisations. Not knowing about domestic violence, and in particular the extent to which disabled women experience it, led to fewer services and vice versa. The study found that disability organisations were rarely aware of the issue or able to provide any kind of domestic violence service to disabled women who approached them for help; or, if they did, they almost never prioritised these services at either an operational or management level.

In general, they had a very wide range of issues to deal with across the entire field of disability, and often did not consider domestic violence to be an issue with which they should be concerned. However, given the number of disabled women who experience abuse, this could be viewed

as a substantial omission. Some demonstrated no awareness at all of gender issues.

Overall, the survey indicated a severe lack of resources in disabled people's organisations. However, our findings also indicate a clear need for such organisations to take on domestic violence whenever they can as a fundamental issue of management and operational concern, with some dedicated resources, if at all possible. It must be understood, however, that many disability organisations do not have any funding at all.

Thus, the study recommends that, wherever it is possible to do so, disabled organisations (where relevant to their brief) need to start to monitor for domestic violence and to develop relevant services, in tandem with Women's Aid and other local domestic violence specialists. These would be expected to include focussed advocacy services and support, specialist worker posts where needed, and the development of domestic violence policies. Most importantly, dedicated domestic violence training needs to be put in place to start the process.

### **6.3 Partnership between the sectors**

Better partnership between domestic violence and disability organisations was viewed as vital, and both sectors have a responsibility to develop this using formal and informal channels. Partnership work, importantly, often enables learning from and taking leadership from disabled women and (for both domestic violence and disability services) from specific organisations of disabled women, generally identified as good practice. However, the present lack of such partnership invites the question as to whether a self-fulfilling prophecy is set in place, in that lack of services in both fields leads to lack of disabled women coming forward, which leads to lack of services, and so on.

Overall, despite the best of intentions, good practice was patchy within both the disability and the domestic violence sectors, which still work largely in isolation from each other. The distressing picture remains that the needs of abused, disabled women are only able to be very partially and inadequately fulfilled.

## Chapter 7: Disabled women's experiences

Throughout the following chapters, the voices of disabled women research respondents are directly used as much as possible. All quotes refer to anonymised women interviewees

### 7.1 The women we interviewed

In Stage 2 of the study, in-depth interviews were conducted with a total of 30 disabled women. By drawing on data collated through these interviews, this section presents an overview of who the participating women were.

It was difficult to locate abused disabled women who wished to be interviewed. After extensive and lengthy publicity about the research project – through websites, email lists, flyers, contact with disability organisations and domestic violence services, individual phone calls, articles and call for interviews – women interviewees were drawn from various settings. Some were informed about the research through existing support networks that they were accessing and made contact themselves. Others were told about the research and asked support workers to make the contact for them. A number of women had seen the publicity and made the contact independently. Some were recommended through 'snowballing', whilst still others were approached by organisations and support workers at the request of the researchers.

#### a) Age

As can be seen from the table below, almost half of the interviewed women were aged between 41 and 50, and the majority fell in the age group 31 to 50 (n=19). Eight were older women and two of these were aged between 61 and 70.

Age	No.	%
20-30	3	10
F31-40	5	16.7
41-50	14	46.7
51-60	6	20
61-70	2	6.7

### **b) Sexuality**

Of the total of women interviewed, 27 were heterosexual women, two were lesbian women and one said she was bi-sexual.

### **c) Ethnicity**

Despite attempts to include a diverse group, the majority of women interviewed were white British (n=20), the remainder having a range of different black and minority ethnic (BME) backgrounds.

<b>Ethnicity (self defined)</b>	<b>No.</b>	<b>%</b>
White British	20	66
White Irish	1	3.3
South Asian	3	10
African Caribbean	2	6.7
Mixed Heritage	1	3.3
Turkish	1	3.3
Greek	1	3.3
Irish/Lithuanian	1	3.3

### **d) Housing**

The largest group of women lived in council accommodation which had been adapted for their needs (n=12).

<b>Type of housing</b>	<b>No.</b>	<b>%</b>
Owner occupier	6	20
Private rented	4	13.3
Council	12	40
Housing Association	3	10
Sheltered	3	10
With parents	2	6.7

### **e) Children**

Nineteen women had children (for 6 the children were grown up) and 11 women had no children.

### **f) Range of impairments that women had**

Women reported a range of impairments, as outlined below in the words they used, with some having multiple impairments:

Degenerative Ataxia (1)
Multiple Sclerosis (2)
Spina Bifida (3)
Hearing impaired (3) – 2 of these women also had speech impairments
Skeletal Dysplasia (1)
Severe Rheumatoid Arthritis (3) – 1 of these also had hearing loss
Brain haemorrhage leading to physical impairment (1)
Visual impairment (2) – 1 of these woman also had hearing impairments
Spinal Muscular Dystrophy (1)
Brittle bone disease (1)
Crumbling discs (1)
Blind (1)
Wheelchair users (4 - no further details offered)
Lost use of limb (1)
Osteoporosis (1)
Mobility problems and impairment (3) including additionally Crohn's disease for one of these women.
Speech impairment (1)

## 7.2 Women's Experiences of Abuse

Women's experiences of abuse were as follows:

### a) Perpetrators

The perpetrators of abuse against disabled women in our research were varied and multiple (with some women being abused by more than one partner) as follows:

Intimate male partners	25
Intimate female partners -	2
PAs	3
Other family members including children, in-laws and siblings	5

Thus, perpetrators ranged from intimate partners (heterosexual in the main, but including same sex relationships) to personal assistants, care agencies and family members.

Some women, especially those who had high dependency needs, had experienced abuse from more than one abuser, and the abuse had been perpetrated by PAs, care agencies, parents, siblings and by intimate partners, and, in some cases, by adult children. Some of the women had had more than partner who had been abusive.

Because of dominant perceptions about disabled people and especially disabled women, intimate partners had often constructed themselves as the ones having a difficult time, because they had to perform all the caring responsibilities. They tended to gain the sympathy of others, even though they themselves had on occasion got rid of PAs who had previously offered assistance – *‘if you isolate somebody who needs a lot of personal assistance, you’re going to be the one who has to do it or not do it and then it’s made out it’s hard on them cos’ they always have to do it all’.*

### **b) Period of abuse**

The time period over which the abuse was experienced tended to be fairly long, ranging from 1 to 22 years. For severely disabled women who were dependent on care, the experience had sometimes been life-long, until the recent past:

*“Severely disabled women are often quite abused anyway throughout their lives. And it’s not obvious abuse, it’s not violence particularly, it’s kind of sometimes quite manipulative and that...because you have to receive care you’re quite passive and people can abuse that very easily. It’s a very easy thing to abuse.”*

This was also the case for those women who had experienced multiple abuse from a range of individuals and agencies.

### **c) Types of abuse**

Overall, 17 women had experienced physical, sexual and emotional abuse, 10 women had experienced physical and emotional abuse, and three had experienced emotional abuse only. Sexual violence was commonly reported. Women’s impairments had very frequently been used as part of the abuse and, in most cases; humiliation and belittling were an integral part of the verbal and emotional abuse experienced, as discussed later. Some of the abuse the women experienced is listed below, as they described it.

#### **Physical abuse** included:

Being pushed down stairs

Forced onto the stairs or floor and left there, unable to move

Thrown across room

Jammed down onto wooden edge of chair

Wheelchair moved out of reach

Pushed over as she was getting into her wheelchair

Stabbing

Strangulation

Dragged along by her hair

Having a hand placed on her mouth so she could not breathe while her head was banged repeatedly on floor

Special equipment being thrown across room and cut up

Holding down and stamping on her body

Kicking her when she was on the floor

Petrol bombs or bricks through windows

**Sexual abuse** – from partners, fathers or other male relatives – included:

Rape and sexual assaults (sometimes in front of children, and sometimes several times a day)

Held down on the floor to have sex

Forced sex when she was in pain, bruised, or when bones had been broken.

**Emotional abuse** included:

Isolation from other people: keeping them away, preventing her from going out, or getting any help

Taking (or threatening to take) the children away

Turning the children against her: for example, saying 'look at her, how pathetic she is,' etc.

Intrusion into every aspect of life, leaving her no privacy

Domination and control of everything she did

Humiliation, e.g. saying 'you're no good', belittling her or calling her insulting names

Made fun of her or ridiculing her for being disabled

**Financial abuse** included:

Stealing her money

Taking control of her finances

Denying money for housekeeping or other essentials

Not paying for necessary prescriptions

Some of the effects of this abuse included: bruising, broken bones, loss of use of limbs, miscarriage, ongoing damage to eyes and hearing, and permanent disfigurement.

### 7.3 Being disabled and the domestic violence experienced

*“I think that the domestic violence thing in a way kind of misleads disabled women because you always think of a man and a woman married or in a partnership. He hits her. But actually it’s far more complex than that...it’s big, it’s so big and I think it’s uncomfortable for non-disabled people to face up to.”*

A number of the women whom we interviewed questioned prevailing definitions of domestic violence/abuse, as they saw it as being far more pervasive and wide-ranging than intimate partner violence of non-disabled women.

Some of the points raised about vulnerability to abuse and being trapped in abusive situations included:

- Not being able to escape.
- Not being able to move after attack.
- Not being able to see or hear an attack coming.
- Lack of training and jobs so you could not be independent in the way you would be if not disabled.
- Perpetrators using the impairment to make the abuse worse.
- Being disabled encouraging the perpetrators to think they could abuse in the first place.
- Humiliation and verbal abuse especially regarding being disabled making the experience even worse.

Every one of the women interviewed stated that being disabled affected the abuse and made it worse, and that the experience of domestic violence is different for disabled women. It was evident that it was extremely, and distressingly, common for abusers to use the woman’s impairment to perpetuate various kinds of abuse, often including insults about the woman’s condition and ridicule. The following quotes from women’s narratives speak for themselves. (All quotations are from disabled women whom we interviewed unless otherwise stated).

## **Women's Stories**

*“At night times, he'd be in the living room and I'd be in my bedroom and he'd shut the door on me so I couldn't call him for anything, so he wouldn't hear me. And if I wanted to like use the toilet or anything he'd tell me to just piss myself there and then. Now obviously for me if I was non-disabled I'd be able to get up and do it. I'd be able to find some way of doing that. I'd get up and use the toilet. I wouldn't have to rely on him. I could get up and open the door. It was awful.....obviously it got worse because I wouldn't do any sexual things as well, intimate with him at all. That was my only weapon really.”*

*“There was slapping on the face, chucking me out of the wheelchair. And he grabbed me round the neck. He did slam me into my food a few times.”*

*“Or one time he got so jealous when he was picking me up from a respite place because one of the carers that worked at the respite place gave me a kiss on the cheek goodbye. All the way home from (..) to here he thumped my leg all the time and my arm, as well as shouting at me all the time, telling me he was going to take me back to my Mum's house.”*

*“One time, he actually took the battery out of this wheelchair I'm in now. He just unplugged it so I couldn't move and if it wasn't for a mutual friend that came to the house he wouldn't have plugged it back in. And I don't know how long I'd have been staying there with a dead battery. There was no one else that was supposed to be going round to the house.....He'd make me wait for help or he'd tut a lot or he'll say 'Oh god you have to do it again, Oh come on then, get it over and done with'. And shove me about sometimes and push me hard...”*

*“He was drinking and getting worse and worse, I had a motability car, he would take it and disappear for days on end with it, leaving me stranded in the house, unable to get the shopping etc. But you don't say anything as a disabled woman, I felt so ashamed that this was happening, so I didn't tell anyone, didn't ask anyone for help. I'd just be stranded. Most able-bodied women could get out of the house or drive your own car, if you are disabled you might not be able to, I couldn't”.*

*“What he liked to do was to hold the chair down just as I was trying to move in it somewhere — with his hands on here like this so I couldn’t move -- or, this is a great one, move it away just at the very moment I was shifting myself into it...”*

*“Oh yes, he would drag me along the floor because I couldn’t walk or get away that was how it would start, the way it always went. He’d insult me with all those names, ‘you spassy’ and so on, who’d want to marry you. And he smashed me against the wall, shouting insults, ‘you cripple’, all that sort of thing.”*

*“Once he threw me on the floor with my dinner and said ‘that’s where you eat your dinner, that’s where you belong’.”*

As the above selection of quotations highlights, women repeatedly spoke about the complexity of abuse. For example, interviewees who had developed their impairment after being in the relationship reported specific and particular emotional difficulties. Where the impairment had become more severe, the abuse had often increased as the impairment/condition itself worsened.

Some of the women interviewed stated they had not realised they were experiencing abuse, often because it started some time after they had been in the relationship and built up gradually, so that they had not recognised it until it escalated, became very physical and pervaded various aspects of their lives, or until after separation.

*“I didn’t really get the abuse to begin with, I got it afterwards. When I thought about it, after leaving him and everything, I got it afterwards and then I thought that’s abuse in a way. It’s all like shouting at me or just pushing me into doing things or telling me off. And that was the first abuse. Later on is when the physical abuse came in.”*

At the other end of the spectrum, tragically, some women in the study who had high dependency needs reported daily, pervasive abuse, described as ‘non-stop’ which had gone on, unchecked, throughout large sections of their lives and certainly since becoming dependent on others

for care. Such life-long abuse was perceived as not always acknowledged by professionals.

### **a) Sexual abuse**

Sexual abuse was a recurring theme, and appeared to be more common (proportionally) than for non-disabled women. Many of the women who we interviewed spoke about being sexually violated by the perpetrators. This included repeated rape, forced sex while being pinned down, and demands for sex in return for the provision of care. Sometimes, more than one perpetrator had been involved. Women who reported sexual abuse as part of a range of violence experienced had sometimes also been sexually abused by fathers, and then later by partners. A number of them had not disclosed this to anybody previously until the interview. Disclosing was part of a long process of beginning to deal with what had happened to them.

Interviewees who had to maintain intimate relationships with their abusers who had sexually violated them spoke about the strain this had on them:

*“Yes I am exhausted, absolutely exhausted, shattered. And being Deaf is hard work you know, you have to concentrate so much harder and tiring, tiring has to lip-read all the time. And as well as having two small children and having to go to work and in the evenings I’d be exhausted. And he’d be furious and slap me and kick me awake. And he used to like: ‘Don’t you fall asleep on me; I want a wife, a real wife not an old woman’. And you know it was sex all the time, twice a day and he would shout at me and then hold me down and I hated it, I hated it.”*

### **b) When the abuser is the main carer: neglect, isolation and intense vulnerability to abuse**

These various difficulties were especially acute where the abusive partner was also the carer, which compounded abusive experiences, and often made it impossible for the woman to get help.

As highlighted earlier, our interviewees spoke about a range of abuse – financial, emotional, psychological, physical, and sexual and neglect. Neglect was a strong feature of abusive situations for many women when being looked after by family members and partners:

*“He would use me being disabled. I felt useless because he wouldn’t do anything for me and I’d be stuck. He would watch me get worse. I had a two-burner cooker on a trolley, he chucked it across the room and broke it up and then said ‘now you try cooking something’.... “*

Isolating a disabled woman from other external carers had the effect of multiplying neglect, and appeared to be a direct strategy of abuse adopted by some abusive partners.

*“I suppose you don’t even recognise it to start with. And I lived here with two of my live-in PAs. And then we got together and I think even then right at the beginning of our relationship, she was actually quite abusive. I just didn’t really notice it. And at the time you think ‘Oh never mind’, you just kind of skim over it and don’t think about it. ... And then there was a big fight between her and my two PAs that lived in at the time and they decided to leave.”*

*“And then [partner’s name] and me were on our own and I think that was kind of what she wanted really, the situation that she wanted. So she had free access to my bank account. She had free access to my van. And it’s really weird because one of the times I was sitting on the loo and I called her because I wanted to get off the loo. She came in and she said ‘well now that the PAs have gone I’m not going to be running around after you. So you’ll have to wait’. So she would like leave me in situations like that quite regularly.”*

Isolating strategies often had the effect of leaving the abused woman with little energy to maintain other interactions:

*“You kind of don’t want to see them any more and they phone and you don’t phone them back. And you become more and more isolated and almost stuck in the situation.”*

The women’s narratives illustrate the intense vulnerability to, and dependence they often had on, their abusive partners/others for everyday tasks, the resulting isolation, and not being able to leave, especially in the face of limited or no support services and lack of opportunities:

*“Because I can’t feed myself and often he would go out in the evenings and I wouldn’t have eaten anything for a twenty-four hour period or more. So that wouldn’t have happened to anybody that could feed themselves. And it’s much easier to hurt me you know. I’ve got weak bones, I’ve got weak muscles.”*

*“You know the same opportunities are not there for Deaf (or disabled) people. We’re forced to become dependent to a certain extent because the facilities aren’t there. You don’t want to add to it. You know that awful dependence through no fault of your own you know because the opportunities are just not there. You don’t have the educational opportunities that other people have and training and job opportunities.”*

### **c) Financial abuse by abusers who are carers**

Financial abuse included abusive partners taking over control of a woman’s finances, or using her personal allowances and payments. Some of our research respondents had been subjected to severe financial abuse, even where their husbands were well-connected professionals.

Women were often made to feel they contributed little to the household and were not given money they needed: *“I wasn’t allowed any food for the children. I had to take that from child allowance”*. As part of this abuse, several women were denied money for their prescriptions and for essential personal needs related to their impairment. For a few of our interviewees who were highly dependent, abusers had gained total control over their finances, at times using the money to fund alcohol and/or drug dependency.

Where family members were carers, disabled women were often remonstrated for not doing enough, and not pulling their weight. For one woman, becoming disabled had led to her husband and his family conspiring, in her own words, *“to get rid of me”*, after she could no longer work:

*“He and the whole family caused arguments. They threw me out one December. When I fell ill, they blamed me because they wanted me to go to work and get money.”*

**d) Being physically dependent, not believed and meant to be grateful**

When abusers were also carers, the abuse was often linked in with the caring and used to exert greater power and control, a situation that made it very difficult for women to name abuse and to do anything about it - and one in which agencies were sometimes collusive: *"It was easy for him. I noticed through social services that they left me alone because he was around"*. Interviewees explained how hard it had been to seek help when dependent physically on the perpetrator.

*"It's like...your heart goes out to your partner because they are doing all your care work. And I do appreciate that... because some of it's quite physical and some of it's hard work. But also this was their home, and also I was the money as well. And to end all of that for one person, it sounds really awful. Can I kick them out of the house, make them lose everything? So it's really harsh..."*

*"That time the neighbour banged on the door and said leave her alone. But later it was even worse; he dragged me along by my hair. Once he threw me downstairs."*

*"I could walk a little then, holding on to things, he would kick them out from under me so I was staggering, I'd be crying, he'd be swearing and shouting, he'd put his hand over my mouth so I couldn't be heard and hold me down. I couldn't breathe and then he would bang my head on the floor...Then he would leave saying he'd kill me otherwise and when he came back he would cry and cry, please forgive me, you're the only one that can help me and I would feel that I could help him."*

Given the dominant view of disabled women and intimate relationships, a number of the women said they were made to feel, and indeed often felt, that they were undeserving of a relationship and should be grateful *"for somebody there to look after me although he didn't always do"*.

*"And for some disabled women, not me but for some, there's a feeling that to put up with you, your partner must be a saint for putting up with them you know, so you kind of deserve it."*

*"People pity him because he is taking care of you and so noble. So people are reluctant to criticise this saint or to think he could be doing these terrible things. And possibly as well as that there's a*

*sort of I think an idea ... people don't really 'see' disabled women. And people don't easily see a disabled woman as a wife, partner, and mother. So I think for some people it's hard to think well this might be a woman who's being sexually or physically abused by her partner, ... because disabled women don't have sex, do they?"*

Women who were in same sex relationships were often disbelieved:

*"Because you can't run away from it. It's not like I could have gone to a safe house or anything like that. Don't have hoists. They wouldn't understand the PA system. You know the whole system just wouldn't work. And as well it was a woman abusing me. Which people don't really see as abuse... people still laugh if I say 'Oh yeah she was really abusive'."*

#### **e) Reinforcing control and dependency**

Sometimes the abuser deliberately emphasised/reinforced the woman's dependence as a way of asserting and maintaining control.

##### **Perpetrators asserting control**

*"He was the one that charged up the wheelchair. If he didn't charge it, it turned off and if he didn't charge up the wheelchair, I couldn't move. Or he didn't help me in the hoist and get me into the chair. I thought I was completely reliant on him...But I mean it was like he was making me think I needed him here all the time. But as you see now I'm here by myself. I'm living here with my dog. I have home care coming in but I don't have anyone here all the time. But I'm better now and I think he was dragging me down. I think he was definitely dragging me down."*

*"Being disabled, well it just dominated it, the way he was able to treat me because of it like.... But he would go round and close the windows so the neighbours couldn't hear, he would take the phone, and throw it out of my reach, grab my hair and drag me because he knew I couldn't do anything about it. And then plonk me on the stairs where I would be stuck, pin me down with his hand around my mouth all the time."*

*“Because they become your carer and they make you believe that you need them because of your disability. And they do everything. ‘And I’m making life so much easier for you’. You know and I thought it was wonderful. Nobody had taken care of me in that way. No one. You know, and it was like, god, he’ll do the ironing. He’ll cook. He’ll clean. And bit by bit though he was taking everything. He was buying my clothes. He was telling me who I could see. Where I could go. I mean part of that is about being a woman, but a lot of it was being disabled. Non-disabled women don’t have that problem. He always made a thing about not pushing me out in my wheelchair. He’d carry me out to the car. Just to emphasise it more.”*

*“Yes, being disabled affected it because you are so vulnerable, I felt so dependent and not able to get around that I learned to drive and now I have my special car. If disabled women can get their own transport it makes all the difference.”*

*“And I think this thing of growing up as a hard of hearing young person, and being used to being dependent, and being used to having someone there to do things for you a bit, just makes it all worse and you are a bit more needy. And I didn’t get the training I would have done if I was not Deaf so I was at a disadvantage in terms of qualifications and training. For me, my self-confidence was not great at that time as a Deaf woman. And I looked up to him as someone more experienced and could sort things out. And I was not shy but I think my Deafness made me appear shy. So it could be quite difficult with new people and he would take the role and somehow I became more subservient.”*

Interviewees who had been subjected to intensive verbal and mental abuse thought that the service response to physically abused women tended to be more positive whereas, in their case, control issues and threats to harm were not taken as seriously. This was also seen to be part and parcel of the view of disabled women as asexual who should not be in intimate partnerships, often making women feeling ashamed to disclose to family and friends, as well as there being pressure on them to tolerate abuse:

*“Your pride’s at stake... look here’s somebody who wants to be with me, and then over a period of time it deteriorates and you don’t want to say to people ‘I’m scared’ you know. I don’t know what to do about it?’... I think definitely for disabled women that there is this issue of like ‘Oh you’re so lucky that you’ve got somebody’ that you think I’m not going to get somebody again. I’d rather put up with this... because there is some nice times and you know he is sorry. So this is better than being on my own.”*

*“Yes it was horrible; it just used to make me cry and cry, all because of being disabled. He would call me names and say I was stupid and that he was embarrassed to be seen out with me. As a disabled woman, there is a reluctance to ask for help you know. You’re embarrassed and you know people are already giving you lots of support. You don’t want to add to it. You don’t want to become even a bigger burden.”*

The vulnerability felt by disabled women was often greater when subjected to physical abuse even though they may not have been passive recipients:

*“She would kick me quite regularly. She was doing a martial arts course, doing karate. And so if I was doing something she didn’t want me to do she would throw things around. She was always breaking telephones and broke the TV once.. I mean she’d take my mobile phone off me and then quite deliberately verbally abuse me and then physically kick me.”*

*“He would take away the things I needed. I would say ‘it takes two to tango, I know I am awkward, but please don’t hit me’. He’d say ‘You’ve got a mouth on you. You can’t defend yourself though, can you?’ And he’d hit me.”*

The daily terror of being dependent on and living with an abuser was a reality for many of the research respondents. However, when women regained some power back by moving into their own accessible accommodation (with or without their partner), this sometimes made the abuse worse because the partners felt displaced. In some cases, the abuse often led to additional, otherwise un-anticipated health problems.

## **f) Some general themes**

In sum, the general points raised included:

- Some of the abuse being different in type from that experienced by non-disabled women.
- The invisibility of disabled women and being viewed as asexual.
- Conversely, the existence of particularly high levels of sexual violence/abuse and sexual insults.
- The use of degrading language related to being disabled which had great impact.
- Difficulties in getting help - feeling unable to communicate and get help and not feeling able to make a fuss.
- Greater control by the abuser because of a woman's condition.
- Being made to feel undeserving of a relationship, and the need to be grateful for the partner's help.

In particular, the study findings indicated that disabled women are likely to experience:

- Higher levels of sexual abuse than non-disabled women.
- Higher levels of degrading emotional abuse, particularly related to being disabled.

## **7.4 Abuse by Personal Assistants (PAs, including paid/informal care workers)**

A minority of the women interviewed reported abuse from their personal assistants (PAs). However, this form of abuse was generally considered to be widespread and common in disabled women's lives. Our interviewees demonstrated that understanding of both the relationship of disabled women with PAs, and the nature of the abuse perpetrated by them, was seen to be limited. In particular, lack of attention to mental and financial abuse was highlighted, and issues to do with privacy raised. It was evident from the interviewees that the control exerted by PAs over them had been pervasive and continual, and was seldom acknowledged in definitions of abuse and by agencies.

Abuse from PAs was seen to be especially subtle, as it was often non-physical:

*“I think that all abusive relationships can be very psychological but I do think that PA abuse seems to be more psychological because it’s a lot more subtle and it’s very very hard to prove. Whereas if you’ve been ... if there’s been a violent attack on somebody, you’d usually have the scars to show it. But when it’s not that form of abuse, how do you prove it? How do you get people to take you seriously?”*

*“Well, I have been stolen from and abused by my care workers and then there was a huge argument with social services and the housing people because they refuse to believe it or even investigate it. They were just on the care worker’s side and got all serious and judgemental if I started to try to tell them about it.”*

Collusion between care workers and professional or investigative agencies sometimes led to the marginalisation of the disabled woman herself:

*“Because there’s a lot of relationships between the agencies and you can be left out in the cold, they talk without you and decide what they think and if you are disabled you have even less say. So they [social services and housing association] were just laughing with the care workers behind my back, I thought. ... what I said didn’t count. Was not so much exploited by them as by the whole system. If you complained about the PAs, not only were you in trouble with them, you were in trouble with the housing association, social services. So they’d say why are you refusing care.”*

*“You know as if I’d done something wrong...And it is to do with them all being private now. There are less controls and the wages are bad so they get different people and there are fewer checks.”*

In relation to privacy and general intrusion into their lives by PAs, other interviewees made the following comments:

*“There’s a lack of understanding around privacy and that can be quite abusive when people don’t respect that and they think they should be privy to everything that you do in your life. If you buy something new and they see it in the wardrobe ‘Oh I’ve not seen*

*that before' you know. Listening into phone calls and knowing too much about your finances. That abuse of power is a big thing."*

*"If you want anything to be kept without anybody looking at it, you've really got to lock it up. Because I made a list of things for a new PA that was coming to work for me, I left it on there and the PA that was there said 'Oh I see you've got a lot of things on the list for her to do'. And I'm thinking to myself well why did you turn it over and read it you know...they might sound very petty things, but they are a form of abuse really."*

A blurring of the boundaries can also occur in relation to the professional relationship between PAs and women. Women who directly employed PAs also reported the difficulty of criticising or 'disciplining' PAs while they were dependent on them for care:

*"It's quite a difficult one to explain really but it's extremely difficult to act as an employer and discipline people in this position, when in the next moment you might have to ask them to do some very intimate task for you. So basically once you've got somebody working for you, you're more or less stuck with them because most people who do this don't do disciplinaries because they're frightened to do them."*

Indeed, in situations where there were huge difficulties and women needed to take action and ask PAs to leave, this was found to be difficult in the face of little or no support available for disabled women in relation to such issues. The self-directed support programme (which, as noted in Chapter 5, extends the previous direct payments provision) will now give women greater control over whom to employ.

However, the absence of adequate professional support (peer support is all that is available) led in our study to much anxiety and a fear among disabled women in this situation of having their funding cut back. (Direct payments conduct an independent living review every year.)

### **7.5 Responding to the abuse**

Absolutely every woman interviewed - 100% - felt that being disabled made the abuse worse (as we have noted above) and limited their capacity to get away from the violence or to respond to it in other ways.

### **Being disabled making it worse**

*“Yeah, because they can’t fight back, because like I can’t walk out. So when it happened... sort of say like an able bodied person would just get up and walk out or what have you. But no, I couldn’t. It’s very difficult to escape, say, for me...”*

*“Well people are going to use whatever they can to abuse you, so whatever they can. If you’ve got mobility problems, that’s a good one! Ideal for an abuser ----, isn’t it, you can’t get away or fight back, perfect...”*

*“One way it made it worse was like it was hard for me to talk to other people and hard to be understood, and like I would just feel so pathetic, like I was going to be pitied and I was pathetic anyway because of not hearing and speaking like other people. And in getting away --- well, I didn’t feel I could for a while, because I was so used to him and us going out together and it could be hard to call for help, I’d feel stupid and my voice would come out funny if I called out and people might laugh and not realise so I would keep quiet...”*

*“Yes, it makes it worse because you can’t physically get away, for example, on the night he got picked up for drunk driving, I was on crutches, I tried to defend myself, he took a crutch and broke it across his knee and said you’re next...Without the crutch I couldn’t move way...I was in a helpless position.”*

Women who had no recourse<sup>8</sup> to public funds were especially caught in the abusive situation, even where they had attempted to leave.

Without funding, they could not access the services they needed.

*“I got the number of a refuge from somebody at work but when I rang them they said they couldn’t help because I had no indefinite leave.”*

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<sup>8</sup> Women who have no settled immigration status or indefinite leave to remain in the UK have no recourse to public funds, which often makes it very difficult to leave an abusive situation. This frequently arises because they have married a person who has settled in the UK, and therefore their immigration status is dependent on remaining within the marriage.

Women whose first language was not English were in an even more difficult situation.

Disabled women's reasons for being in abusive situations and staying in them were seen to be complex, and often led to them staying in abusive relationships for longer:

*"I would imagine that they put up with it longer than women without disabilities because we find it more difficult statistically and every way to have a partner. We find it more difficult to have a supportive partner who knows the difference between being a carer and a controller. I mean I can't speak for all the people with disabilities, but I think some see us as sort of children and all, think we're women that need looking after a bit more. And those are the men that are more likely to become controlling and take it too far you know.....we're very cautious about men and their motives and why they want to be with us."*

Many of our interviewees did not tell anybody about the abuse for some time - if ever (before the interview).

*"I didn't tell anybody. I kept it to myself really. I just tried to make things as pleasant and as normal and happy as possible in my own home. Especially like so the youngest one wasn't affected by it. If anything I was probably hiding it really."*

This was especially the case for those women who developed an impairment later in life and those who had children. Some women said they were ashamed and believed the abuse was their fault, something which tended to be reinforced by the abuser, making it more difficult to seek help:

*"I think I was just ashamed really ... in the beginning I thought it was my stupid fault. What did I do to deserve this and it must have been my fault. And the way he was saying it as well. He was saying that it must be, go and think about what you've done wrong. So he sort of told me I was wrong and it was me. So I thought it was all me in the beginning."*

For some, the prospect of being with an abusive partner was preferable to "a life of care agencies" and this had led to them staying in the abusive situation for many years. Thus, having to receive care from agencies or

being in care homes and being institutionalised was often a real fear and horrifying prospect.

### **a) Triggers to leaving/separating**

All the women we interviewed had separated from abusive partners or were no longer in a situation of abuse. Most of the women spoke about the triggers that had led to them making the decision to leave/separate from those abusing them. In these cases, all spoke about the moment that they realised it had to end.

#### **Triggers to leaving**

*"[Partner's name] was driving me around these roundabouts screaming at me. I was nearly falling out of my chair. I was strapped in, but I was nearly falling out. And I kind of said well that's it... And I said, well, that's it, it's over, it's finished. I started laughing, I don't know at that point something in me just kind of... this calmness came over me. And it was like, 'No, sorry, you've got to go. I've had enough. It's too much. You're going to kill me.'"*

*"He became really abusive, verbally abusive to me. He was really screaming at me. It's all like using my disability against me... And just him saying that I just thought I can't do this no more. I think it was something that clicked that just sort of said you've got to get out of here... And I thought, well, how am I going to do that because he's in here. And I thought right, come on. What do you need? You've got a coat, and I got a coat and I got a lead for the dog and opened the door and went out.. But he grabbed my wrists and he held me on the bed and grabbed my arms and got me to sign paperwork, and I just kept getting away from him round the house. And eventually he pushed me up against the wall. Both my daughters were in the house. And it was after that I knew that I'd got to do something."*

Factors which assisted women to make the decision to leave included having access to a supportive organisation, becoming more confident, and escalation of the abuse:

*"But at the end, when I did actually go, he tried to strangle me with a telephone wire and raped me at the same time. And I passed*

*out. And I took that cue to get out. And I had to leave my children. I didn't know I could take them with me. If I'd have tried to take them as well he would have got suspicious."*

In several instances, women had left because of the children.

*"And then it got to the point where I used to get him arrested and take him from the house because he would start crashing things about. [Daughter] never saw any of it because she was either away at nursery, with friends, with mum and dad. And when I finally sort of split up it was because I was reading her a bedtime story, it was half past eight in the evening and he came in and he was drunk and [verbally abusive in front of her]."*

In a number of the cases, interviewees stated that it took them many years to leave/separate, even though they had made the decision to leave psychologically and emotionally a long time ago. Factors which made women stay longer than they wished to included 1) believing they had nowhere to go, 2) services being absent and 3) the abuser's threats of suicide.

### **b) Post-separation**

Separation did not always help, however. Even where women had been separated for some time, they spoke about their vulnerability. Post-separation violence was a reality for many, continuing for many years after separation – ranging from six months to up to four years for some.

*"He used to make phone calls at three o'clock in the morning to wake the household up. He used to write very nasty letters at least... well I suppose every other day I used to get a letter."*

Post-separation abuse reported included continuous texting and phoning, answer phone messages, turning up unannounced, stealing loved pets, and harassing family members. Sometimes this was because it was harder for disabled women to leave an area so they were more likely to encounter perpetrators even after separation.

On a more positive note, women also spoke about the relief after an abuser left.

*"It's weird, when I left him it... I know it sounds really strange but it's almost like a big weight had just lifted off my head when I got*

*out of the house. And I felt stronger. I mean I really did break down when I was round to see neighbour and my brother and I really was crying. But when I came round a bit more I did feel stronger. And I felt I can do this now and I've got to do it and I've got some backing."*

## **7.6 Personal impact of the abuse/impact on self**

Although the impact of the abuse was manifold, different women often recounted similar experiences. A number reported getting very depressed, losing a sense of themselves and feeling worthless.

### **Feeling worthless**

*"It had a massive impact on me. I lost who I was, my identity really. He left me with some things, and up to this day I can't get them out of my head...I feel not very good about myself in that sense. And I feel that can be just as bad, even worse than being physically abused."*

*"He'd go to pub and come back in hopeless frustration. He calls me a useless piece of shit and stuff like that. When I had just had the accident, I was incapacitated, I tended to agree, and I felt worthless."*

*"I suppose he felt a bit trapped by me and then he started insulting me. He would make fun of how I speak and say I smelled, which I don't, I know. And I would feel so hurt and humiliated, it was my first major relationship, it put me off, I felt that I couldn't be good enough to have relationships after that."*

*"It was a source of annoyance to him that if we were in a group of people, if I didn't understand or if I got left out of the conversation because I couldn't hear, you know, he'd get annoyed with me and angry. I was dragging him down, he said. It just made me feel really small, bad."*

Women who had experienced abuse from their PAs found themselves not being able to trust anybody:

*“It’s probably made me very cynical about why people go into this line of work. I think it can damage all other relationships if you’re not careful, outside of the PA relationship, because you look for ulterior motives as to why people might want to relate to you.”*

When abuse was gradual and perpetrated by partners who were also carers, women spoke at length about the profound and deep impact it had on them:

*“But the verbal abuse was so.... difficult, so deeply undermining. I mean I thought at least he’s not beating me to pulp but then you just feel worse and worse about yourself.”*

*“He really really ground me down so much. I cried to sleep a lot of the nights. But it was really making me worse, my MS, and that made it worse physically.”*

It was evident that the impact of the abuse had taken many of the women interviewed a long time to deal with, either because they had not had any support and were trying to come to terms with it on their own or because it had been so pervasive and lengthy that it had taken them many years to move on – *“All I do is struggle and fight and keep on going...keep going...And it’s like I’m so tired.”*

The profound impact of multiple and lengthy abuse on women who had had a life-time of abuse, and where the abuse had been perpetrated by partners, agencies and parents, and, in particular, where they had also been subjected to sexual abuse by fathers and partners, was obvious and emotionally shattering. A number of the women spoke about being severely depressed and about eating disorders:

*“And the fact that during the marriage got me so controlled. He took everything. He took my complete independence where I had to ask him a fortnight before I needed sanitary towels to make sure that I’d get them. Like one time I ended up with too many because... because I was so underweight my periods were irregular anyway. I only weighed four stone for nine or ten years while I was with him.”*

Others reported problems sleeping:

*“I’ve got a thing about not going to sleep, because you’ve got to be awake; you’ve got to be on your guard. And I suppose I’ve never got over that. I can’t get comfortable at night.”*

Living in fear was also something that women said was an on-going issue for them even after many years of separation, and especially where women had children – *“To this day I think he’s going to turn up. It’ll never go; it won’t go until I know he’s dead”*.

### **7.7 Impact on children**

Every single one of the nineteen women who had children felt that the children had been badly affected by the abusive situation. Having children raised different issues for different women. For some, it meant they had stayed and /or left, specifically because of the children. For a few of the interviewees, the abuse started, or increased, when children were born or were little, as they were often unable to look after them on their own and needed greater support from their partners or family members. Those women with children who were at an age to be aware of what was happening reported the strong direct impact the abuse had had on them.

Some interviewees strongly believed that their condition had been used against them in dealing with professional agencies about the children, and they had often felt pressurised by social services. For one woman with high support needs, for example, having children had meant that she had had to fight with social services when her children were taken into care. Being able to show that she was in a relationship, albeit abusive, had assisted another woman in getting her children back. For another, her daughter was almost taken into care because there were no facilities for her. In a further case, the woman’s husband and his family had colluded to keep her baby daughter, when she was forcefully made to leave because of becoming disabled.

Those women who had had to leave because of danger to their lives had often left alone, not knowing they could take the children with them, or whether the accommodation they were going to would be able to house their children as well as themselves. One child (aged 3 yrs) was left with a violent father when the mother fled. Social services and others said nothing could be done to help and refused to assist her to get him back.

This woman believed this would have been different if she had not been disabled.

Some children had themselves experienced direct abuse, at times both physical and sexual. In a couple of cases, women reported their children being sexually abused by the same perpetrator (with one being raped). One son was severely physically abused by his father for some time before the woman was able to have him back.

For some older children who carried out caring tasks for their mothers, the abuser disapproved of this support for the woman, and the situation created obvious problems:

*“Well my eldest daughter, the relationship between her and my partner was just disrespectful really. And there was a lot of tension...because she was obviously doing things for me at that point. Me mum stepped in and started helping me out in the home and helping me to get ready. And her little sister, they started doing more stuff in the house. .... he was there and he was criticising instead of helping. And me eldest daughter was doing it for me. She made it quite clear she was doing it for me and her younger sister, not for him. It was that kind of relationship.”*

In some cases, at a time when they had minimal support in terms of assistance, women reported feeling bad about not being able to care properly for their children who had to assume greater responsibility in the house. Where our interviewees had very severely suffered from the impact of abuse, it was evident that children had grown up with great anxiety, often thinking that their mother would die.

Where children still had contact with their fathers, some women reported the children being used against them or being poisoned against them as a way of continuing the abuse – *“slowly but slowly he was using her to get at me as well. She’s still quite nervous around him”*. Often abusive ex-partners manipulated the children to turn them against the mother or to participate in the abuse. While children sometimes spent time with both parents separately, one father had persuaded the children to stay with him and abandon their mother.

*“I mean mentally I knew he was doing a lot of damage to my son by saying that I was no good, I was a slag, and I preferred other men to him.”*

A number of the women said they had not realised until later the damage living with and/or directly experiencing abuse had done to their children; at the time they had believed living with the father was the right thing to do. In many of the cases, women reported 'containing things' to minimise the impact on their children, believing their children were okay if they didn't see the abuse – *"in my mind everything was okay because my children didn't see it. I forgot about the hearing. The honest to god truth is I really didn't know how it affected my children at the time"*.

### **7.8 In conclusion**

In conclusion, it is the case that non-disabled abused women experience difficulty in disclosing intimate violence, may also feel stigmatised, may be isolated from getting help, and may take a long time before they feel they are ready to leave or can take any other action. However, for all our interviewees in this study, stigmas, difficulties and fears of this type, which are common experiences for women experiencing domestic violence, had been crucially and significantly amplified because they were disabled.

## Chapter 8: Service provision: statutory and voluntary sectors agencies: women's views and advice to agencies

### 8.1 Women's help seeking

Several of the women we interviewed had never sought help, formal or informal, for the abuse that they were experiencing.

#### a) Barriers to getting help

As discussed in Chapter 7, in a number of cases, our interviewees did not recognise their experience as abuse, especially when it was not physical. In other cases, women blamed themselves and had not told anybody, because they believed they had no choice. Even some women, who felt strong in other aspects of life, believed that they could not disclose what was happening in their private lives or look for help to deal with their situation. A couple of the interviewees had a high profile for their own work around disability issues in their locality, and they, especially, felt they could not disclose the abuse, which in turn served to isolate them further:

*"It wasn't that I went to bed hungry certain nights or whatever, it's that complete isolation that there really isn't anyone to turn to. And partly if you do turn to someone, the shame of it is enormous. And even more because I'm a disability equality trainer ... I mean I went on a course with social services on how to train people around issues of abuse for vulnerable adults... and there I was being abused at the same time. And you're kind of stuck in the situation that... I don't know. It would have been just too embarrassing."*

Some women who had had professionals in their lives said they rarely sought help subsequently, because they were made to feel as if everything was their fault and that their abusive partners were, in the words of one interviewee, "*absolutely brilliant*". For example, a health visitor colluded with the abuser in imposing his view:

*"So she reinforced him -- but he was stood behind her laughing and smirking."*

Others who had had negative experiences early in their life with helping agencies said they did not trust them enough to reveal their experiences, especially where the abuse was mental and not physical:

*“They were people to be feared. They were the people who were going to come and look at you and scrutinise you. I was being scrutinised enough. So the trust wasn’t there. Agencies hadn’t given me any reason to trust them until much later on. But then I’d still say it was very confusing because a lot of mine was mental abuse. And because of my disability it was so subtle. It was actually a doctor that said it to me that way.”*

Even where professionals picked up on the abuse, some of our interviewees said they needed a positive/definite sign that they would be supported, and without this they were reluctant to disclose:

*“But I wasn’t picking up that they were picking up. And I wasn’t picking up that they were having any sympathy. They never give me any indication that they would support me. None. If they’d have gone out on a limb like that social worker did when I got placed in the bungalow, if they’d have just gone out on a limb. If there was intervention earlier you know. But then maybe they’re still only learning. I don’t know. Because disabled people are... it’s not been that long that disabled people have been speaking out for themselves. Twenty years. What’s twenty years? It’s nothing.”*

Fear of losing their independence, or in some cases of being judged as an inadequate mother and losing their children, were primary factors for women who did not disclose abuse to any formal agencies/professionals. Some interviewees said their pride had acted as a barrier to their seeking help:

*“Mostly pride really. I couldn’t possibly... you know, I lived this lovely independent life in the community. I fund my own care package. It’s all hunky dory, lovely lovely. But actually no, there wasn’t anyone I could talk to.”*

Interviewees talked about trying to put up a front that ‘I’m coping okay, I’m fine. I’m fine’, but explained that, ultimately, this had taken a serious emotional toll.

Accommodation and physical accessibility were also a significant barrier for women in seeking help. Many of them believed they could not be accommodated according to their needs, as support services rarely had fully-adapted accommodation. They were also reluctant to leave their own housing, if it had been adapted. Accessibility was talked about, both

in terms of physical access, and in a broader sense of attitudes and sensitivity.

Believing there was nowhere to go because of the lack of services, or of information about services, impacted on women looking for help:

*“There was nowhere to go. Well I thought there was nowhere to go, especially with my ex-husband. There weren’t many refuges but there’s thousands of places for pets. If you weigh up the difference - I mean there’s a huge difference. So it just goes to show what a human being’s... what they value more.”*

For some women, phoning for help was not possible and neither was leaving their home, because of the absence of real options in terms of accommodation:

*“And I did think about phoning like phonelines and things like that. But (a) that was quite difficult physically to pick up the phone and find the number and dial it. But also it felt kind of a bit futile really because you know it had to be a big thing to make [partner’s name] go away really. I couldn’t ever go to a safe house which would... I know it’s not really a real option for a lot of people. But you know I had to use a hoist. I have an electric bed. I have lots of support needs.”*

Lack of information about services was also a common barrier for many of the women, and believing refuges/domestic violence services were not for them was another:

*“For various reasons I think a lot of disabled women are not so aware of the resources that ARE there to support you. I mean I didn’t know what was out there for people like me. I didn’t associate it with me. I thought, that’s not me.”*

*“For example, for Deaf women you don’t overhear things in passing. You don’t hear general conversation, you don’t hear stuff on the radio for example, you don’t just pick things up like hearing people do. You have to hone in on things, make an effort deliberately seek information out. You have to make a point of it. There’s this thing about information not getting to you or you not realising that the things are meant for you.”*

Not being understood and facing racism were real fears and/or actual experiences, for some of the BMER women we interviewed:

*“When I have opened up about something I haven’t been understood. They just didn’t know where I was coming from. If anything, I felt like they were being very disrespectful not hearing me....I’ve had that experience and I don’t want that again. The help that I need isn’t out there. That’s the reality...locality, ignorance, racism. I’m not afraid to say that anymore. I’m being judged by the colour of my skin before anything...I’ve experienced this in the so-called disability organisation where I was judged for my colour.”*

Some BMER women did not feel they could ring other agencies for help as they, as disabled women, felt doubly different and perceived that services would be unable to offer them the support they needed. Black women living in predominantly white areas, in particular, thought services could not support them as both disabled and black women – *‘it’s just a no win situation for me’*. They believed that their needs would not be understood, and that there would be little sensitivity to their impairment or condition. In these situations, and especially where black women had had negative experiences with statutory services, they believed they had to rely only on themselves – *‘the only choice I’ve had is to find my own way really...it’s really me helping me out really’*.

Women with no recourse to public funds<sup>9</sup> had had a negative response from agencies and had stayed in abusive relationships for longer than other women. Only when things had very severely escalated and they had no choice at all, had these women then contacted the police. Scepticism about being believed by agencies was a factor for not reporting for the two lesbians in our study who thought they would not be taken seriously:

*“I don’t ever think that they would fundamentally take it really seriously. I don’t know if that’s my scepticism about the police or whether that’s true. But I think that people still have this vision of abusers to be male, to be stronger.”*

*“She was stronger than me but she was really skinny. And in those kinds of situations there are no bruises left to be seen, it was her word against mine.”*

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<sup>9</sup> Both those participating in the study and others whom we were informed about by domestic violence agencies

In practice, this assumption had turned out to be correct, when the woman in the above quote had sought help.

## **8.2 Informal Support**

Although some of our respondents had not sought any form of help, as discussed above, many women had used informal networks of support – friends, siblings, neighbours, parents - and were more or less equally divided as to whether these contacts had been helpful or unhelpful.

Telling their mother (or the mother seeing what was happening) was the only disclosure that took place for some women.

*“Eventually I started telling her everything. Me mum could see and to the point where she started coming round like once a week and really that once a week was... she’d come round and cook dinner and sort me out...but really she was keeping an eye on things and making sure I was alright before she left at night.”*

For others, disclosing to their parents and family, albeit a very difficult thing to do, had enabled them to leave – *“I just sat there all night with them and didn’t say anything and then the next day I said ‘I’m scared of him”*. In a few cases, interviewees had spent time with their parents before being re-housed, especially where they did not need adapted accommodation. Clearly this was not an option for those women who had accessibility needs, unless the parents' house was already adapted. Younger women had found parents helpful and supportive but, in a few cases, controlling and dominating. The situation of a daughter returning home after domestic violence seemed to give some parents an opportunity to be in control again, sometimes after painstaking efforts by the young person to break away. The particular parents involved seemed to like this (although being distressed by the violence), and to see their child as being re-vulnerabilised -- and themselves as therefore needed.

For a few of the women, siblings had worked out what was happening and intervened in a way that was positive – giving the woman a leaflet with contact numbers, for example, or providing information about abuse, putting her in touch with support services, etc. However, in some situations, a woman’s reluctance to name the abuse left family members powerless to do anything until after separation. Some interviewees had limited contact with their family who felt uncomfortable with the fact that they were disabled, and some did not have any family to whom they could turn.

Aside from support from their mothers, siblings or friends, many had not sought any kind of help, even after separation. This was especially so for BMER women whom we interviewed and who had often experienced profound isolation, as discussed above, though lessened for those who were either able to access specific services or had some mobility. For a few of the women interviewed, contacting the researchers to give an interview was the first time they had spoken about their experiences to an outsider. This was often a part of their recognising that they had to/wanted to deal with some of the painful memories around what had happened, and it was their way of initiating this process. A couple of women were using writing as a way of dealing with their experiences to share their stories.

A few of our interviewees who believed abuse to be only physical, and who had grown up in a situation where their fathers were violent towards their mothers, had only started the process of naming the abuse after their abusive partner had left. One woman had recently started to study domestic violence and saw it as *“part of the healing that I need to go through”*.

Recognising that they needed help to deal with the emotional impacts of their experiences, a number of the interviewees had made attempts to seek help, some time after the abuse ended (in some cases years after) but had experienced mixed responses. For one woman, who had spent a whole year looking for sensitive support, the realisation had gradually come that there was nothing available: no one was going to help.

*“I’ve started to look for some kind of therapy but to be honest I can’t find a counsellor that understands disability equality because a lot of them I find are a bit...they still see me as a dependent person, not who I am, you know the stereotype of a disabled woman who can’t do anything for herself kind of thing.”*

*“And that’s really knocked me. And I can’t get into a therapeutic relationship with someone that doesn’t understand that. I find that really hard. The fact that I’m gay gives it another angle. The fact that most services aren’t physically accessible. It’s been quite hard to find... I haven’t found anyone yet. ...I’ve looked a bit nationally as well. And a friend’s been looking for me as well and he’s quite horrified that there actually really isn’t very much out there...”*

Some interviewees, who had spent years trying to deal with the impact of their experiences of violence, pointed out that the pain never goes away. However, for women with good support networks, peer support had been hugely important, and a few had found supportive groups that were assisting them in coming to terms with what had happened. Living in smaller neighbourhoods where they were known to local residents also seemed to offer women some protection against abusive partners, as the support offered might isolate the abuser. At times, neighbours were found to be more helpful than statutory services:

*“And my next door neighbour... this is nothing to do with council or Social, this is all people around me that are more use than them. I would have preferred Social being more use, but definitely more use round here. My next door neighbour gave me more help and she got to my brother and my brother came up.”*

Thus, remaining in their own accessible accommodation within their own networks was really important to women, in many cases, in dealing with the abusive situation:

*“Because it’s my house, it’s been adapted for me and everything and it’s my village. It’s where I’ve been brought up and ...I know a lot of people round here, friends or just people I just see every now and again. And it’s just easy. I mean I know it’s adapted for me here in the house itself, but the village too...”*

Even where women were well supported however, they were anxious about not knowing what was going to happen to them if they then had to leave – *‘even then I was terrified because I didn’t know what they were going to do with me’*.

**8.3 Formal agencies**

Women had contact with the following formal agencies (sometimes with more than one agency being approached).

Police	18
Social services/ adult services	17
Refuge organisations/domestic violence services	7
Disability organisations	6
Housing agencies	12

For some women, this contact with agencies was not at the time of the abuse, but later on. When asked if their needs were met by these agencies, women almost always said 'no'. However, there were a few positive examples given. These comprised two refuge organisations (usually where they had purpose-adapted accommodation); three other domestic violence organisations; one disabled people's organisation; one mental health group, one social worker; and two police officers.

When asked which agency had been most helpful and least helpful, the following was reported:

<p><b>Least helpful</b> – Social services / adult services (80%) Police (50%) plus GPs and solicitors in some instances</p> <p>Note: A large percentage identified both police and social services.</p> <p><b>Most helpful</b> – Domestic violence organisations (17%) Disability organisations (10%)</p> <p>Note: the small percentages for 'most helpful' relate to the small number of responses. The rest of the interviewees had not been able to identify any agencies as 'most helpful'.</p>
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**a) Professionals**

Tellingly, our interviewees who had carers or other professionals coming to their homes stated that, unless they themselves had specifically disclosed, no one (except for one sole worker) had picked up on the abuse.

Often, professionals focused only on the impairment and the woman's ability to deal with what was happening in relation to it, especially in cases where the impairment had developed later in life. A number of women reported suffering from depression, which again was dealt with without any questions being asked about what was happening in the home. It was often assumed that such depression was caused by being disabled.

For some women who had had the courage to disclose a little in the hope that professionals would either ask more or take some action, it would appear that, in the main, this did not happen. Even where the issue could have been quite easily pursued, professionals were reported to have not followed things up. Not being asked, coupled with the reluctance of some women to disclose, maintained the secrecy of abuse for disabled women.

In a few cases where the abuse had been disclosed, there had been one professional in a long line of encounters who provided a lifeline for women – sometimes through referring to an agency for support or assisting with rehousing. Where professionals knew about the dynamics of domestic violence and had been positive, it made a substantial difference to the way that the woman concerned was able to respond to her situation:

*“He was very worried about what was happening. I mean it’s almost like he knew what was coming, it’s almost like he knew it was going to get worse. He tried his hardest.”*

In such situations, women were often gratifyingly surprised by the professional’s positive or sensitive response and commented on it very positively:

*“He was different and he noticed what was going on because he’d worked a number of years with vulnerable disabled adults and I’m sure he came across somebody like me before because he just knew. I could tell he knew. He did the best thing he could have done. He introduced me to the (disability organisation). He put it across to my ex husband that it would do me good maybe to meet up with other disabled people like myself. He was very clever.”*

(Same woman as above)

## **b) The Police**

Our interviewees varied in the type of responses they had had from the police in terms of whether they were positive or not, but there were far more negative or unhelpful responses than positive ones.

## Responses from the police

*"I did phone the police once and they were OK when they came, but by then he had left in his car and I told them I would be OK. I felt that they felt sorry for me, like what's that word, patro..., what is it, patronised, because I was pathetic and couldn't talk well and they had to struggle to understand me...."*

*"Yes the police were concerned about my safety, but he'd left by then, and they said to call straight back if he turned up again and wanted to know about whether I had safe places to go to and everything they were OK. They asked if they could get in touch with anyone for me.*

[Interviewer: Did they mention domestic violence officers or units to you, lots of police stations have that sort of special unit these days.]

*No they didn't I don't know anything about that and I wish I had, they might have helped more."*

*"The police a couple of times, once when he broke the crutches and once when he threw the coffee. On the first occasion, he was fined and put on probation. Second time, I dropped the charges; I didn't want to pursue it. The police were OK till then but then they looked at me as if I was stupid. It wasn't the domestic violence officers, just the ordinary police I think, they did try to pick him up after the incident, they issued a warrant for him."*

*"He hits me, he abuses me, and he gets away with it. He needs to be taught a lesson, I pay with my pain but it's worth it. Police doesn't help me not council not solicitor...all bureaucracy and excuses. I'm thinking of chaining myself to No.10, as I have no other options."*

Although responses varied and a few were very good, some of the experiences women had with the police demonstrated an almost complete lack of insight into the nature of their abuse experiences. The police, in a few cases, had told women to *"leave him until the morning"* or *"let him sleep it off"* and, at times, warned women they would have their children taken away from them or placed on the child protection register if they continued to live in the situation, but without any offers of support.

*“I didn’t know where to go, who to talk to. And I believed that the police would somehow solve it for me and they didn’t. And their response was well if you take him back it’s your problem again. And it was like you have no idea why I’m taking him back. I’m taking him back because it’s that or he’ll boot my door anyway.”*

Where partners were also carers, it was sometimes assumed by police officers that arrests could not be made, illustrating the (very real) contradiction for disabled abused women who have limited options in such situations:

*“And ironically as well one night she smashed a window at the front door actually and someone in the street must have called the police. The police came round and she was very drunk and the policeman came in and said ‘Oh, is everything all right’. And I was like ‘Oh yeah it’s fine’. And he said ‘Oh we could arrest her for breaking the window but we won’t because she’s got to look after you’. And you’re kind of like, ‘Oh, OK then’. And I didn’t even want to say, you know, well actually...”*

[Interviewer: And if they had arrested her?]

*And if they’d taken her away then I wouldn’t have got to bed that night. I wouldn’t have got to the toilet. You’re really, really stuck.”*

In some cases, the police had responded very positively, especially where a third sector community organisation had alerted them to the potential threat to a woman’s life, illustrating the importance of advocacy. Where the police were positive, proactive, and offered helpful options, the interviewees were very positive about their response.

Women stated that a more proactive response was needed from the police than for non-disabled women, as many disabled women are particularly vulnerable, living in extreme fear and will not disclose:

*“They could give lots of advice about, you know, go here or go there, or come to interview me on my own when he wasn’t there to find out a bit more about my situation generally. I mean, I do remember ringing up and telling them, well he’s just been here and they should go and look and ‘Oh we can’t find him’. I go, ‘But he will come back tonight’. ‘Well, ring us again’.”*

Motivated to raise awareness from her abuse experiences, one woman had contacted the police to share with them the barriers that had existed for her around help seeking:

*“I said to her [the police officer] basically, what would you have done if I’d have come to you? I didn’t phone anyone up because he’d always smashed the phone up to stop me from ringing someone. So I didn’t phone anyone up. But if I had actually got to a phone what would you have done if I’d have got in touch with you?.... Someone in the domestic violence unit at [the] police station, they got in touch with me and basically he said ‘can I come out and see you?’ So he came out and he said ‘if we’d come to you and you were distressed and all the rest of it, not showing any signs, nothing, no slap marks or whatever, we still would have taken him away’.”*

### **c) Social services / adult services**

Women’s experiences of social services / adult services were almost entirely negative.

#### **Responses from social services / adult services**

*“Social services, yeah they came, they said do you need an ambulance, and then they said all they could offer was [...] House. There were no refuges available for a disabled woman, they said. That place was a Cheshire Home! I wasn’t going there.....totally inappropriate and I’d just get dumped there. All they offered was an institution! There was no accessible space at the refuge. So they said ‘well if you won’t take that, there is nothing we can do for you, sorry, goodbye and just left me in the situation!’ Can you believe that! They said that was all they could do so – so tough really. And they left me!”*

*“Nothing was done to help either of us even though [my daughter] was only 14 – surely they must have had a responsibility to her?..... All they would offer was this institution and I said no thanks so they said well that’s it, we’ve done what we can, it’s your funeral, and left me in this abusive situation and left.” (Same woman as above).*

*“For example they [social services] could only think to send me to a completely inappropriate disabled care home, it was outrageous, and I couldn’t even consider going there. They also know nothing about domestic violence, not really, not for disabled women anyway, maybe for others they do know, but not for disabled...”*

*“Social services have still not improved, not sensitive to the needs of disabled women. Social services have a very naïve attitude; like that your family will be supportive if you are disabled.”*

*“And I was active, going out, etc., getting around and able to speak for myself a bit -- imagine how much worse it could have been...In theory they are sensitive, in practice they weren’t; they go for the cheaper option. That is why I got the cheapest option or nothing. We’re unique individual people, all different, all amazing, all deserving of respect.”*

Thus, where our respondents had had some contact with social workers, they felt they had not responded positively to their situations, in almost all cases. In particular, the nature of abuse did not seem to be understood:

*“I did actually have a social worker then and when she came round, she knew...we went out for a walk at our village and she knew what had been happening and she knew just a little bit, the shouting was still going on. And I told her that I was having a lot of hassle and well she didn’t understand because she didn’t really know what to do. I honestly don’t know whether she said ‘me phone her’, but I mean that would be difficult as well because of him being here all the time. And I couldn’t really phone people out. I didn’t have a mobile phone because he didn’t agree with mobile phones.....She was no good, she never came back to see what was happening. She never kept up with it so there was no aftercare or anything like that... but at the time, I really did want someone to come and help me.”*

For very few of our interviewees, a social worker who was aware of abuse had been proactive and become a lifeline for the woman. Simply doing their best to help a woman remove herself from the situation through exploring options for her, or putting her in contact with a disability organisation, made a huge difference.

*“How would I have ever reached out to anybody if that social worker hadn’t have gone out on a limb for me?”*

A minority of BMER women said they did not trust social workers after having had some negative experiences. Some reported problems with care workers being unwilling to carry out certain tasks for a black woman and this issue being badly dealt with by social workers – *“because I kept on voicing about the cultural needs, I ended up not getting any care for about over a year. Can you believe that?”* In this situation, the woman was left to receive care from her family members, creating greater isolation and dependence on family for her. This interviewee suggested that abuse for minority women not only came from individuals known to the woman, but also from organisations.

In a minority of cases, as discussed in Chapter 7, social services had removed children resulting in our interviewees spending considerable time, trying to get them back. Generally, for those women who had left their homes due to violence and therefore needed extra help, social services / adult services were thought to lack understanding of their support needs and were seen to be inflexible in ensuring care was put into place. Our respondents painted a damning picture.

#### **d) Disability organisations**

Responses from disability organisations were more positive but were still mixed.

##### **Responses from disability organisations**

*“I didn’t try them, they don’t know anything about it, not their business is what they think if they think at all...”*

*“The disability people’s movement has been so empowering for me, hugely empowering...”*

*“Often the disabled organisations, they have not taken on DV at all, not part of their remit they think. They don’t see it. Just don’t see it, do they, it passes them by.”*

*"I don't feel that there is very much, if any, awareness among disability-led Deaf-led organisations of domestic violence. They need to be able to signpost disabled and Deaf women appropriately to good support services certainly. You don't really see anything about it in those services. "*

*"The disability organisation I am involved with now, we are doing drama, putting on plays about abuse, it's fantastic."*

Few of the women had been able to access disabled people's organisations, and, where they had, it was in the main just for general advice. Most contacts had been of little help, with a couple of very positive examples. The majority of BMER women had no contact with disabled people's organisations and there was a perception that such organisations were white, a perception reinforced by a negative response when approached. Overall, the majority of the women we interviewed had been unaware of local disability organisations.

However, in those cases where they did have positive direct contact, or where professionals had introduced women to a helpful disability organisation, being in a supportive environment enabled the women concerned to get stronger and / or finally leave the abusive situation:

*"The course was held... it was just a ten-week course so he felt 'Oh that'll be it and she's only going talking to other disabled people, she'll be fine'. What he didn't know was I was being empowered by a strong disabled people's movement. And when I went for that course, I mean, god, I can talk now, I can talk a glass eye to sleep, but I didn't speak then."*

*"And when I went on that course, that's how I was. And I said 'sorry' every five minutes. And they knew, because obviously they'd experienced things. That's the reason why they were doing the course in the first place. It was one of the trainers who knew because she'd said my life mirrored hers. And by the end of that course I got an award for staying in a sorry free zone. But it was a start, you know. And then they were trying to get disability equality trainers, they saw a potential, but they also saw that I was suffering systematic abuse. So then they encouraged me. And to cut a long*

*story short, from doing index cards I became Chairperson eventually of the organisation. And it took me two years to leave him. But really it wasn't just that... the violence was escalating because he noticed the confidence in me. He noticed I was changing."*

Where women had positive encounters with disability organisations, they said it took them a while to begin to share their abuse experiences. Being asked about it by someone they had learnt to trust helped them to disclose, and such positive input had continued to have ramifications for the rest of their lives:

*"They were one of the leading ones to teach about the medical model and the social model of disability. I'm still involved because I knew what power that organisation had and what it gave me. What power it gave me. But if [only] all other organisations would learn from organisations like that. They really get things done."*

For one woman, for example, the disabled people's organisation was still providing support and activities after a year or more and sending visitors round. In some cases, however, women had found disability organisations lacked understanding of their situation, offered no support, and made it quite clear they were not interested.

#### **e) Domestic violence organisations**

Domestic violence organisations had provided mixed responses to our informants, but there were more positive responses than for disability organisations. In the main, the difficulty identified with them was that they were not accessible. In a few cases, very positive work had taken place.

#### **Domestic violence organisations**

*"The facilities were excellent. You could tell they'd liaised with disabled people because it was that good."*

*"Oh, god, I went to some awful ones and they were horrendous."*

*“Even when I ended up in a refuge, I was seen as a problem. A burden. And the social services down here would not allow me to have a care worker that could take me out as well as come in. I felt like it’s your fault, this. You’ve been here before; you’re in your probably sixth refuge. You know it just felt like I was old news. Even in the refuge, I felt imprisoned again. And it’s because the pressure they’re put under, I realise now, I didn’t then, and because there’s only limited funds and things like that, they’re more willing to help them that’ll help themselves. Well the majority of us don’t help ourselves, do we. We need their help.”*

*“I didn’t approach the disability orgs or the DV orgs, the refuge was not accessible. If I had been able to use these facilities, or if they had access, I would have left much sooner and not suffered so much violence, but they weren’t.”*

*“Refuges? I never thought they were for disabled women.”*

*“Women’s Aid nationally... they have lots of stuff which is great but it doesn’t make it to the local groups, they don’t have it, it’s a system breakdown.”*

Only a minority of the women we interviewed had actually accessed a refuge organisation. For some, this had been a negative experience. On the other hand, when women had gone into a refuge where the staff and management had thought about accessibility issues, and had made provision for disabled women in a principled way, they were extremely positive about the service they had received:

*“They were just amazing, fantastic, I had this purpose built place to live in and all the adaptations I needed. Yeah, all my needs were met and it was just wonderful. They couldn’t have been better. It changed everything for me. I cannot speak highly enough of them.”*

In general, with one exception, refuge accommodation had been accessed by women with fewer support needs. A few had not accessed

refuge accommodation, but had been supported post-separation by a variety of other domestic violence services.

Some of our interviewees who had accessed refuge accommodation spoke at length about the sometimes paternalistic attitude and approach of workers to them as disabled women, and felt refuge organisations were ill-equipped to deal with their support needs:

*“It was like we’re going to need to sort this out for her or we’re going to need to sort that out for her. But it was like said in front of me.”*

*“It wasn’t like... what do you think we need to do that would make things easier for you? Even when I was in [refuge] there was no one to take me shopping ... I had to eat and it was left to the other women to take that role on. Well, I think that was really unfair. They’re going through their own emotions. Why should that burden be passed to them? And it was exactly the same when I came down here; the other women were asked to look after me. Well what did that do to my status? I was even lower than what they were. I became even lower down the ladder.”*

However, where women had been given support around court cases, for example, this was commented on very positively:

*“And the next time I had to go back to court the refuge were fabulous. They arranged for a worker from a refuge in (local), there was two of them, to meet me at the railway station and go into court. They couldn’t actually go into court, but they were there waiting for me... And they were absolutely brilliant. And they put me on the train again afterwards.”*

Women had also appreciated the emotional support that was given to them:

*“But mentally, there was always like [the worker] would take the kids off and do fun things with the kids so we could sit and talk about our experiences because that was important to all of us. So they made time for us as well as, you know, keeping the children entertained.”*

In a minority of cases, interviewees had continued to receive support through an outreach service – *“it’s something that’s for me because I’ve never had anything for me before”* – or had received positive non-refuge based advocacy support.

A few women had only had contact with domestic violence services after they had dealt with the abusive situation, but were seeking further emotional support to help them deal with the ongoing effects of their situation and also to help others. Sometimes this contact was very short-term or limited. However, it is apparent that disabled women often need support years down the line with what has happened to them from services sensitised to provide this kind of support.

BMER women supported by specialist domestic violence services spoke very positively about this, stating that being able to speak to people in their language who understood their experiences was of great importance:

*“Without them, I would have taken my own life. I have tried to once before. They have helped me with everything especially emotional support.”*

*“They listen to me and help me a lot. I need to see them regularly to keep my spirits up and make me feel less alone.”*

None of the lesbians who were interviewed had used refuge accommodation.

Aside from the above comments and the fact that some respondents had a perception or knowledge of refuge organisations as not being accessible, the majority of interviewees had little knowledge about domestic violence services. Lack of information about refuge organisations, or the perception that they were not for them, were significant issues among many of our interviewees:

*“I would have liked to have gone to a refuge at one point but I didn’t know how to. That was after he’d hit me and I was so upset...but I didn’t know what to do. I was living in a flat on my own and I was just so ... frightened of him.”*

*“I was told that refuges were not for people like me, or that’s what I thought anyway....but I could have done with that, with getting some support and help and feeling safe. It would have helped so much but they weren’t for women like me.”*

*“I suppose they need to be more accessible – I thought they weren’t for me and I couldn’t use them. Now I’ve found out I could have if I had known but it didn’t feel as though I was the sort of woman who could go there or who they would help or they would want to have there.”*

*“Refuges? I didn’t approach them, I thought they were just for domestic violence and nothing to do with disabled women, I didn’t think they were for ME...”*

Very few respondents had used domestic violence outreach projects but those who had had mainly found them helpful, though some had not been very accessible.

#### **f) Other agencies**

Where women were not aware of refuge and domestic violence services or other similar support organisations, they contacted organisations such as the CAB and MIND, or solicitors, or GPs. When they did finally disclose abuse in these situations, they appreciated being informed about specialist support services for domestic violence:

*“And she just said to me, ‘You know you need to talk to somebody. Do you want to tell me what’s been going on?’ And I told her. And of course I fell apart. She said ‘Look you’re not on your own. And I’m going to pop out the room and get this phone number,’ and she said, ‘It’s a direct line, carry it with you all the time and have you got a phone?’ And I said, ‘Yes there’s one by the side of the bed’. She said, ‘Well, if anything happens like that again, you must ring this number’.”*

A number of women reported their solicitors being very unhelpful, paying little attention to their safety or confidentiality. In one case, a solicitor had disclosed a woman’s new address to the abuser. Where formal counselling services had been accessed, these had been found to be unhelpful:

*“They obviously didn’t pick up how frightened I was and she actually recommended we get back together, and that we work at the relationship. But she didn’t seem to pick up all the signals or didn’t even sort of get me on my own or anything.”*

In one case, after a woman disclosed to her GP, the doctor told her husband (also her carer) everything. In another, however, where a woman had sought to remove her partner from a jointly owned property, she had found the judge to be supportive of her right to live in the property because of the adaptations. A few women had made use of injunctions in order to prevent their partners from harassing them in a property previously shared. In the cases described to us, they had pursued their cases with the support of family members and had not received any formal support.

#### **g) Advice to other disabled women**

When asked what advice about agencies they would give to other disabled women, our interviewees repeatedly emphasised the importance of telling someone:

*“Try and tell someone who is close by...not keeping it a secret and not to feel ashamed by it. Because that’s one of the reasons that they get away with what they do, they play on that. And recognise that it’s not acceptable to be abused. And if you’re uncomfortable with something, think it through and try and talk to someone else about it, not necessarily the person that’s doing it to you. But see if you can develop strategies to deal with it...because you can minimise things as well.”*

Those women who had remained silent about their abuse felt particularly strongly that telling someone was critical to disabled women dealing with their situation:

*“Talk to somebody. You can go on line and find an online agency or ring somebody up. At the end of the day you’ve got to tell somebody.”*

Naming the abuse was also seen as an important step – *“first they’ve got to realise that they are in an abusive relationship themselves”*. Similarly, interviewees emphasised, in their advice, the need for disabled women to believe they do not deserve abuse:

*“No-one ever deserves it...you need to feel you're worth something different – say to yourself that you are worth more. Doing that is so hard for disabled women (what with all the stuff about women being perfect and beautiful)...”*

Some women wanted to tell their own story to help others in similar situations:

*“And I just have been feeling that I really wanted to say this happened, to tell other women. So that perhaps my experiences can be of help to other people. I’m not upset about it anymore, when I look back, it’s like I’m some other woman.”*

As noted earlier, a few women were using writing as a way to deal with their experiences and to share their stories, engaging in drama productions, or working in disability organisations themselves to offer others help based on what they had learned.

#### **8.4 Women’s suggestions for improvement in practice**

*“I get the very strong impression that a lot of people are not really aware of the things that affect us. It’s not that the agencies don’t want to be supportive; it’s just that there is a lack of knowledge. Disabled women should be there in a supporting advising role and they are not.”*

*“All the serviced offered to non-disabled women should be offered to disabled women. What we need is equality and respect. Equality. We are part and parcel of society and society should make us part and parcel of IT. Not discriminating against us instead...”*

*“We’re not equal at all, you know. I think it just needs acknowledging for a start, because I don’t think it’s acknowledged. Until it’s acknowledged that this is happening and it’s probably happening to a lot of disabled women. And then there is nowhere for us to go. There’s no one for us to talk to. We talk to each other and that’s why I know it’s apparent.”*

Some of our research informants believed strongly that the issue of disability and domestic violence should be mainstreamed, and have greater visibility among all relevant organisations, so that these organisations are sensitised and better able to respond to issues for disabled women. When asked what agencies should do, one woman said the following:

*“I can list them for you if you like:*

- *Be aware of it.*
- *Don’t patronise.*
- *Don’t assume.*
- *Quite possibly the experience of abuse has been worse, but don’t assume.*
- *Don’t define her by her disability.*
- *Take her impairment on board in assessing the situation but don’t define her by it.*
- *Don’t have a ‘special’ different tone of voice.”*

Consulting disabled women was seen to be key for agencies at both strategic and operational levels, to enable them to develop improved policies:

*“I would say consult with disabled women who have experienced domestic violence and with disabled women in general. You know, bring in a disabled consultant to monitor progress, to review their policies, practices, procedures. Not only their physical access but the way the support services are carried out.”*

*“Also disability reviews at a more strategic level with disabled women in a consulting role.”*

*“They need to learn from women who have been there, and got out of it, willing to talk about it and give them advice, look at their facilities and services and assess what they need”.*

*“They need to involve disabled women in service plans -- learn that way, it is the only way to get it right.”*

Thus, in the view of our informants, the involvement of disabled women advisers needs to go further than consultancy, and to extend to strategic and policy reviews, service plans and monitoring progress.

For BMER women, it was important to have support services that were run and led by people of similar backgrounds, and who were sensitised to issues of disability and domestic violence. Sensitivity, confidentiality and safety were mentioned repeatedly by the BMER women interviewed. Safety was talked about in terms of physical safety, but also of emotional and cultural safety; hence the importance of having counsellors who were from similar backgrounds was considered vital. Food and hygiene were noted as particular issues for African-Caribbean women:

*“I know my food ...I’d like it to be cooked in a particular way without any hassle from someone from another cultural background. The way I like to be washed in a particular way and the way the house is being cleaned and that. Do you know what I mean? It would have to be somebody from my background who won’t be offended by all that and the way I like... you know I like my body to be creamed of moisturisers afterwards and my hair in a particular way. Just don’t get that with somebody from say white English.”*

A telephone helpline run specifically for disabled women affected by domestic abuse was suggested by a number of the women interviewed. Even those women who were reluctant to access support services said they would use such a dedicated telephone helpline. This suggestion was especially reinforced by women who had mobility related impairments.

Equally, some women stated that they would use an on-line counsellor or adviser who specialised in domestic abuse, if this was available, and suggested this was an important service for women who were restricted in their mobility and unable to leave their house, or for women who did not want face to face contact.

Interviewees who were in receipt of direct payments felt strongly about the lack of support available to them around this. They suggested that an external agency which could provide supervision and support for staff and women employing staff should be set up. Such an agency could also provide general support around employment issues, including in cases of disciplinary action against exploitative employees<sup>10</sup>.

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<sup>10</sup> It was further suggested (although not endorsed by the researchers) that in order to protect disabled people against abuse from PAs, the employment law should be reviewed to enable PAs to be employed on continual temporary contracts.

An important recommendation from our interviewees was the creation of a buddy system for those employing PAs, so that the more experienced can guide and support others:

*“So that you can have somebody that you can ring up. I would always say, although I have to say it’s not easy this, because a lot of disabled people are quite lonely so they welcome someone to go out with them. But try to not become too friendly with them because at the end of the day, it’s life to us, but it’s only a job to them.”*

One of the interviewees was in the process of designing a website called ‘*Being the Boss*’ to support people who are directly employing PAs.

It was suggested that attention needs to be given to where disabled women are rehoused, and some interviewees talked about being incredibly isolated. Policies on rehousing provision need sensitivity and care and to extend beyond simply providing accessible accommodation. A number of the women we interviewed also spoke about the difficulties they experienced in getting their non-disabled partners out of accommodation that had been specially adapted. Some had had to go to court and had found judges understanding while, for others, it had taken considerable time to get their adapted accommodation back. One authority had changed its rules so that only the name of the disabled person was put on the tenancy agreement and rent book.

Those women who had been unaware about support services and had not, therefore, accessed much help said it was important for disabled women to be informed about disability organisations and other services. The need for innovative ways to disseminate information to disabled women was underlined. It was suggested that posters could be placed in disabled toilets, supermarkets, and health centres. It was also suggested that images of disabled women, in all their diversity, should be included in any general and specific publicity around domestic violence.

Greater multi-agency/partnership work was seen to be needed when responding to disabled women experiencing domestic violence – ‘*so they’re all talking from the same page*’.

#### **a) Disability organisations**

Some of our interviewees had accessed disabled people’s organisations for general support and advice, as noted above, but had not disclosed

domestic abuse to them. The reasons for this varied. Some did not feel comfortable disclosing abuse, and others suggested there was no appropriate setting in which to do this. Most women thought disability organisations needed to have greater publicity and information about abuse, available in various places and formats. Further, it was suggested that issues of abuse needed to be openly discussed within the organisation:

*“I’ve thought long and hard about this one. I think for a start there kind of has to be this ‘no shame’ policy because I think it happens a lot. I don’t think I’m an isolated case really. I mean part of my abuse was quite extreme I admit, but a lot of it you see on a day to day basis, you know. People not being able to go to the loo when they want to or... I think there needs to be some kind of openness about it. Almost some like really healthy debate where people actually go, ‘Well, actually, I do feel intimidated by my carers,’ or ‘I do wish that they wouldn’t do X, Y and Z but I’m too scared to tell them’. There has to be some way of something being done about [it].”*

The issue of disabled women being able to recognise/name what is happening to them, and then formulate a way to tell someone, was seen as critical to then be able to receive support. It was suggested that relevant disabled people’s organisations needed to play a crucial role in this, through campaigning and information provision. The importance of addressing general abuse issues through specific support groups within disability organisations was highlighted – *‘even if women could see it, just not even have to be a part of it, it might open up more avenues to talk to other people about it’*. Disabled people’s organisations embracing the issue and being trained through abuse awareness courses was identified as an important aspect of improving practice around disabled women and domestic violence.

It was suggested that funding should be available to disability organisations to run self-confidence courses for disabled women which also included issues of abuse in a way that did not create warning bells for the abuser:

*“But flagging up in self-confidence and assertiveness about abuse but not actually saying it’s about domestic violence...because I think it’s hard for a disabled person to get beyond their doorstep. So that’s why I’m saying if disabled people’s organisations did*

*things but definitely not called them domestic violence but to flag these issues up.”*

## **b) Domestic violence organisations**

As for disability organisations, our interviewees had much useful advice for domestic violence organisations:

### **Women’s advice for domestic violence organisations**

*“Domestic violence projects should maybe be a bit more in tune with kind of disability equality issues.”*

*“In general, it really needs an overhaul, particularly in terms of how they are reaching people and the message they are sending out.”*

*“There’s always just the assumption that those services are for other people, they’re not for us. Just think if you see a picture of a woman being abused, it is never a Deaf woman or a disabled woman.”*

*“Domestic violence services? Yes, they need to take it on; they need to make their info accessible, especially to disabled women who suffer with information starvation.”*

*“They could tell people like me that they are there, reach out a bit so disabled women know they can go there. I thought they were not for me, and I expect other women do too... they don’t feel like they are there for women like me.”*

*“They [disabled women] need to be told about their rights and options, to have information to be made independent. We need to have the fear removed; the more fearful you are the worse the abuser suppresses you.”*

*“To support women like me who have no recourse to public funds, it saves our lives. I would have killed myself.”*

Physical accessibility was mentioned by all of the women interviewed. The following were typical statements made:

*“They need to have accessible buildings. They need to make sure they’ve got things in place for someone like myself.”*

*“There was only one that had an actual disabled hoist and, at that time, when I phoned up, the hoist was being used. I couldn’t go there -- so I couldn’t leave. That was one time I was thinking about leaving but I couldn’t because there was nowhere for me to go.”*

The women we interviewed stressed that domestic violence organisations needed greater awareness and training around the issues of disability and abuse, and that they should advertise the availability of their services to disabled women. In particular, the importance of recognising the complexity of impairments and their impact was seen to be important. A minority of women who stated they would never go to a refuge thought that a telephone helpline, as discussed above, staffed by people sensitised to the issues should be made accessible to women in similar situations.

### **c) Other services**

Clearly, available services are key in disabled women’s lives. The following quotes summarise some of the advice which our interviewees gave:

#### **General advice to services**

*“We need leaflets, publicity campaigns, more publicity, more resources and accessible services, all of it really. They have to start taking it seriously.”*

*“Treat us sensitively as individuals, services should be accessible, they should work in partnership with carers and with social services so they can learn about disabled women and assist them.”*

*“Well, I think just to be open-minded. It’s going to be more difficult if you’ve got the extra disability problems on top of the problems with being abused that everyone faces. So you’re bound to need some extra support, and they need to be open to that and learn more about it and just be open and accepting and human.”*

*“They always just look at medical needs, medical model, they are supposed to look at the social side as well but they don’t. You have to fight for services; they only improved for me because I pushed. Took five years fighting for everything, it never stops.”*

The need for professionals in all services (including adult services / social services) to ‘pick up on it more’ was highlighted by our interviewees, as was the need to develop greater sensitivity regarding asking women about their situation or enabling them to disclose.

In summary, women mentioned the following general issues in relation to good practice:

- Be informed about disabled women’s needs.
- Take advice from and consult with disabled women.
- Develop accessible services.
- Provide accessible well-publicised domestic violence services (including refuge accommodation) that disabled women know about.
- Do not threaten disabled women with institutionalisation if no refuge space is available.
- Develop good accessible alternative accommodation, both temporary and permanent accommodation, plus support to use it.
- Develop disability equality schemes and reviews with input from disabled women.
- Take disabled women seriously and do not patronise them.

#### **d) General**

The need for ‘open healthy public debate’ about the abuse of power in a relationship in relation to disabled people, as well as about domestic violence in particular was emphasised by a number of the interviewees, including for BMER women, older women and lesbians.

It was pointed out that, even though domestic abuse is pervasive and common, it is not widely known about. Sending out a message through a campaign to disabled women that it was okay to talk about abuse was highlighted repeatedly:

*“It’s kind of about raising awareness again, that it’s OK to talk about it. It’s OK to do something about it. It’s OK to stop it. It’s got something to do about being valued.....I think I’ve always been abused a bit throughout my life because I’ve always needed personal assistants. But intrinsic to that is that disabled women probably value themselves less because they are disabled. And that kind of feeds our passivity...like it doesn’t matter if I don’t eat one night because it’s just me.”*

The issue of taking care packages and PAs (if receiving direct payments) with them when going into an accessible refuge was repeatedly identified as a crucial one for disabled women experiencing abuse, as it severely limits options if a trusted PA cannot accompany them and the refuge organisation cannot provide a temporary substitute.

*“As far as I know there are very few safe places to go that are accessible, that’s one thing. And if the person that’s been the abuser is the person working for you, then obviously you won’t want to take that person with you to a shelter. So you might have to suspend them and if you suspend somebody you have to pay them. So how are you going to pay for your support whilst they’re being paid because the local authority, as far as I know, are not obliged to give you double funding for something like that. If that person isn’t the person that’s been abusing you, it’s very unlikely that one of your other PAs would be able to drop everything and come to support you in a safe house. And if that isn’t the case, who would pay for it if your care package is being paid by one authority, which it’s not easily transferable for a small period of time to another authority.”*

*“If you are having domestic violence from a close partner you might want to move away from the area. That in itself poses a problem because you can’t easily transfer one package across another authority. It prevents a person getting away. And I think that local authorities ought to now address the situation of it being a postcode lottery and it should be like your National Insurance number, it goes with you wherever you are. The fact that you’ve moved from one county to the other makes absolutely no difference to the amount of support you might need.”*

The excellent advice given by the abused disabled women we interviewed as to what agencies should do to improve their practice informs the following chapters, and has been extensively drawn on in producing our recommendations and good practice guidelines (see Chapter 11).

## Chapter 9: Good practice

A set of interviews was carried out with organisations which were attempting to develop good practice in meeting the needs of abused disabled women, and with individuals with particular expertise in this area. In these case study interviews with organisations (drawn from both the domestic violence and the disability sectors), more than one interview was carried out in each case, using topic guides developed by the research team in consultation with Women's Aid at the beginning of the study. Where possible, a manager, a worker and a service user were interviewed, although service users could not always be located.

One case study was a domestic violence organisation which had developed services for disabled women in a systematic way (but still felt that they were just at the beginning of the process and had a great deal to learn). One was an inter-agency project which offered liaison and policy development services but did not work with survivors of violence directly. This project had a particular commitment to addressing issues of oppression on grounds of ethnicity, sexuality, social class, age and disability. A third case study project was a disability co-ordinating project in a local area, committed to developing good practice. Two specialist domestic violence organisations for BME women, and a further local domestic violence organisation which had taken on the issue of services for disabled women, were also consulted.

In consultation with these various agencies, the decision was made not to name them or to describe their services in detail, since they believed themselves not particularly to be examples of good practice, but rather of agencies which were at least trying. The exception to this policy is the readily identifiable good practice developed by the Leeds Inter-Agency Project which is named in various examples noted in the subsequent chapters on recommendations for good practice and strategic development.

Key interviews were also given by two disability consultants and trainers who were members of disability advisory groups/working groups on domestic violence.

These consultants had taken an active part for many years in the disabled people's movement and in attempting to bring the issue of domestic violence and disabled women to the fore within this movement,

within Women’s Aid and in agencies across the board. An interview was conducted with a key disabled activist working on the coordination of disabled people’s organisations. Two further interviews were conducted with domestic violence strategy coordinators in local areas. Further consultations were held with three domestic violence forum coordinators, and a variety of disabled people’s and domestic violence organisations.

These interviews supplemented the findings of the interviews with ten national stake-holders (including with Women’s Aid nationally and with a representative from the National Domestic Violence Helpline), and the focus group and national consultation with disabled women, conducted earlier in the study. Ideas for good practice were drawn out from these various interviews and consultations, including those with disabled women themselves. The findings of the study in terms of good practice in dealing with disability and domestic violence have been noted throughout this report. Through the interviews described above, they were then supplemented and developed in the form of *Study Recommendations* which are laid out and discussed in detail in Chapter 11. To avoid repetition, these issues are, therefore, only briefly summarised here.

*“Good practice means all relevant agencies attempting to break down the invisibility and silence about disability and domestic abuse.”*

**Disability consultant**

**9.1 A brief selection of findings on good practice**

All the good practice interviews and consultations emphasised the need for more accessible refuge and outreach domestic violence services, and the need for both domestic violence and disability organisations to take the issue on in a fundamental way and to effect a ‘sea change’ in how abused disabled women are treated. To respond to their needs in an appropriate and effective way, resources are clearly needed in the two sectors, both of which, despite their admirable and important work, suffer from constant resource shortage and threats to funding. Attitudes to, and knowledge about, domestic violence and disabled women’s needs also require attention in all relevant agencies.

The need to accompany the development of accessible and welcoming refuge provision, with a reaching out to disabled women who might be

experiencing abuse to inform them about the provision, was also highlighted as good practice in the domestic violence sector.

Overall, practice cannot improve without the disability and the domestic violence sectors increasing their liaison and learning from each other.

*“The agencies need to work together. It is no good if the refuges don’t know about the disabled people’s organisations and the disabled people’s organisations don’t know about the domestic violence ones. Daft, isn’t it?”*

**Disability adviser**

The good practice interviewees were unanimous about the importance of such partnership. They also particularly emphasised the fundamental importance of disabled women themselves being involved in all policy and service development on domestic violence and disability. A principle of the disabled people’s movement is that attempts to meet the needs of disabled people should not happen without the involvement of disabled people. While this would appear to be an obvious and easily understood principle, our findings are that it seems to be often overlooked in general by both statutory and voluntary sector agencies and by local and central government. In this study, specifically, the involvement of disabled women in developments which affect them, and in service responses to the needs of women who are being abused, had often not been thought of by the agencies concerned. It is, however, a strong message from this study that such involvement must happen.

*“Discussing together what would work and what wouldn’t work. You know, actually consult with disabled women and look at what you can and can’t do practically together. And like it’s not a cheap option I don’t think. But I think it’s something that agencies should definitely think about. And look at getting specific funding to do that exercise as well”.*

**Disability and domestic violence coordinator**

Thus, learning from disabled women themselves, together with partnership and joint working between the various sectors, will be vital in

the future if services are to develop in which disabled women's needs are to be met.

Informants highlighted the need for local authorities and multi-agency initiatives to develop good practice guidelines on community care packages in terms of practice provision when disabled women have to leave home due to domestic violence; and they also stressed the need to improve the practice of statutory agencies more generally, in order to meet disabled women's needs more effectively. The following selection of quotations from interviews demonstrates how far, perhaps, we have to go.

*“Deeply patronising attitudes to disabled women remain throughout the statutory and voluntary sectors even though they may ‘pretend’ to have better developed attitudes than they really do.”*

*“Lack of awareness among social care agencies specifically is profound. Alternatively, they may have very limited awareness (for example, regarding wheelchair accessibility only).”*

*“Attention to disabled women's needs in relation to abuse needs to be mainstreamed in the statutory sector, written into their work and targets and integral to all relevant budgets and policies (rather than tacked on as an afterthought or forgotten until a disabled person arrives).”*

The following chapters discuss recommendations for strategic developments and for good practice in detail.

## **Chapter 10: Strategic development, disability and domestic violence**

A set of interviews was carried out, focussing on strategic and commissioning frameworks and agendas in terms of domestic violence and disabled women.

These included:

- Two interviews with a domestic violence inter-agency project.
- One with a local authority / Primary Care Trust (PCT) disability commissioning manager.
- One with Women's Aid nationally (as the national domestic violence charity supporting a network of over 500 domestic and sexual violence services across the UK).
- Three with domestic violence strategy coordinators.
- Two with disability consultants and advisers to the police.

The Home Office, the Department of Health, the Equality and Human Rights Commission and a Local Area Agreement strategy officer were also consulted, although little information was available from them. Additional documentary information was collected on commissioning guidance, and on the inclusion of disability and domestic violence in relevant policy documents and strategies. Recommendations and advice on strategic development were then drawn out from these interviews and from the related secondary research. In this chapter, we discuss in detail this advice which is also summarised in the Study Recommendations in Chapter 11.

### **10.1 The importance of the strategic, partnership and commissioning agenda**

To meet the currently unmet needs of disabled women experiencing domestic violence, good practice in the relevant agencies is essential. However, the development of such practice often depends on the wider strategic and partnership agenda, both nationally and in the relevant local area, in that policy is now developed in response to 'policy drivers', public services agreements, performance indicators, targets, and so on.

Strategically, therefore, the issue of disabled women and domestic violence needs to be part of all relevant strategic agendas, and national

and local performance indicators, and to be flagged at a sufficient priority level within these to ensure action is taken by local authorities, health services and other agencies to meet the required targets.

*“Strategic partnership working is essential because obviously domestic violence work can’t be delivered by any one organisation; it’s very cross cutting, as are oppression issues generally. So there is a whole range of strategic documents that you need to get it in. And relevant partnerships or plans like the Equality and Diversity Strategy that most local authorities have. Hate Crime strategies... You can ensure that it goes into those plans: Crime and Disorder Reduction Partnerships, Community Safety Plans.....”*

**Domestic violence partnership officer**

In particular, this can be the case in terms of the commissioning of services and of ensuring that disability and domestic violence organisations can feed into relevant commissioning frameworks.

Since local and national strategic frameworks change regularly with policy re-organisations and new national and local government policy initiatives, it is not possible to discuss strategic and partnership agendas comprehensively. A few current examples only are included in the following sections.

While many of present policy frameworks overlap with each other to some extent, those mentioned in this brief summary are loosely divided into national and local categories, although in fact a more holistic approach is required in any locality, depending on local circumstances.

## **10.2 National strategies, policies and frameworks**

### **a) Local Authority Agreements**

Local area agreements (LAAs) are three-year agreements with priorities agreed between the main public sector agencies working in an area and with central government. Partners are brought together under the umbrella of the local strategic partnership (LSP), which agrees a sustainable community strategy (SCS). The SCS is a long-term strategy for the local area based on consultation with local people. New LAAs are

being introduced from 2008, which will have the main role in allocating local funding. The new LAAs will no longer be an add-on to the multiple national performance frameworks under which local authorities operate – rather they will replace them.

Depending on the local situation, the needs of disabled women experiencing domestic abuse might potentially be highlighted within these agreements and indicators. This would, of course, depend on statutory sector and third sector partners (from disability and domestic violence services) being able to take the initiative in introducing the issue into the process.

However, in this policy framework, domestic violence is the subject of new national indicators as further discussed in the section on domestic violence organisations below. These specific indicators are criminal justice-focussed and less than adequate as a driver of comprehensive services. There appears to be little space in them to incorporate disability issues, which is a matter of serious concern. They replace the previously wide-ranging performance indicators of Best Value PI 225.

#### **b) Crime and Disorder Reduction and Community Safety Strategies and Plans**

Very importantly, domestic violence features in all community safety and crime and disorder reduction strategies and plans (CDRPs) across the country (from 2008, partnership plans, to incorporate annual ‘strategic assessments’ and ‘hallmarks’ of effective partnership under the new government Crime Strategy). It is often possible to highlight the needs of disabled women through this route; (see below).

#### **10.3 Further strategic and commissioning agendas**

There is a wide variety of further commissioning frameworks for different services. Domestic violence and disability might be able to be included - or prioritised at best -- within these frameworks, where relevant. For this to be achieved, as for LAAs, capacity is needed in the relevant agencies, including those in the community sector, to conduct the required work. Where possible or appropriate, the issue should also be included within the related service specifications, invitations to tender and service contracts.

*“But I think the key thing is to get it into commissioning... you know the move towards commissioning arrangements now. You need to develop goodwill by partnership working in terms of both commissioning and Service Level Agreements for agencies and there’s a move in the last couple of years is to get domestic violence in at a commissioning level. So an example of that is the Primary Care Trust here have agreed to ensure that in their Service Level Agreement with Accident and Emergency Services and Maternity Services. This will require them to work with ourselves to ensure that midwives are trained, etc...and that will include domestic violence and disabled women.”*

**Domestic violence and disability strategy officer**

The Local Government and Public Involvement in Health Act 2007 requires primary care trusts and local authorities to produce a ‘joint strategic needs assessment’ of the health and well-being of its local community. Joint strategic needs assessments are evidence-based and are expected to link across to other plans (e.g. PCT and local authority commissioning strategies and delivery plans, community safety strategies etc.). Our research informants suggested that there may be some potential for discussing domestic violence and disability in terms of these assessments, which need to be evidence-based, and to include the views of local people.

The Operating Framework for the NHS in England 2008/09 sets out an expectation that primary care trusts will develop an ‘Annual Operating Plan’ by April 2008 which will assist in reducing health inequalities and will be accompanied by ‘commissioning intentions’. In future developments of this framework, research respondents suggested that evidence and services regarding disability and domestic violence issues could possibly be included. Similarly, our interviewees suggested that the issue may be able to feed into ‘quality and outcomes frameworks’ for GPs and into all relevant service level agreements and similar binding agreements, as policy changes and develops.

It is also important to ensure that conducting adequate monitoring and recording of domestic violence as it affects disabled women is agreed at

a strategic level, not only locally, but also nationally, for incorporation into Department of Health figures, for example, as well as those of Women's Aid and disability organisations.

International Human Rights statutes and instruments and the national human rights legislation can also be useful in representing the needs and interests of disabled women who have experienced domestic violence, and in challenging poor service responses.

### **a) The Supporting People programme**

The Supporting People programme provides accommodation and support, including importantly, floating support for disabled people and others, and also for domestic violence survivors. This programme is key, therefore, in terms of providing support to abused disabled women (see also the section below on domestic violence organisations).

However, Supporting People feeds into the LAA framework which has the disadvantage, mentioned above in terms of domestic violence provision, of being driven by national indicators which are principally criminal justice-focused. These indicators do not include the provision of local women's domestic violence organisations -- which are the services most likely to be able to meet a diversity of needs, include those of disabled women. Ring-fencing of these funds is also due to be removed.

The future is therefore uncertain in respect of the provision of dedicated, local, third sector domestic violence services. There is some anxiety that these services, provided by local Women's Aid organisations and other domestic violence providers, and funded through Supporting People, are in jeopardy.

This may apply particularly to specialist services for BME women. (Many such local woman-controlled organisations, both general ones and those for BME women, have already recently lost funding or are under threat of doing so). The provision of disability services within these services, as strongly recommended throughout this report, may therefore be placed in even further jeopardy (see below).

### **b) The 'No Secrets' guidance**

The No Secrets (2005) national guidance produced by the Department of Health and the Home Office gives guidelines to local authorities responsible for investigating and taking action when a vulnerable adult is suffering abuse. Similar to child protection procedures, these include a

multi-agency approach and investigation framework leading to risk assessment, an assessment of the needs of the vulnerable person and the provision of protection, where needed.

Local authorities have developed this guidance, and it might potentially be adapted and used sensitively with disabled women experiencing domestic violence. (Note: 'Vulnerable adults' may not, however, be the best framework in which to consider the needs of abused disabled women, see also Chapter 11.)

### **c) The Domestic Violence National Action Plan and national initiatives on domestic violence**

There are very few or no mentions at all of disabled women in important government documents on domestic violence, for example, in the health context, the Department of Health, *Resource Manual for Health Care Professionals* (2000), *Responding to Domestic Abuse: A handbook for health professionals* (2005) which superseded it; and the Home Office Development and Practice Report, *Tackling Domestic Violence: the role of health professionals* (2000) also fails to mention disability issues. Similarly, there is scarcely a mention, except in sections on definitions and on vulnerable adults, in the Domestic Violence, Crime and Victims Act (2004).

Government policy is now focussed on the Home Office *Domestic Violence National Action Plan* (2005). In the original plan, disabled women were not specifically mentioned. This has continued to be the case in the later progress reports and in documentation and guidance about the recent developments in the criminal justice system (such as multi-agency risk assessment conferences - MARACs, - independent domestic violence advisers - IDVAs - and specialist domestic violence courts). In these documents, there is mainly silence about the specific needs of disabled women facing domestic violence (for example, see the Home Office *Specialist Domestic Violence Courts Resource Manual*, 2006).

To meet this situation a move away from solely criminal justice focussed responses to domestic violence, and the incorporation of a commitment to provide services, which include attention to disabled women's needs, would be recommended in future,.

#### **d) The Disability Equality Duty**

The Disability Equality duty came into effect in December 2006, requiring all public sector organisations to promote equality of opportunity for disabled people, including Disability Equality Schemes. The duty provides opportunities for the needs of disabled abused women to be highlighted and to lead to service development, as further discussed below.

#### **e) The Gender Equality Duty**

In a similar way, the general Gender Equality Duty now places an obligation on all public bodies and local authorities to develop Gender Equality Schemes. Research respondents in our study pointed out that the duty can be drawn on in domestic violence and disability work.

*“The Gender Equality Duty is quite helpful because it talks about relevance and proportionality and so if much larger numbers of women are experiencing domestic violence, then we have to be able to meet that need. So it’s actually quite useful. I think initially people thought it might cause us problems, but actually it helps us justify why we focus on women and disabled women as victims of abuse.”*

**Domestic violence and disability strategy coordinator**

### **10.4 Local implementation: equality and domestic violence policies and strategies**

#### **a) Domestic violence in all equality and diversity strategies/ disability in all ‘domestic violence’ strategies**

Disability and domestic violence are both issues of equality and human rights. Our interviewees pointed out that, as discussed in the following section, there is, therefore, a two-way policy issue in that:

- **Domestic violence** needs to be included in all **equality and diversity** strategies, agendas and frameworks, and
- **Disability** needs to be included in all **domestic violence** strategies, agendas and frameworks.

## **b) Domestic violence included in the equalities agenda**

Equalities strategies and plans - local authorities are now expected to have equalities and diversities agendas and strategies.

It is very important that a) domestic violence features in these, and that b) work is done to raise the profile of this issue for disabled women in the disability sections of any equalities strategies and action plans. (The needs of disabled women experiencing domestic violence are noted in various of the documents of the Equalities and Human Rights Commission and of the Disability Rights Commission which preceded it.)

Disability Equality Schemes - public agencies, local councils and other bodies must now have disability equality schemes in operation, as noted above. They are required to also put into place disability equality action plans, together with disability equality impact assessments. Local disabled people must be involved in and support (i.e. not merely be consulted about) the development of local disability equality schemes, and this should include disabled women. Our informants suggested that domestic violence should be mentioned in relevant disability equality schemes. This is likely to be an area where work could be developed on the issue of domestic violence and disability, both now, and in the future as these schemes are refined and reviewed.

## **c) Disability included in domestic violence strategies**

Domestic violence strategies and action plans - many local authorities now have independent stand-alone domestic violence strategies.

Alternatively, these strategies may be part of crime and disorder reduction plans (partnership plans in the future). Clearly, good practice is for the needs of disabled women to feature:

- in local domestic violence or crime reduction strategies;
- in priorities for action and in indicators associated with these strategies;
- in resultant action plans.

However, in secondary research for the study, we found that very few domestic violence strategies currently in operation around the country included much in the way of reference to disabled women. While some did not mention disability at all, many did include disabled women, but only in sections on definitions and understandings of domestic violence.

Only a minority included mentions in actual action plans, committing local agencies to engaging in action on the issue.

Where such action was included, it was normally minimal or of a general nature e.g. “to have a commitment to improving services for disabled women”. (Out of 124 districts, unitary and metropolitan authority domestic violence / CDRP strategies consulted, disabled women were not mentioned at all in 21. In 77, disabled women were mentioned often in definitions, but in only 26 were there any specific mentions in action plans.)

### **Domestic violence quality marks and minimum standards**

In some localities, minimum standards of service delivery have been developed as part of domestic violence strategies and action plans. This has been the case for Leeds City Council working with the Leeds Inter-Agency Project. To highlight this important good practice example, it is further detailed in Chapter 11 on the study’s Recommendations.

*“We’re part of the Leeds Crime and Disorder Reduction Plan in that our domestic violence strategy feeds into the Community Safety Plan and then it also feeds into the wider council service plan. So our Leeds Local Authority Plan has got domestic violence actions in that that we and others have to deliver on. So it’s a lever for other departments within the Council. If it is in their targets ... then there is leverage.*

*So this idea of having basic work on disabled women and domestic violence as a minimum standard is really important because that ensures that your broader work around domestic violence includes disabled women as part of your minimum standards and that’s naturally in there all the time. And we do the same with BME women’s issues as well. Then you can develop quality marks the agencies get for developing the minimum standards.”*

**Leeds Inter-Agency Project**

In summary, this example of best practice at the strategic level includes:

- The incorporation of domestic violence and disability into all relevant plans and strategies
- All local agencies developing domestic violence and disability action plans (including incorporation into relevant local service agreements)
- The development of domestic violence minimum standards
- Graded 'quality marks' which agencies attain (e.g. on accessibility, training and direct service provision for disabled women)

Most local areas might not be able to achieve such a developed action plan due to the lack of specialist workers to pioneer the work.

However, domestic violence coordinators or strategy coordinators now exist in most areas, and localities with well-developed and embedded domestic violence services are also likely to have capacity to develop this work. Areas without such capacity might still be able to begin the process in partnership with other local agencies.

### **10.5 Domestic violence organisations, local area agreements and fears for the future**

There is anxiety currently about the future of locally-provided, third sector, independent domestic violence organisations, as noted above in the sections on local area agreements (LAAs) and on the Supporting People programme. These organisations are key to the provision of flexible, sensitive, diverse local services on domestic violence. It is such flexible and sensitive provision that is most likely to meet the needs of disabled women.

However, prioritisation of such services will be hard to achieve within the new national indicators for LAAs, as described above. Further, in local procuring and tendering arrangements, local authorities are increasingly commissioning domestic violence services from large commercial or generic organisations (e.g. large housing associations) rather than smaller, flexible, women's services. Large generic organisations, without experience of domestic violence or disability, may be less likely to be able to meet abused disabled women's needs.

In this report, we have highlighted the need for domestic violence organisations to do more to take on the needs of disabled women, to build on the good work conducted in some local areas. However, there may be real doubts about the ability of the sector to survive at all.

Our research interviewees in this segment of the study strongly suggested that: the future of specialist domestic violence services needs to be ensured; the lack of policy drivers to provide such services within the new LAA agenda needs to be rectified; and the current threat to independent local provision outside criminal justice-focussed services and indicators needs to be removed, if there is to be any hope of meeting the needs of all abused women, and in particular those of disabled women, in the future.

Possible action to redress this situation could include the following:

- LAAs and other relevant strategic instruments across local areas need to include domestic violence services, and provision to meet the needs of abused disabled women, and identify sources of funding, where appropriate.
- The focus on criminal justice approaches to domestic violence in the new strategy frameworks (both the National Domestic Violence Action Plan and the local area agreement indicators) therefore needs to be widened to include focussed social, housing and health provision on domestic violence (as under the now superseded BV PI225), including for abused disabled women.
- Local Women's Aid and other domestic violence organisations therefore need to be able to participate in their local strategic partnerships and in the wider policy process, to attempt to achieve the prioritisation of domestic violence provision within LAAs and to ensure that this includes disabled women.

## **10.6 Disability services**

### **a) Disability advisory groups and networks**

Disabled experts and activists may be able to form, or sit as invited representatives, on disability advisory groups and networks advising statutory agencies like adult services / social services and the police.

Such groups may well be able to input into the strategic agenda or the wider practice of agencies in their local area. For example, the Disability

Independent Advisory Group of the Metropolitan Police is a group of about twenty people, including a smaller group who are particularly concerned with domestic violence. This group has put in place new guidance on what is now called 'safeguarding adults' and is developing other guidelines for the police, all of which aim to be based on the social model of disability within a human rights perspective.

#### **b) Disability Organisations**

Disability organisations include umbrella groups which may have a national brief. They may be able to engage in strategic work to encourage local organisations to take on domestic violence work, where this is relevant to their work, and to provide policy and practice advice and assistance to this end.

## Chapter 11: Recommendations and ideas for good practice and strategic development

### 11.1 Recommendations and ideas for good practice with practical examples

In this chapter, we have drawn out and developed all the recommendations for good practice, discussed in the report. We have particularly drawn on the good practice case studies and interviews we conducted, as well as the national surveys of domestic violence and disability organisations, the focus group and consultations, and most importantly, the interviews with disabled women themselves.

#### a) General Points

- More comprehensive services for disabled women experiencing domestic violence are needed in all sectors. At the moment, services for disabled women experiencing domestic violence are often overlooked, neglected or inadequate.
- Training and awareness-raising is also needed in all relevant sectors, to include demythologising disability and domestic violence, challenging prevailing attitudes, and overcoming fear, anxiety and lack of commitment among service providers.
- It is important to be aware that, proportionally, many more disabled women are abused than non-disabled.
- Attention should also be paid to abuse perpetrated by personal assistants (PAs), other carers, and other family members. These issues have been particularly neglected to date.
- Disabled women should never feel at risk of, or be threatened with, institutionalisation, if they report abuse.

These outcomes can only be achieved, most importantly through:

- The allocation of dedicated resources.
- Interaction between disabled and non-disabled women, as both service providers and service users, and the involvement of disabled women in service and policy development
- The domestic violence and the disability sectors learning from each other.

These general points are further discussed in the following detailed recommendations.

## **b) Service provision**

- i. Better service provision is required across the board, particularly more accessible refuge accommodation – taking accessibility in its widest sense -- together with accessible outreach and support services.
- ii. Floating support workers can be particularly effective to support abused disabled woman who wish to stay in their own home.
- iii. All involved agencies should be aware that disabled women may need to take their care package with them if they move due to domestic violence, or to negotiate a new one in the new area.
- iv. It is important to be aware that abused disabled women may need higher levels of focussed support than non-disabled women, and greater advocacy, telephone contact and outreach to sort out issues before they are ready to leave home for alternative accommodation (e.g. a refuge organisation).
- v. Support and protocols should be developed in order to make the self-directed support programme effective for abused disabled women<sup>11</sup>. It is vital, in order to ensure independence, that disabled women are in independent control of payments made to them; however, they also need to be provided with adequate professional support, should difficulties, including abuse, develop. (See also the section on PA abuse below).
- vi. Partnership work is needed between disabled people and domestic violence organisations, in order to build services and develop policies.

## **c) Training**

*“Training is needed for everybody who works around domestic violence...both specific targeted disability equality training and domestic violence training in the same way that there’s been specific training around LGBT domestic violence.”*

**Disability and Domestic Violence Consultant**

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<sup>11</sup> The self-directed support programme provides individual budgets, expanding the previous direct payments system and, in some areas, operates through an ‘in-control’ system intended to assist disabled people to control their support services.

- i. The provision of disability equality training and/or domestic violence training (as relevant) among service providers is required across the board to raise awareness and build expertise.
- ii. In best practice, this training would be provided by disabled women where possible, with knowledge of domestic violence issues.
- iii. Best practice would involve developing understandings of
  - a. a gendered approach to domestic violence
  - b. the social model approach to disability.
- iv. All training – as well as working to overcome lack of knowledge -- needs to challenge
  - a. negative stereotypes
  - b. prevailing social attitudes about abused disabled women.
- v. Training is also likely to challenge perceptions about the dynamics of personal abuse.
- vi. Such a training approach would focus on the complexity of ‘disability oppression’ as caused by social barriers (whilst acknowledging that individual impairments can cause difficulties as well).
- vii. Training would also cover diversity issues, and link insights about types of oppression experienced by disabled women with those experienced by BME women, lesbians, older women, young women and others.
- viii. Where possible, BSL interpreters should be available, and other access needs met in all training, including the use of accessible formats and venues.
- ix. Domestic abuse and disability training may need to be phased, to raise its profile. Numbers may be low initially, so training needs to be geared to availability and to be gradually embedded in the expectations of agencies. For example, short free workshops could lead on to longer two or three day courses.

### **A Good Practice Example - Dedicated training courses**

*“Initially we focussed on providing training in the women’s voluntary sector and disability organisations. We developed a training course (several days long) on Issues, Safety and Disabled Women Experiencing Domestic Violence which looked at building on their understanding of domestic violence and focussed in depth on how does domestic violence particularly affect disabled women and what are the additional issues they face when seeking help. And the training also linked to other oppression issues. So we’d look at disabled black women, disabled older women, disabled lesbians and what the complications and additional issues are for those groups.”*

**Leeds Inter-Agency Project**

#### **d) Policies**

- i. Disability and/or domestic violence policies (as relevant) should be developed across all sectors.
- ii. Service providers should aim, as a policy, to employ disabled workers with expertise in these issues (as further discussed below).

#### **e) Involving disabled women in developing services, decision making with disabled women and employing disabled women experts**

- i. Disabled women with knowledge about the issue should be involved in all developments in policy and practice.
- ii. Where possible, agencies should try to raise funding for a dedicated post: for example, a disability worker in domestic violence organisations or a domestic violence specialist in disability organisations.
- iii. Ideally, in best practice terms, mainstreamed funding should be aimed for, to embed this provision and make it sustainable.
- iv. Even where this is not possible, disabled women with knowledge about the issue need to be consulted about all developments in policy and practice. In best practice, this could be expected to include participation in operational and strategic development.

- v. Such involvement of disabled women should be monitored, including take-up of services, and participation in service plans and reviews.
- vi. Disabled women should be encouraged into management roles in the relevant agencies, as this can assist the issue to be dealt with more effectively.

#### **f) Accessibility**

- i. All relevant agencies should take advice on the needs of abused disabled women.
- ii. Disabled women have complex needs depending on their individual impairments, which extend far beyond physical accessibility.
- iii. All relevant agencies should use different formats in order to provide accessible publicity and information.
- iv. All relevant agencies should aim to provide accessible premises.
- v. Good practice includes the provision of fully accessible adapted accommodation for disabled women seeking refuge:
  - for women with mobility difficulties, a few examples: lifts, ramps, bathroom and kitchen adaptations, smooth floor surfaces, and so on.
  - for women from the Deaf community, a few examples: BSL provision, email and textphones (including, importantly, for helplines), flashing light fire alarms and vibrating pillows.
  - for women with visual impairments, a few examples: appropriate new technology where possible, large print information and colour-contrasted environments.
- vi. Further, small adaptations such as handrails, desk loops, personal listeners, kettle pourers, accessible IT, small moveable aids and extra lights can be provided, which are relatively inexpensive. (Specialist workers may be needed to install some of these or to get them working properly.)

#### **g) Awareness-raising and reaching out to disabled women**

*“Training and awareness is just a huge issue really. It’s getting people to see it as a priority.”*

**Domestic violence co-ordinator**

- i. The first proviso is to take disabled women seriously and to avoid being patronising.
- ii. In general, more publicity, posters and leaflets about the issue are needed, together with more information for service providers, and for disabled women themselves.
- iii. Agencies may be able to work directly with disabled women to raise awareness of domestic violence, and to spread information about available services and where to get help. This can include safety planning for individual disabled women who have experienced abuse.
- iv. It is important particularly to reach out to disabled women who are very isolated and not able to access any services, for example, through local radio, posters, information in disabled toilets, and so on.
- v. To develop such awareness-raising, it is essential to involve disabled women and disabled women's workers in decision-making about what is required and what would work best.

### **A Good Practice Example: Reaching out**

*“Our development work included going into resource centres for disabled people and setting up domestic violence workshops or meetings or going into existing disabled women’s groups to talk through domestic violence...Looking at defining what it is, what is a healthy relationship, what are the additional issues that disabled women may face both within an abusive relationship, but also when you are seeking help. So that was the focus of work with disabled women and the aim was to assist disabled women to identify themselves as victims if they were victims. And also to enable them to identify where they could get help, how they could maximise their safety, how they could minimise the impact on their children.”*

**Domestic Violence and Disability Coordinator**

#### **h) PA abuse (including paid/informal care workers)**

- i. Statutory and voluntary sector agencies need to be aware of, and vigilant for, the existence of PA abuse.
- ii. It may be necessary to overcome a tendency to believe the PA's account of events and to disbelieve or ignore the disabled woman's view. Sensitive and non-judgmental investigation is required, according to the relevant procedures.
- iii. Under the self-directed resources programme, the direct payments system is being expanded, ostensibly to give disabled people more control. This can be difficult for women experiencing PA abuse as they may not be able to access the support and professional help needed to deal with such a problematic issue. Agencies need to be aware of this difficulty.
- iv. Good practice includes providing guidance about such situations, peer support groups, 'buddying' with other disabled women employing PAs and advice-giving websites.

#### **i) Further recommendations for the statutory sector (additional to the major recommendations for all agencies above)**

- i. All relevant agencies should develop disability equality schemes and reviews with input from disabled women, and ensure that the needs of abused disabled women are included.
- ii. Good practice may include disabled domestic violence activists / consultants participating in disability advisory groups to advise statutory agencies on improving services (as also discussed in a wider strategic framework in the last chapter).
- iii. Initially, this work is likely to entail building networks and partnerships between the relevant statutory and voluntary sector agencies, followed by negotiating definitions of domestic violence for disabled women for statutory agencies to work to.
- iv. In good practice, such definitions are likely to include the fact that intimate violence is a common occurrence for disabled women; is sometimes perpetrated by family members in a carer situation or by PAs; may be experienced by a range of women (e.g. BMER women and lesbians); and may particularly include financial abuse and sexual and psychological violence. Thus, the definitions of domestic violence used for non-disabled women may need expanding.
- v. Domestic violence against disabled women is often not recorded adequately by statutory agencies. The next stage in addressing it, after agreeing definitions, is likely to be agreeing better methods of recording and monitoring. For example, the

Disability Independent Advisory Group of the Metropolitan Police has been able to suggest, and work towards the implementation of, improvements in recording practice on disabled women.

- vi. Thirdly, in good practice, the provision of services and of guidance within the statutory sector (possibly on a multi-agency basis) is required. These should be developed with input from disability advisory groups and agency partnerships.
- vii. This guidance may be able to build on the No Secrets (2005) national guidance on the needs of vulnerable people, sensitively adapted by local authorities in terms of disabled women experiencing domestic violence.
- viii. However, it is important also to be aware that ‘vulnerable adults’ may not always be the right framework in which to provide services for disabled women who have been exposed to violence. Separate dedicated support services are likely to be more appropriate.

*“You can look at safeguarding adults and domestic violence. It’s crimes against vulnerable adults. But my argument is it is vulnerable situations, not vulnerable individuals.”*

**Disability and Domestic Violence Consultant**

- ix. Overall, attention to the needs of disabled women who have experienced domestic abuse needs to be ‘mainstreamed’ in the statutory sector, to be written into work targets and to become integral to all relevant budgets and policies. (At the moment, it is usually tacked on or overlooked until a disabled woman needs help.)
- x. Both services provided and related guidance (as well as training and publicity) need to give the disabled woman experiencing abuse as much control as possible, and to balance protection and risk assessment with an empowerment approach.
- xi. Disabled women should never feel at risk of, or be threatened with, institutionalisation, if they report abuse. They should never be placed in residential institutions as a solution to domestic abuse (unless they wish this outcome).
- xii. Welcoming and accessible temporary accommodation and homelessness provision is particularly required to enable abused women to leave violent situations. Ideally, women also

need support to get there, and facilities should be advertised so that disabled women are aware that options exist under the homelessness legislation.

**j) Community care packages**

- i. Good practice includes local adult care services putting in place good practice guidance about community care packages and domestic violence, possibly agreed on a multi-agency basis.
- ii. Disabled women experts, and both domestic violence and disability organisations, need to be consulted thoroughly about such guidance.
- iii. There should be processes in place to ensure it is then fully implemented.
- iv. Thus, best practice is for the community care system and care planning to be flexible enough so that women's care packages are portable. This is likely to include agreements between different local authority areas, in order to avoid disputes in individual cases about who is responsible.
- v. Additionally, even in localities where it may be too ambitious to agree multi-agency guidance on care packages, social services / adult services staff need to have training on responding to disabled women who are experiencing domestic violence, including how best to support those who wish to leave home.
- vi. Similarly, refuges need to be aware of how their local services work so that they can achieve the best outcomes for disabled women coming to them.

## **A Good Practice Example: Agreed guidelines on community care packages**

*“We worked with adult services to come up with guidelines around community care packages because some disabled women will already have a community care package in place, so that would mean that either they have a personal assistant employed or some sort of allowances in place that would supplement their living standards and their carer. The guidance means that social services now know how to respond to women experiencing domestic violence and to assure the women that the community care package does not end because they move house. It includes doing reassessments and seeing what changes there are in what the woman’s needs are. But for the package to still continue...”*

*The guidance is aimed both at social workers and at refuge staff as well so that they know how to interact with social services and what they need to be asking for. It also makes adult services aware about domestic violence and disability issues.*

*These guidelines on community care packages were sent out to local organisations, to the refuges, but also to the disability organisations... So that they were aware that this was in place...It was also circulated through social services email so all their staff were aware of it.*

*With any guidance or policies when they are first written, the issue then is getting agencies to know about them and getting people to actually action them which is quite problematic and entails continual work.”*

### **Domestic Violence Inter-agency Project**

#### **k) Fair Access to Care Services.**

Fair Access to Care Services (FACs) policy and practice guidance and eligibility criteria regulate access to social and support services for disabled people, through assessments by social workers and relevant professionals as to their level of eligibility or non-eligibility to receive services. The threshold criteria for the various levels of eligibility have relevance as to whether abused disabled women are able to access help. Local work should be conducted to

ensure abused disabled women receive the right level of support and are eligible for services.

**I) Further recommendations for disabled people's organisations (additional to the recommendations for all agencies above)<sup>12</sup>**

*“Disabled people's organisations may want to provide services on domestic violence– it is not that they are intending to overlook it – but they tend to have no resources, or are currently being cut back, so they just can't; it is not that they don't want to.”*

**Disability Consultant working with organisations of disabled people**

- i. As noted above, disabled people's organisations with a relevant brief need to be able to take on domestic violence issues.
- ii. Thus, secure resourcing is the first requirement, in order that they are in a position to do this.
- iii. Some disabled people's organisations are not aware of gender issues and of violence against women, and need to engage in training and awareness-raising on these issues.
- iv. Domestic violence and disability training, including on all related equality issues (see Training section above) is therefore key, including training about asking about domestic violence and being able to respond appropriately if disclosures are made.
- v. Awareness-raising about domestic violence is clearly needed throughout the disability field, to include posters, leaflets, awareness-raising events, and so on, as well as training.
- vi. If disability organisations are to take on domestic violence as an important issue of concern, they need to develop their own domestic violence policies.
- vii. Organisations with a relevant brief should employ workers with domestic violence knowledge (as noted above).
- viii. It is helpful if organisations providing support and advocacy are able to offer a choice of male or female advocates to those using their services.
- ix. A further example of good practice in this area is to find out

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<sup>12</sup> We recognise that large disability organisations will have more resources than many organisations of disabled people, and therefore should be more able to implement these recommendations.

about, and to set up liaison with, local domestic violence organisations. This is likely to entail working to increase awareness regarding domestic violence organisations among disabled women.

- x. Thus, partnership and inter-agency work with local domestic violence organisations, forums and services is vital in developing good practice.
- xi. In general, there is a need to raise the profile of the issue as a core one within the work of relevant disabled people's organisations and the disability movement.
- xii. In terms of prioritising responses to abused disabled women, where possible, this needs to be embedded in any action plans, operational priorities and budgets within relevant disability organisations (particularly those which are more developed).

**m) Further recommendations for domestic violence organisations (additional to the recommendations for all agencies above)**

- i. Local domestic violence organisations need to be fully inclusive of all women, including disabled women, as discussed throughout this report.
- ii. This means that there is an urgent need for more facilities for disabled women of all types, including outreach, advocacy and refuge provision, embedded across all services.
- iii. Disability equality training should also be provided (delivered by disabled women experts where possible) in all domestic violence organisations (as discussed above in the Training section).
- iv. Good practice is that all refuge organisations should have full physical access, as discussed above, and should be compliant with the Disability Discrimination Act. Good practice is demonstrated by premises which are fully accessible in all ways, for example, providing a fully adapted flat or bungalow for refuge users.
- v. Best practice means going above and beyond what is required under the DDA which is a basic minimum, and negotiating this together with disabled women.

### **A Good Practice Example: Prioritising disabled women**

One refuge provider had a choice between providing a much-needed new office or a disability access suite, and chose the latter, out of commitment to the issue.

- vi. However, after the provision of such accommodation, good practice necessitates that further work will be required in order for it to be successfully used, including advertising, meetings with disabled women's groups and individuals and incorporating the disabled community in such outreach. Unless disabled women are specifically 'targeted' in domestic violence publicity and outreach, they are unlikely to know that accessible facilities are now available.
- vii. A further example of good practice in this area is to find out about, and to set up liaison with, local disabled people's organisations. This is likely to entail working to increase awareness regarding domestic violence organisations among disabled women through women's organisations, day centres, floating support, outreach, community services etc., to explain the way the domestic violence organisation could meet their needs.
- viii. Outreach and publicity of this type might include inviting disabled women to participate in events on disability and domestic violence, and on provision of services, organising focussed meetings with disabled women. It might also entail the employment of a disability advocate as noted above.
- ix. Thus, best practice is that availability of accessible services needs to go hand in hand with a wider 'reaching out' exercise, both with other service providers and with users of services.
- x. Reaching out needs to be to all disabled women, including BMER women and lesbians experiencing abuse. Abused disabled women, of course, do not form a homogeneous group, but rather are likely to come from diverse backgrounds, and to have different types of impairment, needs and life experiences.
- xi. Thus, publicity information needs to take on these different needs, to be provided in different formats, and to be a) accurate and b) detailed.

- xii. Good practice in using accessible formats may require lengthy communication and cannot necessarily be done quickly.
- xiii. A disabled woman coming to a refuge may need prior visits to assess, for example, whether it is possible for her to cope there, whether PAs can be provided or can be accommodated if accompanying her, and so on.
- xiv. Good practice involves avoiding isolation for disabled women. This includes reaching out both *before* a woman comes to the refuge and also *after*. For example, an adapted suite may exist but be on the ground floor away from other refuge residents and communal meeting areas. There, therefore, needs to be a commitment to encourage interaction and to make shared spaces accessible, e.g. laundry facilities.
- xv. Both workers and residents who are not disabled may need to work on demystifying disability and addressing the social model. This may entail breaking down the 'taboo', talking about issues for disabled women in the refuge, honestly and openly addressing issues and overcoming anxieties that non-disabled workers and women may have about 'getting it wrong'.
- xvi. In terms of making the needs of disabled women a fundamental issue in domestic violence organisations, managements need to embed the issue in their action plans, operational priorities and budgets.
- xvii. Best practice is for disabled women to be represented in the work of the domestic violence organisation (including, where possible, minority women and lesbians), as helpline, refuge and outreach workers. In order most effectively to foster change, it is particularly important for disabled women to be represented at management level in local domestic violence projects and also regionally and nationally in Women's Aid.
- xviii. Women's Aid national office should promote best practice and embed attention to disability as a core issue in domestic violence work, both locally and nationally, in order to effect the 'culture change' identified in this study. This can begin to be achieved through the dissemination of these findings and recommendations, and through associated resources.
- xix. Incorporation of issues for disabled women should be included in good practice guidelines and National Service Standards, along with other equality and diversity issues.

## 11.2 Recommendations for Strategic Development

This section summarises the discussions in Chapter 10.

### a) Strategic and Commissioning Frameworks

- i. A strong recommendation of the study is that all relevant strategic agendas and commissioning frameworks should feature domestic violence in general, and responding to disabled women's experience of abuse in particular.
- ii. These issues should be flagged at a sufficient priority level to ensure policy responses, and included in all relevant national and local performance indicators.
- iii. Guidelines for adequate monitoring and recording of domestic violence against disabled women should be developed at a strategic level, both locally and nationally (e.g. by the Department of Health).
- iv. International Human Rights statutes and instruments and the national human rights legislation can be used in representing the needs of abused disabled women.
- v. Local services are now provided through local area agreements (LAAs), and domestic violence needs to be included at various levels within them.
- vi. Depending on the local situation, it may be possible specifically to highlight the needs of disabled women experiencing domestic abuse in these agreements, if the statutory sector and disability and domestic violence services are able to introduce the issue into the LAA process, including in terms of performance indicators<sup>13</sup>.
- vii. The needs of disabled women experiencing domestic violence need to feature in the future development of the Supporting People programme (in terms of both residential provision and floating support), despite the new arrangements for this programme within LAAs.
- viii. It should be expected that the difficulties of disabled women experiencing abuse will be addressed in the Home Office National Action Plan on Domestic Violence (which currently has very little to say about this issue).
- ix. Similarly, it may be possible to include the issue in joint strategic needs assessments in local areas, as well as in 'commissioning

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<sup>13</sup> There are no longer multiple national performance indicators for domestic violence work, however.

intentions' and frameworks and a variety of other relevant PCT and local authority strategies. This also applies to tendering arrangements, as well as to service level agreements and plans, and similar documents.

#### **b) The Disability and Gender Equality Duties**

- i. The needs of disabled abused women can be highlighted in the disability equality duty for public sector organisations, including the development of disability impact assessments and disability equality schemes.
- ii. Similarly, the gender equality duty provides opportunities to provide services on domestic violence for disabled women.

#### **c) Domestic violence strategies and the diversity and equality agenda**

- i. All equalities and diversity work should include attention to the issue.
- ii. Domestic violence is included in all **crime and disorder reduction and community safety strategies and plans** across the country (from 2008, **partnership plans**). The needs of disabled women should be specifically addressed in these plans.
- iii. In particular, local areas have developed domestic violence strategies, either as part of their crime and disorder reduction agenda or as stand-alone strategies, which should incorporate services for abused disabled women.

Thus there are two general principles:

- Disability needs to be included in all domestic violence strategies, agendas and frameworks developed by local authorities and strategic partnerships.
- Similarly, domestic violence and disabled women should feature in all diversity and equality strategies, agendas and frameworks, both locally and nationally.

#### **d) Domestic violence quality marks and minimum standards**

- i. Local domestic violence strategies and action plans (and agencies themselves) should work towards developing domestic violence minimum standards to include meeting the needs of disabled women.
- ii. In best practice, services could then qualify for graded 'quality marks' which agencies attain (e.g. on accessibility, training and

direct service provision for disabled women) and could subsequently use in their publicity, targets and documents.

### **A Good Practice Example: The Leeds Domestic Violence Strategy and Action Plan**

The Leeds Inter-Agency Project (LIAP) has worked extensively with Leeds City Council to develop a recurring three-year Domestic Violence Strategy and Strategy Action Plan for the city which integrates action points on developing services for marginalised groups of women, including disabled women and BME women.

In delivering the Strategy, thirty-five agencies have developed Domestic Violence Action Plans. As a minimum standard in their Action Plan, they must ensure that their services are accessible to disabled women, so that this issue then becomes integrated into planning and into the work agendas of other agencies. Work plans have to include action on producing information in a range of formats, on sending staff on training, and on access issues in terms of physical barriers, attitudinal barriers and structural barriers for disabled women within the organisations concerned.

The Leeds Project found it was useful to have a dedicated worker focussing on the issue of disability to ensure these issues were integrated at a strategic level to embed them in the work of other agencies.

This work has developed into the **Leeds Domestic Violence Services Minimum Standards Quality Mark**. There are three levels to this quality mark with requirements to be achieved for each one for disabled women and BME women experiencing domestic violence. For level one for example, these include training and accessibility. They are then incorporated into local Commissioning Frameworks for agencies and the relevant Service Level Agreements, which are consequently permitted then to use the domestic violence Minimum Standards Quality Mark in their policies, publicity and documentation.

#### **e) Domestic violence organisations**

- i. The study strongly recommends that the future of specialist domestic violence services needs to be ensured within the Local Area Agreement agenda, as discussed in detail in the last chapter.
- ii. LAAs and other relevant strategic instruments across local areas need also to include domestic violence services to meet the needs of abused disabled women, including the provision of funding where appropriate, or information on funding sources.
- iii. Local Women's Aid and other domestic violence organisations need to be able to participate in their local strategic partnerships and the wider policy process, to attempt to achieve the prioritisation of domestic violence provision within LAAs and to ensure that this includes disabled women.
- iv. The current focus on criminal justice approaches to domestic violence in the new strategy frameworks (both the National Domestic Violence Action Plan and the Local Area Agreement indicators) must be widened.

#### **f) Disabled people's organisations**

- i. Umbrella groups and partnerships in the disability field might be able to promote the strategic inclusion of services for disabled women experiencing domestic violence in the work of disabled people's organisations and disability services.
- ii. Disabled experts and activists might be able to form, or to participate as invited representatives in, disability advisory groups advising statutory agencies; (e.g. adult care services and the police).

Overall, it is essential that all relevant services, including the statutory sector and both domestic violence and disabled people's organisations take on the issue of domestic abuse experienced by disabled women - throughout service provision, training and awareness-raising, policy development and the wider strategic agenda, locally and nationally.

**For too long, disabled women facing abuse have been ignored and left without assistance from the agencies meant to offer help. Now is the time to make a change.**

We hope that the recommendations of this first national study of domestic violence and disability will contribute to this change.

## **Chapter 12: Conclusion**

In this report, we have discussed the experiences and needs of disabled women in the UK in terms of domestic violence, and made a series of recommendations for domestic violence and disabled people's organisations, statutory agencies and local and national government.

In overall summary, much greater attention needs to be given to the issue of disabled women's experiences of domestic violence in all relevant agencies, policies and services. At both the strategic level and in the development of best practice, what is needed is the integration of both domestic violence into all relevant disability work and disability into all domestic violence work, within a broad human rights perspective. All agencies with a relevant brief need to develop understandings of violence against women and of the social model of disability – and, in general, to evolve an intersectional way of thinking and acting about this complex and distressing issue.

In conclusion, a national study of this type has been a long time coming, and the research team and Women's Aid are privileged to have been involved in it. You are only reading this report today because of the courage of disabled women - both service users and service providers - who have experienced domestic violence, and who have worked together with activists from both the disability and domestic violence movements. Collectively, their efforts have made our study possible. Our heartfelt thanks to the brave and steadfast women involved who have continued to pursue the issue in the face, often, of ignorance, disbelief, voyeurism and lack of commitment.

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## **Appendix: Methods used**

The research team was managed by Women's Aid. It included both disabled and non-disabled researchers and was advised and monitored throughout by a small Advisory Group of disability experts, set up by Women's Aid. The project had the services of two disabled project consultants from the disabled people's activist movement and disability organisations, and a non-disabled research consultant. The non-disabled team members together with Women's Aid managers undertook disability equality training.

The study received ethical approval from the Ethics Committees of both universities and was conducted according to the strictest ethical principles in terms of protecting the safety, privacy and confidentiality of those interviewed, gaining informed consent, involving disabled interviews further in the research process, if they wished, and interviewing in a supportive, respectful way.

### **Stage 1**

In Stage 1 of the study, the methods used included an initial focus group with disabled women to inform the development of the interview schedules and the content and design of the research overall, together with interviews with ten key professionals and activists in women's and disability organisations about issues for abused, disabled women. The topic guides for both of these were piloted, and provisions were made to conduct the focus group and the interviews which were specifically with disabled women sensitively and to provide accessible and supportive environments, transport and facilities.

A review of all the relevant national and international literature was conducted, accompanied by an analysis of UK policy and legislation related to domestic violence and disability. At the same time, an email, telephone and correspondence consultation with disabled abused women was conducted through Women's Aid nationally, supplemented by consultations with a range of disability and domestic violence organisations, and the distribution of publicity through the UK Disabled People's Council and a wide range of both disability and domestic violence organisations.

The two national postal surveys, one of domestic violence organisations and one of organisations of disabled people, were then conducted. The questionnaires for the surveys assessed the extent and quality of a) local domestic violence services and b) disability organisations, in meeting the needs of abused disabled women throughout England; the scope of provision for disabled women in both sectors; accessibility and the use of adaptations and aids; compliance with the Disability Discrimination Act (1995 and 2005); gaps and services needed; and examples of good practice. Awareness and attitudes to disability and to abuse were also assessed.

In regard to the latter: for domestic violence services, we assessed attitudes about disability, as indicated by the presence or absence of the following:

- Measures to make communication and support easy, effective and comfortable;
- Attempts to reach disabled women experiencing abuse within specific communities;
- Interaction with local disability organisations;
- Provision of information-raising materials for both disabled and non-disabled women;
- Provision of Disability Equality Training as a means of increasing knowledge and understanding.

This last point – the provision of Disability Equality Training - could be expected to translate into shifts in attitudes towards disability and to lead to improved accessible services. We also looked at the proportion of organisations employing disabled women as workers, thus enabling women using services to work with staff members who shared experiences of disability as a socially created exclusion.

With regard to disability services, we assessed attitudes about domestic abuse in relation to the follows:

- Knowledge of domestic violence services and what they could provide;
- Whether disability services could offer specific support for disabled women experiencing domestic violence;
- Whether they had specialist workers in post;
- Whether workers had had domestic violence training, and their attitudes towards domestic abuse.

For both types of services, information was collected on equal opportunities policies and on whether domestic abuse organisations had disability policies, audits and impact assessments, and disability organisations had dedicated domestic violence policies.

The survey questionnaires for the two surveys were each drafted, piloted with three specialist organisations in the relevant sector and re-drafted, with input from the project Advisory Group and Women's Aid. The survey to disability organisations was distributed by the research team and the survey to domestic violence organisations was prepared by the team and then sent out through Women's Aid National Office. All questionnaires were sent out with a covering letter and research background sheet, with a three-week response time. Both surveys were followed up with a reminder letter giving a further two weeks to respond, followed again by reminder emails.

Further, both surveys were then extensively followed up with telephone contacts. This was particularly the case for the survey to disability organisations for which the initial response rate was poor. A great deal of work was undertaken to enable organisations to complete it. Many disability organisations, located in the voluntary sector, are transient and over-worked and it was difficult for them to find time to work on a survey about a subject that some of them viewed as tangential to their core responsibilities. The survey revealed that 26 organisations had closed within the time span and many were threatened with losing funding. The most vulnerable were small organisations of disabled people. The initial response rate from domestic violence organisations was substantially more favourable, partly because the questionnaire was circulated through established Women's Aid and domestic violence networks. However, staff shortages, and the number of surveys to which domestic violence services are expected to respond, were also identified as militating against a high response rate. A number of domestic violence staff expressed the fact that they were overburdened with work and responsibilities, while simultaneously recognising the importance of the survey.

Not all responding organisations for either survey completed the questionnaires in full, resulting in some missing data for both. The surveys were analysed using SPSS.

The results of these surveys were supplemented by a) statistics from Women's Aid's 2005-6 Annual Survey of domestic violence

organisations, which included a count of women and children using refuge accommodation and other domestic violence services; and by b) information on facilities provided by domestic violence organisations, from statistics collected in 2006 for UK refuges on line (UKROL). Data from both these sources were provided by Women's Aid.

## **Stage 2**

In stage 2, disabled women were interviewed about their experiences of domestic violence. The interview schedules were drawn up in consultation with Women's Aid and the Advisory Group, and three pilots were conducted. The interview schedules were then modified accordingly. Thirty women who had experienced abuse were interviewed in a sensitive and supportive way. We attempted to form a purposive and diverse sample of disabled women who have experienced domestic violence, including women with mobility, hearing and visual impairments and other conditions, and from diverse backgrounds, on the basis of ethnicity, sexuality, socio-economic status and age. All the interviewees were approached and treated with particular attention to safety and to confidentiality, and with sensitivity in addressing specific issues raised by each individual woman's access needs. Accessible locations and interpreters were found, where needed. (Most interviews took place in the women's own homes and our thanks are due to them in welcoming us in this way). Some interviews were conducted by telephone where the woman preferred this. Each interviewee was asked for her consent. All interviews were then conducted in a supportive and safe manner. The interviewees were paid an honorarium and provided with a contact and information list. They were offered the opportunity to change or amend their interview schedules if they wished and to keep a copy of the transcript or tape.

Topics in the interview included:

- Women's personal experiences of domestic abuse in general, and in terms of being disabled.
- Women's experiences of services requested and received.
- The benefits and shortcomings of the services provided.
- Any difficulties experienced in accessing services.
- Ideas and advice for good practice to feed back both to other abused disabled women and to service providers and policy-makers.

All interviews were transcribed, but treated with the utmost confidence.

It proved difficult to locate enough interviewees, and the team conducted substantial and lengthy work producing and distributing publicity about the interviews, following up possible contacts, networking as relevant, building links with organisations, travelling to distant interviews, and in general making contact with disabled women. The latter sometimes involved extensive telephone contact and provision of support before and after interviews. The interviews were then analysed thematically, to draw out key themes about disabled women's needs and their views of the services they had used. Particular attention was paid to the needs and views of black and minority ethnic women, lesbians, and younger and older women in the analysis. Together with the results of the consultations with disabled women and the input of disability and domestic violence services, these various data sets were triangulated to consolidate and evidence themes and findings.

Good practice was then identified through a series of case study interviews and interviews with individuals with expertise on practice issues, using a piloted topic guide. These interviews assisted us to identify features of actual best practice at this time, and we then produced recommendations for the further development of good practice in the various agencies and organisations concerned. A further set of interviews with strategic and commissioning managers and disability consultants was conducted, after consultation with Women's Aid, to draw out relevant strategic and policy issues at both national and local levels. Recommendations for strategic development and input were then developed.

The study will lead, through Women's Aid, to a publicity campaign, the production of a strategy and good practice document and the holding of a high level strategy conference with representatives of government and relevant agencies.