CDFV Re@der

Volume 10 No. 1
September 2011

Domestic and family violence database summary – disabilities

Preparing your agency to be responsive and accessible

A human rights approach to disabilities

CQUniversity AUSTRALIA

www.noviolence.com.au

Director's message

Women with disabilities are among the most vulnerable victims of domestic and family violence, as discussed in this edition of the Re@der, and policy and practice that responds to their particular needs is vital. There are two major policy initiatives addressing domestic and family violence, which are currently operating in Queensland. These are *For our sons and daughters: A Queensland Government strategy to reduce domestic and family violence 2009-2014* and the Council of Australian Government's (COAG) *National Plan to Reduce Violence against Women and their Children 2010-2022*, which is to be implemented through a series of four three-year action plans. The federal government and each state and territory is to develop and implement three-year action plans, which reflect their jurisdictional priorities, within the framework of the 12-year National Plan. For the period 2010–2013, the Queensland Government's action plan will need to respond to areas of required action outlined in its own strategy, as well as those identified in the National Plan.

Both policy documents acknowledge disability as one of a number of particular factors that must be taken into account in the way their strategies are implemented. However, and while the National Plan identifies women with disabilities as a priority target group for initiatives funded under the Local Community Action Grants, both the State and National policy frameworks appear to see service delivery as the area requiring most urgent development in responding to the needs of women with disabilities. The National Plan commits to supporting "... better service delivery ... through the development of new evidence based approaches where existing policy and service responses have proved to be inadequate ... (and)... investigate and promote ways to improve access and responses to services for women with disabilities." (pp 27-28). Under the heading *Connected victim support services*, one of five identified areas for reform, the Queensland Government strategy states that an expected benefit of its initiatives is "improved responsiveness to the safety and needs of ... people with a disability..." Several performance indicators are identified in the strategy, including "...increased referral pathways for victims and perpetrators; increased provision and variety of services and programs; and improved coordination between services".

Healey et al (2008)[1] analysed policy and practice in Victoria to determine the extent to which it was responsive to the needs of women with disabilities affected by family violence,[2] and to make recommendations to improve responses. Particular issues highlighted in their report include inadequate collaboration between the disability and family violence sectors; a lack of understanding that 'access' is not only about physical needs; the general lack of adequate information in family violence standards, codes and guidelines on how best to support women and children affected by violence; lack of adequate training on working effectively with women with disabilities; and the failure of most services to routinely identify women with various disabilities in data collections. Each of these points is expanded on in the report and the implications are well illustrated through a number of case studies.

The article on CDFVR's Domestic and Family Violence Database on page 3 demonstrates that people with a range of disabilities are frequently accessing domestic and family violence support services in Queensland. What is not clear is the ability of the services to adequately address their needs. The report of Healey et al (2008) is recommended reading as a basis for reviewing internal service policy and practice and developing strategies to ensure genuine inclusion of people with disabilities in efforts to address domestic and family violence.

---

[1] Healey L, Howe K, Humphreys C, Jennings C & Julian F 2008, *Building the Evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria*. Women's Health Victoria and Victorian Women with Disabilities Network.

[2] *In Victoria the term "family violence" is inclusive of spousal, and other family relationships, affected by violence.*

Inside this issue

Centre News

Proposed international research collaboration

CDFVR Director, Heather Nancarrow, who was recently invited to be a member of the Canadian Observatory on the criminal justice system's response to intimate partner violence, attended a meeting with Observatory members in Montreal on 15 and 16 September. The purpose of the meeting was to develop a grant proposal to explore the various justice approaches to intimate partner violence in Canada, Australia, the United Kingdom and the USA, particularly as they relate to outcomes for victims, the accused and children exposed to intimate partner violence. Other Australian members of the Observatory are Professor Paul Mazerolle (co-investigator) from Griffith University and Dr Stephen Sellers (also from Griffith University) and Robyn Holder from the Australian National University.

Immediately prior to the Montreal meeting, Heather had the opportunity to spend several days with Professor Jane Ursel in Winnipeg, Manitoba, where she sat in on the specialist family violence bail and trial courts; met with crown prosecutors, staff of the Criminal Organization High Risk Offenders Unit, and the Victim Support Services; and visited several women's services.

Canadian Observatory members meeting in Montreal, Canada.

Panel discussion - National Plan to Reduce Violence Against Women and their Children 2010-2022

Wednesday, 26 October 2011
9.00am to 11.45am
CQCM, CQUniversity, Boundary Rd, Mackay

Domestic and family violence database summary – disabilities

by Annie Webster, CDFVR

In 2009, the Australian Bureau of Statistics (ABS) reported that 18.5% of all Australians reported having a disability. Disability is defined as *any limitation, restriction or impairment which restricts everyday activities and has lasted, or is likely to last, for at least six months. Examples range from loss of sight that is not corrected by glasses, to arthritis which cause difficulty dressing, to advanced dementia that requires constant help and supervision*. Although more males experience disabilities in their earlier years, females make up the larger proportion of disabilities over their lifetime (ABS 2009).

In keeping with this quarter's disability theme, this article analyses the 8% (n=13 135) of new client matters[1] where people who have one or more disabilities, and are either subjected to or use violence, have sought assistance from one of the 24 non-government agencies who contribute data to the Queensland Centre for Domestic and Family Violence Research's database. The results, taken from data collected between January 2007 and July 2011, do not represent the prevalence of abuse among people with disabilities in Queensland, but provide an insight into the new client matters recorded, including the type of service provided, the reason for contact, and the type of relationship the client was in at the time. Physical, intellectual and psychiatric disabilities make up the largest proportion of disabilities in this data collection sample (83%, n=10 864). The remaining five disability types (specific learning, autism, acquired brain injury, neurological, sensory and speech) made up the remaining 17% (n=2 271).

Gender and types of disabilities recorded

Table 1 indicates the range of total disabilities and separate them by gender. The disability recorded most frequently was psychiatric disability (n=5 994). It was recorded for 4 470 females (46% of all female clients with a recorded disability); and for 1 518 men (44% of all male clients with a recorded disability). Psychiatric disabilities include conditions such as schizophrenia, stress, psychosis and depression – conditions which evidence suggests, could directly relate to their experiences as victims of domestic violence.[2] Physical disabilities represent 26.6% (n=3 494) of client matters where a disability was recorded and intellectual disabilities made up 10.4% (n=1 376). The majority of the overall data was made up of females 74% (n=9 709), with males accounting for 26% (n=3 417) and transgender 0.6% (n=9).

Of the 3 417 total males with disabilities, 66% (n=2 267) reported having used or using violence in a current or past relationship, compared to females in that category, who made up 316 (3%) of the total number of female clients for whom a disability was recorded.

Table 1: Total number of disabilities x gender	**Female** (n=9 709)		**Male** (n=3 417)		**Transgender** (n=9)		**Total** (n=13 135)	
Disabilities proportionate breakdown	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Physical	2 370	28	764	22	0	0	3 494	26.6
Specific learning/ADD	340	3	167	5	0	0	507	3.8
Intellectual	1 028	10	347	10	1	11	1 376	10.4
Autism	66	1	33	1	1	11	100	.76
Acquired brain injury	157	2	190	6	0		347	2.6
Psychiatric	4 470	46	1 518	44	6	67	5 994	45.6
Neurological	543	6	296	9	0	0	839	6.3
Sensory and speech	375	4	102	3	1	11	478	3.6

No value entered 12 849 (8%); No disabilities 92 624 (59%); Unknown 38 871 (25%); Total sample 157 479

The balance of power in an abusive relationship is even further weighted where the victim of the abuse has a disability, with increased possibility of reliance on abusers for mobility, communication, food, showering, eating, shopping or medication. Relying on an abusive partner can prevent women from seeking help for fear their primary carer will be removed. As in all domestic violence situations there is also the shame of reporting, the lack of knowledge about what constitutes a violent relationship, lack of

---

[1] *A person is a 'new client' if: they access a service for the first time; they stop contact with the servi.ce, as planned (e.g. an exit interview has been conducted), and then initiate contact again at any point in time; they stop contact with the service unexpectedly, and then return after at least six months since the last contact.*

[2] *See for example Mouzos & Makkai 2004; Nancarrow et al 2009; VicHealth.*

awareness of services and options available and the confidence to access them.

Type of service required

Table 2 highlights the type of service provided for the three most common disability types in this study – physical, intellectual and psychiatric disabilities (n=10 857). Crisis intervention accounts for 41.8% (n=3 417) of the services sought by women who are experiencing violence in these three major abuse categories; it is also the service most sought by women in all remaining disability types (acquired brain injury, neurological, sensory and speech) with the exception of autism, where counselling is the main service provided for 42% (n=28) of female autism clients (n=66). For men with a disability the biggest single category for service sought was court support (61%, n=1 595) followed by counselling (24%, n=626). The remaining 15% (n=386) of services provided were made up of crisis intervention, advocacy and 'other'.

Protection orders in place

Of the 10 857 client matters analysed in this sub-sample, only 6 331 (59%) had obtained domestic violence orders, compared to 72% (n=66 265) of new clients for whom no disability was recorded. Proportionately, females made up 4 299 (68%) of clients with orders 85% (n=3 670) of whom were aggrieved and 7.5% (n=323) respondents. Males accounted for 2 032 (32%) of the total sample of which 20% (n=411) were aggrieved clients and 73% (n=1 485) were respondents. The remaining 7% of the total sample (n=442) were either: aggrieved and respondents; had cross orders; or were a combination of two or more of these previously mentioned clients.

Table 2:
Type of service provided x disabilities x gender

Type of service provided	Physical (n=3 459)		Intellectual (n=1 364)		Psychiatric (n=5 957)		Total by service type
	Female	Male	Female	Male	Female	Male	
Counselling	764	222	239	77	1 247	327	**2 876**
Court support	468	429	330	199	802	967	**3 195**
Crisis intervention	1 112	44	336	51	1 969	188	**3 700**
Advocacy	139	13	58	4	225	9	**448**
Other	224	44	58	12	202	21	**561**
Total	**2 707**	**752**	**1 021**	**343**	**4 445**	**1 512**	**10 780**

No value entered 77(.7%); Total sample 10 857

Type of relationship

Table 3 compares the type of relationship by gender for clients with physical, intellectual and psychiatric disabilities. Transgender clients made up .05% (n=7) of matters in these three disability groups and .06% (n=9) of the overall sample. The sum of new client matters in this category for all disability types is 13 277[3]. The three disability types used in this table make up 83% (n=10 963) of that total. The three largest relationship categories are 1) spousal, which include people who are, or have been, married or in a de facto marital relationship; 2) intimate personal relationships, which include couples, whether of the same or opposite sex who are, or were engaged to be married, promised or betrothed under customary law, or in an 'enmeshed' dating relationship; and 3) parent/child respondents, with the age range for 'children' between 16 and over 65.

Clients in spousal relationships (including same sex relationships) comprised 69% (n=7 439) of new client matters with female spouses accounting for 77 % (5 751) of total spousal relationships and 68% of total female relationships. Male spouses accounted for 23% (n=1 688) of all spousal relationships and 66% of total male relationship types. People in spousal relationships with a psychiatric disability were the highest represented relationship/disability category making up 57% (n=4 238) of the total spousal relationship/disability type. Females made up 75% of female spouses with a psychiatric disability and males the remaining 25% (n=1 039). Of the 1 247 (11%) total matters relating to intimate personal relationships, females comprised 12% (n=1 011) of all female relationship types and males 9% (n=236) of total male relationships. When males and females are separated in these relationship categories, intimate personal abuse is still the second highest relationship type for females, but parent relationships where a child is the respondent made up the second highest relationship type at 11% (n=292) for male clients. Parent/child respondent relationships remain the third highest relationship type for females at 6% (n=538).

---

[3] *The sum of 13 277 is greater than the total sum of disabilities (n=13 135) because clients may be experiencing abuse in more than one category – e.g. as a spouse and as an informal care receiver.*

Table 3:
Type of relationship x disabilities x gender

	Physical (n=3 531)		Intellectual (n=1 383)		Psychiatric (n=6 049)		Total by relationship type
Type ofrelationship	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	
Spousal	1 884	473	650	171	3 173	1 032	**7 383**
Spousal (same sex)	13	4	5	1	26	7	**56**
Intimate personal	264	68	141	38	556	119	**1 186**
Intimate personal (same sex)	20	4	8	1	22	6	**61**
Informal care provider	10	4	2	1	10	1	**28**
Informal care receiver	51	13	13	1	28	10	**116**
Parent/child respondent	259	80	58	49	221	163	**830**
Child/parent respondent	61	40	53	40	223	55	**472**
Grandparent/grandchild respondent	18	1	2	1	10	1	**33**
Grandchild/grandparent respondent	1	1	1	0	1	2	**6**
Family - sibling	70	31	65	22	116	62	**366**
Other relative	119	42	41	19	153	52	**426**
Total	**2 770**	**761**	**1 039**	**344**	**4 539**	**1 510**	**10 963**

There is considerable research evidence that women who have a disability are more likely to experience violence compared to people without a disability and men with a disability (Sobsey 1994) and that the majority of perpetrators are male and known to the victim (Brownridge 2006). The scope of abuse is greatly increased for people with a disability and can include a range of violent and abusive acts. As well as the more 'common' forms of abuse, such as physical, sexual, emotional, financial and psychological abuse (which for a person with a disability can include exclusion and isolation), a person with a disability can also be subjected to abuse related to their impairment, such as being restrained in order for a non-prescription drug to be administered; denial of medication and subsequent care when illness ensues; removal of mobility aids; or failure to provide for basic needs, such as the provision of food and sanitary requirements.

Primary reason for contacting a service

Table 4 compares gender, disability (three most common) and the primary reason for clients contacting services. The three largest categories for males and females are 1) experiencing violence in a current relationship 2) using violence in a relationship and 3) experiencing violence from a past relationship.

Table 4:
Primary reason for contact x disabilities x gender

	Physical (n=3 436)		Intellectual (n=1 354)		Psychiatric (n=5 909)		Total of reason for contact
Primary reason for contact	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	
Experiencing violence in current relationship	1 977	264	636	81	2 954	249	**6 161**
Previously experienced violence in a relationship	230	17	121	29	464	51	**912**
Experiencing violence from a past relationship	427	50	210	22	825	41	**1 575**
Using violence in current relationship	41	316	35	137	133	992	**1 654**
Used violence in a relationship	9	45	9	18	20	66	**167**
Using violence in a past relationship	8	52	3	53	13	101	**230**
Total	**2 692**	**744**	**1 014**	**340**	**4 409**	**1500**	**10 699**

No value entered 158 (1.5%); Total sample 10 857

Females with a psychiatric disability who were experiencing violence in a current relationship made up 28% (n=2 954) of male and female clients' primary reason for contacting a service and 36% of females' primary reason for contact overall (n=8 115). Conversely, males with a psychiatric disability who were using violence in a current relationship made up 9% (n=992) of the total reasons for contact and 38% of the primary reason for male contact (n=2 584). Females comprised 91% (n=7 844) of total primary reasons for contact for having either experienced or experiencing violence in a current or past relationship (n=8 648) and 97% of the total female reason for contact overall (n=8 115). Females who either used or were using violence in either a current or past relationship made up 13% (n=271) of primary reason for contact and 3% of the total female reason for contact overall (n=8 115).

The main reason for contact for males was either having used or using violence in a current or past relationship. Male use of violence accounted for 69% (n=1 780) of reasons for males contacting a service and 87% of male and female clients whose primary reason for contacting a service was because they were either using or used violence in a current or past relationship (n=2 051). Males who were experiencing or had experienced violence in a current or previous relationship accounted for 9% (n=804) of the total 8 648 primary reasons for service contact for males and females in these three categories and 31% of overall male reasons for contact. Physical disability was the highest reason for males who had experienced or were experiencing violence in a current or past relationship, contacting a service.

Conclusion

A summary of these 13 135 overall new client matters and further analysis of the 10 857 new clients who reported physical, intellectual or psychiatric disabilities (the most frequently recorded disability types) shows that females and males with psychiatric and physical disabilities are more likely to access services than those with other disability types. Females with psychiatric disabilities, who were experiencing violence in their current relationship, was the most common circumstance in regard to contact with a service. Crisis intervention was overwhelmingly the primary type of service provided to female clients. Spousal relationships for all disability types were the most likely relationship for which people reported, with females making up the majority of cases. The low number of domestic violence orders could indicate either a fear of consequences that this action may pose to the aggrieved or that contact with the domestic violence service was the first intervention that the client had experienced.

References

Australian Bureau of Statistics 2006, *Disability, Ageing and Carers, Australia: summary of findings*, cat. No. 4430.0, http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/9C2B94626F0FAC62CA2577FA0011C431/$File/44300_2009.pdf

Brownridge DA 2006, Partner violence against women with disabilities: prevalence, risks, and explanations, *Violence Against Women*, *12*(9):805-822.

Mouzos J & Makkai T 2004, *Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey (IVAWS) Australian Institute of Criminology, Canberra,* http://www.aic.gov.au/documents/5/8/D/%7B58D8592E-CEF7-4005-AB11-B7A8B4842399%7DRPP56.pdf

Nancarrow H, Lockie S & Sharma S 2009, Intimate partner abuse of women in the Central Queensland mining region, *Trends and Issues in Crime and Criminal Justice* No. 378, Australian Institute of Criminology, Canberra.

Sobsey R 1994, *Violence in the lives of people with disabilities: The end of silent acceptance?* Baltimore MD: Brookes.

VicHealth 2009, *National survey on community attitudes to violence against women*, http://www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/NCAS_CommunityAttitudes_report_2010.ashx

Types of disabilities

Definitions are sourced from the Australian Disability Clearinghouse on Education and Training (http://www.adcet.edu.au/Specific_Impairments.chpx).

Acquired brain injury can have minor effects, occurring over a short period of time, or can be severe and lifelong. This may be caused by accidents, stroke, lack of oxygen and degenerative neurological disease. This type of disability can affect cognitive, physical, emotional and sensory functioning.

Autism Spectrum Disorder is a lifelong developmental disability characterised by marked difficulties in social interaction, impaired communication, restricted and repetitive interests and behaviours and sensory sensitivities.

Developmental delay occurs if a child develops at a slower pace when compared to other children of the same age. Indicators might be how they move, communicate, learn, understand or interact with other children.

Intellectual disability refers to a group of conditions caused by various genetic disorders and infections. These conditions result in a limitation or slowness in an individual's general ability to learn and difficulties in communicating and retaining information. As with all disability groups, there are many types of intellectual disability with varying degrees of severity.

Neurological disabilities include learning disabilities such as dyslexia or dysgraphia, acquired brain injury or Multiple Sclerosis.

Physical disability refers to a number of conditions, some of which are permanent, others of a temporary or intermittent nature, may impair physical activity and mobility. These conditions include cerebral palsy, arthritis, muscular dystrophy, multiple sclerosis (MS), Parkinson's disease and repetitive strain injury (RSI).

Psychiatric disabilities may be transitory or of longer standing with symptoms ranging from mild and episodic to severe and ongoing. There are wide ranges of psychiatric disabilities and these can impair a person's functioning in normal social activities. Conditions of a psychiatric nature could include schizophrenia, stress, psychosis and depression.

Sensory disabilities affect how people interact with the world around them, the most common being hearing loss, vision or speech impairment.

Preparing your agency to be responsive and accessible

by Renette Viljoen, CDFVR

Domestic and family violence agencies and service providers deliver invaluable services to the community, but are often strapped for time and resources. A further challenge is the growing awareness that generic services and support, for women experiencing domestic violence, are not appropriate for all women. High expectations are placed on agencies to support women with disabilities by responding to their unique experiences and distinct needs for services and outreach (Lightfoot & Williams 2009).

Agencies and service providers, imagining accommodating a person with a disability, may think about the structural changes, such as installing a wheelchair ramp. Although this is one way of supporting women with disabilities, it does not represent the breadth of strategies that may be needed to support the disability community.

> "... without a TTY (textphone) for example, a hotline is of little help to a deaf woman ... a shelter without a ramp is inaccessible to a wheelchair user who has been repeatedly abused and needs to leave home" (Groce 1990)

Growing evidence confirms findings that the presence of disability in women's lives increases their risk of domestic and family violence beyond that experienced by women in general (Powers, Hughes & Lund 2009). Moreover, research has demonstrated that women with a disability have to contend with typical and unique forms of violence and types of perpetrators *(see pages 3-6 of this CDFVRe@der)*.

Common barriers that keep women with disabilities – and women without disabilities - from escaping domestic and family violence include embarrassment, not having a trusted person to talk with about abuse, not being believed, fear of losing independence or connections with family or friends if domestic violence is reported, and fear of retaliation (Powers, Hughes & Lund 2009). Most women require support and encouragement to take action against abuse. Women with disabilities are no different in that they need support to acknowledge and identify the abuse in their relationship and encouragement to think through the options available to them (DVIRC 2008).

Providing support to women with disabilities who are experiencing domestic and family violence is not necessarily easy, however, the skills and qualities needed to do it are the skills and qualities that define good practice (DVIRC 2008; Jennings 2007). The following key actions are an example of steps that could be taken to increase accessibility and responsiveness to domestic and family violence survivors with disabilities:

- **Validation and respect**

According to Jennings (2003), as services and practitioners we need to understand we are in the best position to offer validation and support to women with disabilities who experience violence and we need to remember the problem is the violence, not the woman's disability. Women with disabilities who are abused face both personal and systemic barriers to being able to disclose the abuse. Service providers should show that they are prepared to hear any disclosure of abuse and be supportive. They should encourage women to talk about their experiences of abuse by asking direct questions, resourcing women to access information about family violence services and if appropriate making direct referrals (DVIRC 2008). They need to know what the impact of living in abusive relationships is and be able to use this knowledge and expertise to effectively support women.

Agencies or services have both an ethical and legal responsibility not to discriminate based on disability – if the core business is domestic and family violence, then the core business includes women with disabilities who experience domestic and family violence (Jennings 2007).

- **Disability awareness**

Workers should be open to reflecting on their own feelings and any preconceived ideas about disability and domestic and family violence. They should be prepared to look at their own values and attitudes and how these may impact on their support role to increase the likelihood of a positive client/worker relationship.

Services should participate in disability awareness training, explore what attitudes exist within their service toward women with disabilities and challenge the myths, stereotypes and assumptions relating to women with disabilities. Furthermore, agencies should include a regular service review, professional development and supervision, and reflective practice on an individual and team level (Jennings 2007).

- **Accessible information**

Services play a vital role in assisting women with disabilities to connect with information and services that can support them to identify the abuse and take action (MDAA 2010). Often, women with disabilities experiencing domestic and family violence don't have access to information about which facilities are able to accommodate them. Agencies should work towards becoming known within the community as an accessible service. Providing accessible information highlights a positive attitude towards women with disabilities and increases their confidence in, and awareness of, what supports are available (DVIRC 2008).

- **Personal safety**

For women with disabilities the barriers to leaving the perpetrator may seem overwhelming for both the woman and her support services. Once the risks to immediate danger have been addressed, a well prepared safety plan could be used to enable a woman to increase her personal safety while still in the relationship, giving her and others time to work on future options (Cockram 2003; DVIRC 2008; Nosek & Howland 1998).

> "few of the strategies listed in the classic safety plans are possible for women who must depend on their abuser to get them out of bed in the morning, dress them, and feed them" (Nosek & Howland 1998)

- **Collaboration**

Agencies and service providers should work collaboratively with other community organisations to facilitate safety planning. There is a need for integrated, co-ordinated strategy between government departments and non-government organisations and to incorporate accommodations into internal policies (Cockram 2003; Jennings 2003; MDAA 2010). Furthermore, services need to become part of a sustainable solution – all services advocating for access and support, and justice for all victim/survivors.

- **Support**

Service providers play an important role in positively engaging women and working with them to strengthen their capacity and resilience to deal with the experiences and trauma of violence. This can be improved by resourcing family and friends on how to raise the issue of abuse, hear a disclosure, and offer constructive support (Erwin 2008).

- **Research, education and training**

Agencies and service providers should document any limitations and challenges faced in providing a service to women with disabilities as an important basis for the service's reflective practice and continuous improvement (Jennings 2007). Further research is also needed on the effectiveness, accessibility, and appropriateness of existing services for women with disabilities who are also subjected to domestic and family violence. Programs designed for the general population of violence survivors should also be evaluated for their responsiveness to women with disabilities and their compliance with the Acts (*see this CDFVRe@der page 6*). Likewise, disability organisations should be evaluated for their capacities to identify and refer women with disabilities who are survivors of violence to appropriate sources of help. It is particularly important to evaluate the benefits of policy and practice changes resulting from collaborations and to make recommendations for successful collaborations that effectively serve these women (Powers, Hughes & Lund 2009).

Education and training should not only focus on the role of agencies and service providers, but broader community services who also need to become better informed so that they too can assist women with disabilities to live free of violence (DVIRC 2008).

It is critical that any response to domestic and family violence recognises the needs of all women – services must be designed and delivered to take into account the diverse needs and experiences of women. An understanding and commitment to improve services to women with disabilities which acknowledges current barriers and strategically plans toward future inclusive practices and policies, are important steps toward a respectful and considered response to women with disabilities who are also subjected to domestic and family violence.

References

Cockram J 2003, Silent Voices: Women with Disabilities and Family and Domestic Violence, People with Disabilities (WA) Inc.

DVIRC 2008, *Getting safe against the odds*, www.dvirc.org.au/Disability/GettingSafeAgainstOdds.pdf.

Erwin P 2008, *Violence Against Women with Disabilities, Battered Women's Justice Project-Criminal Justice Office*, http://www.zimbio.com/Domestic+Violence+Awareness/articles/152/Disabled+Women+Abuse

Groce N 1990, 'Special groups at risk of abuse: the disabled.', in M Straus (ed.), *Abuse and victimization across the life span*, The Johns Hopkins University Press, Baltimore.

Jennings C 2003, *Triple disadvantage: Out of sight out of mind*, DVIRC violence against women with disabilities Project Report.

Jennings C 2007, Access & Equity Equals Best Practice for Women with Disabilities Experiencing Violence, *DVIRC Quarterly, no. 3*, pp. 24-25.

Lightfoot E & Williams O 2009, The Intersection of Disability, Diversity, and Domestic Violence: Results of National Focus Groups, *Journal ofAggression, Maltreatment & Trauma (18)*2:33-152.

MDAA 2010, *Violence through our eyes*, Harris Park, http://www.mdaa.org.au/service/systemic/topics/women.html.

Nosek M & Howland C 1998, *Abuse and women with disabilities*, Violence Against Women Online Resources, www.vaw.umn.edu/Vawnet/disab.htm

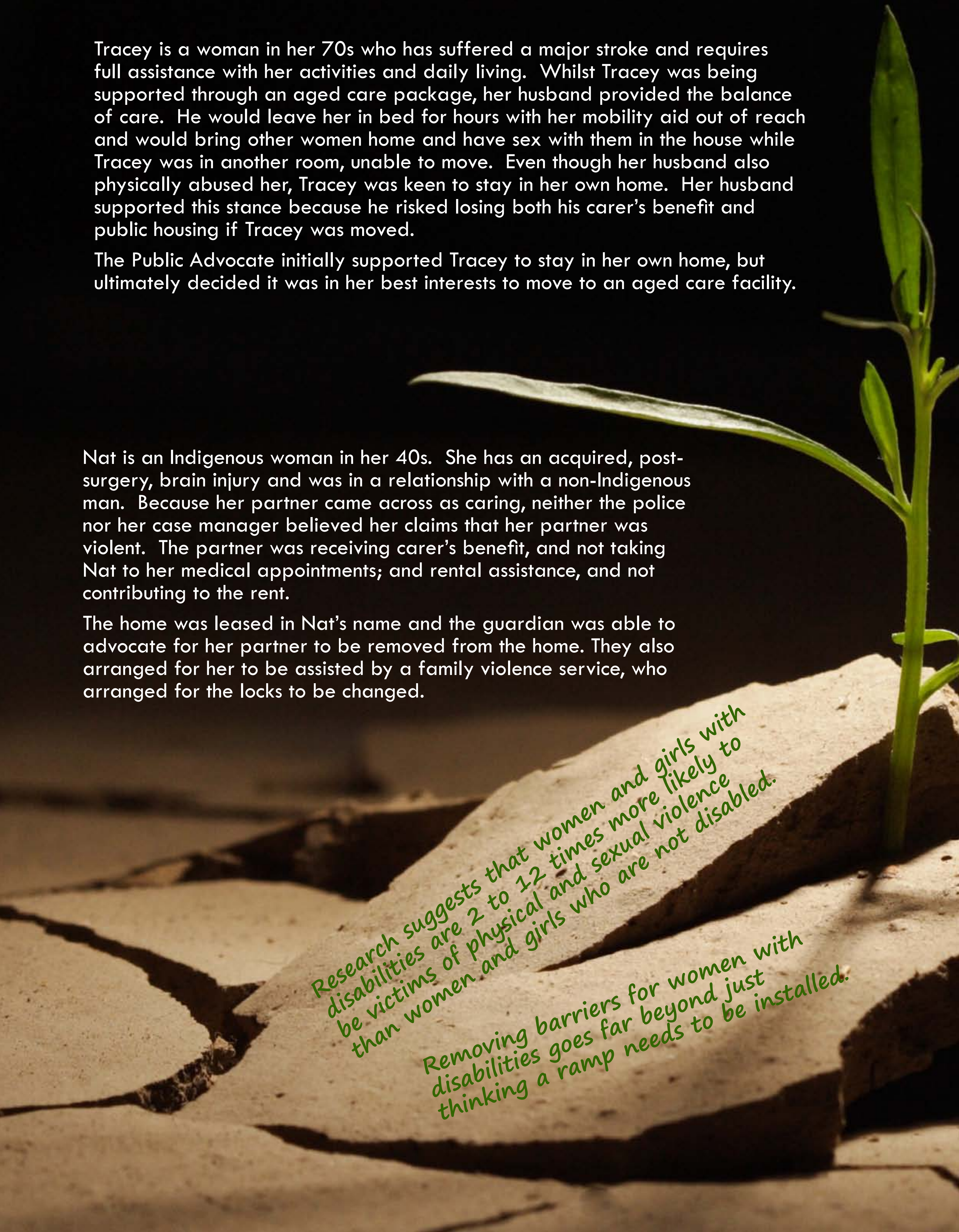
Powers L, Hughes R & Lund E 2009, *Interpersonal Violence and Women With Disabilities: A Research Update*, http://www.vawnet.org.

Tracey is a woman in her 70s who has suffered a major stroke and requires full assistance with her activities and daily living. Whilst Tracey was being supported through an aged care package, her husband provided the balance of care. He would leave her in bed for hours with her mobility aid out of reach and would bring other women home and have sex with them in the house while Tracey was in another room, unable to move. Even though her husband also physically abused her, Tracey was keen to stay in her own home. Her husband supported this stance because he risked losing both his carer's benefit and public housing if Tracey was moved.

The Public Advocate initially supported Tracey to stay in her own home, but ultimately decided it was in her best interests to move to an aged care facility.

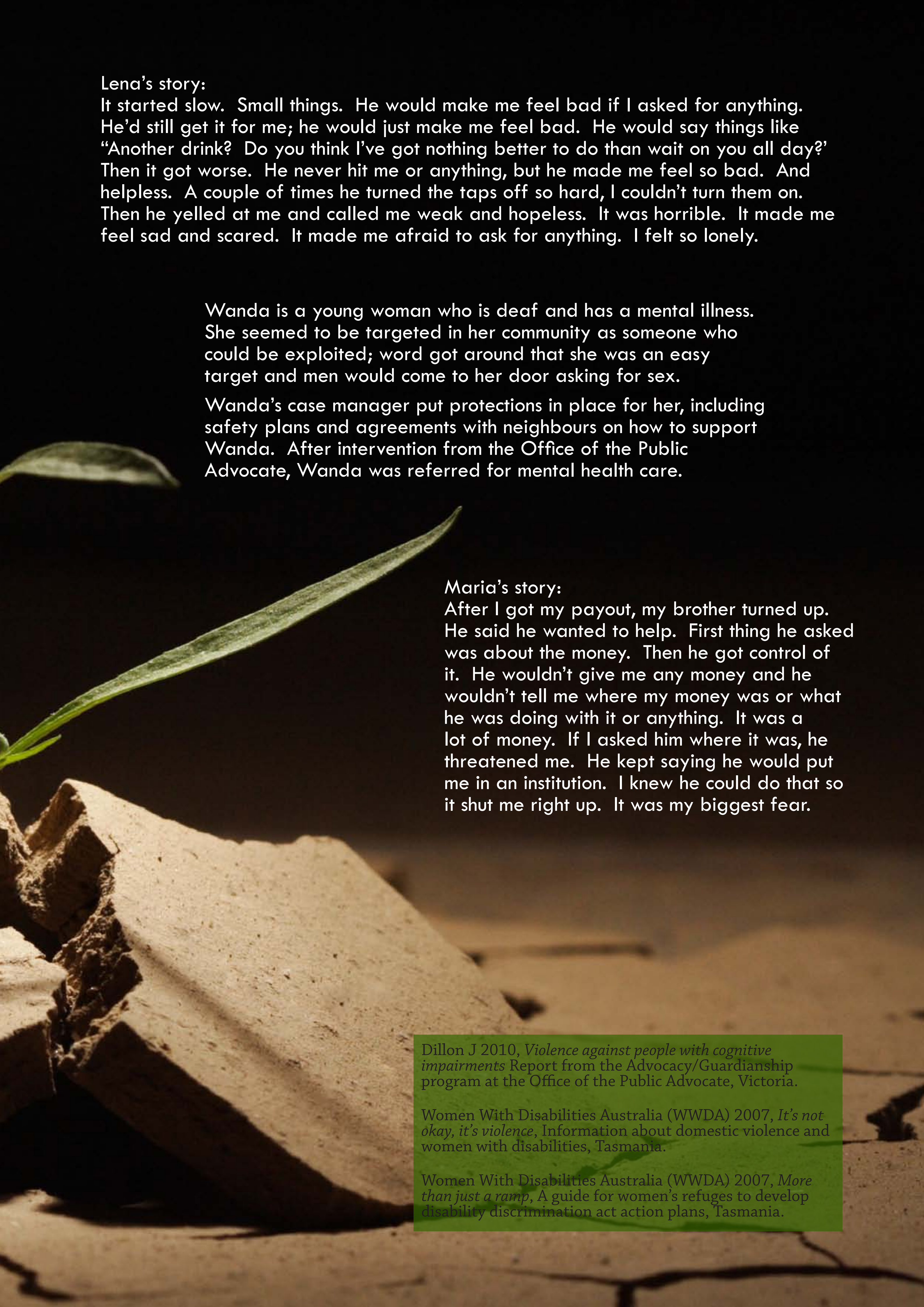
Nat is an Indigenous woman in her 40s. She has an acquired, post-surgery, brain injury and was in a relationship with a non-Indigenous man. Because her partner came across as caring, neither the police nor her case manager believed her claims that her partner was violent. The partner was receiving carer's benefit, and not taking Nat to her medical appointments; and rental assistance, and not contributing to the rent.

The home was leased in Nat's name and the guardian was able to advocate for her partner to be removed from the home. They also arranged for her to be assisted by a family violence service, who arranged for the locks to be changed.



Research suggests that women and girls with disabilities are 2 to 12 times more likely to be victims of physical and sexual violence than women and girls who are not disabled.

Removing barriers for women with disabilities goes far beyond just thinking a ramp needs to be installed.



Lena's story:
It started slow. Small things. He would make me feel bad if I asked for anything. He'd still get it for me; he would just make me feel bad. He would say things like "Another drink? Do you think I've got nothing better to do than wait on you all day?' Then it got worse. He never hit me or anything, but he made me feel so bad. And helpless. A couple of times he turned the taps off so hard, I couldn't turn them on. Then he yelled at me and called me weak and hopeless. It was horrible. It made me feel sad and scared. It made me afraid to ask for anything. I felt so lonely.

Wanda is a young woman who is deaf and has a mental illness. She seemed to be targeted in her community as someone who could be exploited; word got around that she was an easy target and men would come to her door asking for sex.

Wanda's case manager put protections in place for her, including safety plans and agreements with neighbours on how to support Wanda. After intervention from the Office of the Public Advocate, Wanda was referred for mental health care.

Maria's story:
After I got my payout, my brother turned up. He said he wanted to help. First thing he asked was about the money. Then he got control of it. He wouldn't give me any money and he wouldn't tell me where my money was or what he was doing with it or anything. It was a lot of money. If I asked him where it was, he threatened me. He kept saying he would put me in an institution. I knew he could do that so it shut me right up. It was my biggest fear.

Dillon J 2010, *Violence against people with cognitive impairments* Report from the Advocacy/Guardianship program at the Office of the Public Advocate, Victoria.

Women With Disabilities Australia (WWDA) 2007, *It's not okay, it's violence*, Information about domestic violence and women with disabilities, Tasmania.

Women With Disabilities Australia (WWDA) 2007, *More than just a ramp*, A guide for women's refuges to develop disability discrimination act action plans, Tasmania.

Assessing the situation of women with disabilities in Australia: A human rights approach

by Terese Kingston, CDFVR

A review of Carolyn Frohmader's policy paper for Women With Disabilities Australia (WWDA)

This policy paper, developed by Carolyn Frohmader for WWDA and released in June 2011, seeks to address the acute lack of disability and gender specific data at all levels of Government.

The paper begins with the premise that Australia, as a signatory to a number of human rights conventions and instruments regarding disability rights and gender equality, is required to take appropriate steps to ensure that girls and women with disabilities are able to fully enjoy and exercise their fundamental human rights. Frohmader argues that, in order for the Australian Government to honour the commitments it has made as a member state of the United Nations, it is critical to both gain a detailed understanding of the current situation facing girls and women with disabilities; and to determine what needs to be done in order to address the barriers identified.

Utilising a human rights framework, this paper documents the wide range of quantitative and qualitative data, research and information necessary for a comprehensive assessment of the situation facing women with disabilities in Australia. Additionally, the paper links each piece of required data collection to specific key international obligations and domestic policy context.

The context for the recommended assessment is provided in the paper with an overview of the intersection of disability and gender and a brief summary of the relevant human rights instruments. Australian disability policies, Frohmader states, "have consistently failed to apply a gender lens" (p. 9); with most based on the assumption that women's and men's experience of disability is identical. However, gendered differences due to biological, psychological, social, economic, cultural and political factors impact greatly on these life experiences; patterns of disadvantage are often related to the social positions of women and men. Women with disabilities therefore face particular disadvantages in accessing educational and employment opportunities, reproductive and health rights and freedom from violence and abuse. These disadvantages are illustrated by studies which indicate that women with disabilities are more likely than men with disabilities to: experience family and institutional violence; experience gender-based violence, including domestic violence and sexual assault; live in poverty; be engaged in vulnerable, informal and subsistence employment; be affected by a lack of affordable housing; and face medical intervention to control their fertility. The multiple discriminations faced by women with disabilities in Australia, Frohmader argues, amounts to the systematic denial of equal enjoyment of their human rights.

The issue is further contextualised through an examination of the human rights imperative. Australia is party to a number of international human rights instruments which are based upon the fundamental principle of the equal right of both men and women to basic human rights. Of particular relevance to girls and women with disabilities are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities (CRPD). Both affirm the rights of women with disabilities, seek to address related human rights violations and highlight the importance of data collection and research in identifying and removing barriers facing women with disabilities in exercising these rights.

CEDAW is an international human rights treaty developed in 1981 and aimed at promoting gender equality in the areas of economic, civil, political, social and cultural rights. Australia entered into a formal agreement in 1983, resulting in the legal obligation to "respect, protect, promote and fulfil the right to non-discrimination for women and to ensure the achievement of equality between men and women" (p. 12). Although designed for the promotion of equal human rights for all women, it also emphasises the need for special measures to deal with women who are discriminated against because of disability, race, nationality, poverty or age. The treaty additionally requires State parties to report on measures taken to address these multiple discriminations.

Thus far, contends Frohmader, the Australian Government has failed to meet this obligation, neglecting to either instigate the necessary research or to provide details regarding the implementation of the CEDAW provisions.

The Convention on the Rights of Persons with Disabilities (CRPD) has the human rights of people with disabilities as its main focus, while similarly acknowledging the multiple discriminations created through the intersection of disability and gender. Like CEDAW, the CRPD highlights the importance of research and data collection in adequately assessing the scope and nature of the issue as well as outlining possible solutions. These obligations, Frohmader argues, provide the rationale and framework for the Australian Government to commission and resource the collection of quantitative and qualitative data and research on the situation of women with disabilities in Australia.

> "Our goals remain to have our needs recognised and seek an end to exclusion, inequality and violence.
>
> We need to be able to participate in education, employment and political, civil, social and cultural organisations.
>
> We need to have our safety guaranteed whether we live in the community or in institutions.
>
> Recognition and respect by governments and by broader society are fundamental to our identity and to achieving our goals."
>
> (Frohmader @ Meekosha [forthcoming])

Having established the need for research, the paper then provides a list of rights requiring urgent attention: the right to freedom from torture or cruel, inhuman or degrading treatment or punishment; the right to freedom from exploitation, violence and abuse; the right to found a family and to reproductive freedom; the right to education and to work; the right to an adequate standard of living; the right to participate in political and public life; the right to health and the right of access to justice and to equal recognition before the law (pp. 15-16). Each of these rights is examined separately in the paper, with a corresponding and comprehensive list of the quantitative and qualitative data and research required to address them. Apart from articles from CEDAW and CRPD, the paper also identifies the International Covenant for Civil and Political Rights (CCPR), Convention on the Rights of the Child (CRD), the Convention Against Torture (CAT) and the Universal Declaration of Human Rights (UDHR) as relevant United Nations (UN) Treaties.

The overall domestic policy context includes: the National Plan to Reduce Violence against Women and their Children 2010-2022, the National Framework for Protecting Australia's Children 2009-2020, the National Disability Strategy 2010-2020, the National Disability Research Agenda 2011-2014, the COAG National Disability Agreement and National Women's Health Policy.

This article will particularly examine the links made within the policy paper between the denial of fundamental human rights to women with disabilities and specific strategies contained in the National Plan to Reduce Violence against Women and their Children 2010-2022, the overarching whole of government 12 year plan endorsed by the Council of Australian Governments (COAG) in 2011. The National Plan "recognises the diversity of the needs of women with disabilities, young women, women from culturally and linguistically diverse backgrounds, Indigenous women, same sex attracted women and older women, and provides scope to tailor responses based on individual needs" (COAG 2011, p. 3). This acknowledgement is confirmed by the fact that strategies from the National Plan are referenced in all eight of the human rights categories covered in the paper.

These links will be examined below:

Freedom from torture or cruel, inhuman or degrading treatment or punishment [Forced Sterilisation]

Frohmader identifies some of the key quantitative data required by including the number of applications sought for sterilisation; and identification and analysis of current protocols regarding sterilisation. A national study into the experience, incidence, and long term effects of the sterilisation; and the practice of menstruation suppression of girls and women with disabilities, is recommended to deliver the government the key qualitative information necessary to inform future policy (2011, p. 17).

Freedom from torture or cruel, inhuman or degrading treatment or punishment [Abuse in Institutions]

The paper recommends gathering quantitative data such as the number of girls and women with disabilities currently residing in institutions; reported incidents of violence, abuse and neglect; the rate of restraint use; and a gender analysis of all data collected by the National Disability Abuse and Neglect Hotline. The qualitative research required, Frohmader suggests, is a Royal Commission or National Public Enquiry into violence, abuse and neglect of girls and women with disabilities living in institutions (Frohmader 2011, p. 19). The domestic policy context provided by the National Plan for these sections are: *Strategy 4.1: Enhance the first point of contact to identify and respond to needs; Strategy 4.2: Support specialist domestic violence and sexual assault services to deliver responses that meet needs;* and *Strategy 4.3: Support mainstream services to identify and respond to needs* (COAG 2011, pp. 27-28).

This section of the National Plan recognises the critical role specialist and mainstream services play in assisting women to rebuild their lives following violence, and commits Commonwealth, state and territory governments to: expanding the domestic and sexual violence national counselling service; developing national standards for prompt and appropriate referral; and support better access to service delivery for women with disabilities (COAG 2011, p. 28).

Freedom from exploitation, violence and abuse

Here, gender and disability-based violence is examined as an intersectional categoy. In addition to the forms of violence and abuse experienced by women in general, women with disabilities may also face: forced or coerced abortion or sterilisation; forced or coerced psychiatric intervention; involuntary commitment to institutions; physical and chemical restraint; strip searches; withholding mobility aids, medication and other equipment; or threats of abandonment, rape or sexual abuse by caregivers (Frohmader 2011, p. 21). Key quantitative information needed includes: figures reflecting the prevalence of violence against women with disabilities; legislative definitions which encompass all forms of violence against women with disabilities and the context in which it occurs; and gender analysis of National Disability Abuse and Neglect Hotline data. Qualitative national research into violence against women with disabilities is necessary to identify: forms, causes and effects of violence; nature of relationship between the victim and the perpetrator; barriers to accessing assistance; effectiveness of the criminal justice system in meeting disabled women's needs; service system response; and accessibility of appropriate crisis and post-crisis accommodation and agency requirements for meeting relevant anti-discrimination requirements (Frohmader 2011, pp. 21-22).

In addition to the three strategies outlined above, this section also links to *strategy 1.2* in the National Plan: *focus on primary prevention* (COAG 2011, p. 18); an approach which highlights the fundamental importance of positive and respectful attitudes towards women as being critical to the development of communities which are safe and free from violence.

The right to found a family and to reproductive freedom

This category is broken into two sections – general parenting; and child removal by authorities. Key empirical research into issues facing women with disabilities regarding their right to parent would include: number of women with disabilities who are parents, including sole parents; annual birth rate and patterns and trends in fertility; rates of termination compared to women without disabilities; examination of inclusive eligibility criteria for access to assisted reproduction and adoption; and childcare centre accessibility benchmarks required for accreditation. Additionally, research into women with disabilities' experience of adoption, foster care, custody, barriers to the parenting role and access to reproductive information would facilitate a deeper understanding of the situation. Similarly, gaining a complete picture of all the issues surrounding child removal would require statistical data regarding the proportion of women with disabilities compared to women without disabilities engaged in care and protection court proceedings, identification of formal processes used to assess parental capacity; and rates of child removal. A gendered analysis of relevant legislation enabling the removal of children from disabled parents; and of the views of magistrates, legal representatives and government officials involved could, Frohmader suggests, be attained through a National Public Inquiry into the issue (pp. 22-25). *Strategy 1.3* from the National Plan: *advancing gender equality*, is cited in this section; with identified government actions including fostering community action through local primary prevention strategies and providing grants targeting key groups including women with disabilities (COAG 2011, p. 20). *Strategy 2.2, support adults to model respectful relationships* is also cited as contributing to the context.

The right to work

Gauging women with disabilities' labour force participation may be measured through a quantitative analysis of their employment status including: unemployment rate compared to men with disabilities and women without disabilities; industry of employment, informal employment, occupational segregation and income. Research into women with disabilities' experience of finding and maintaining meaningful employment should encompass an in-depth analysis of barriers to employment, access to government funded programs, opportunities for promotion and job satisfaction (p. 29).

The right to an adequate standard of living

The need to gather data regarding women with disabilities' access to an adequate standard of living would be met by a quantitative study into the number of women receiving government benefits, percentage of women with disabilities compared to men with disabilities and women without disabilities in the lowest income bracket, extent and risk of poverty, housing stress, levels of homelessness, percentage of women receiving funding from National Disability Agreement (NDA) and non-NDA funded services, percentage of women with disabilities receiving assistance from Non-Government Organisations (NGOs) and percentage of women with disabilities who rely on public transport and taxis. Qualitative information regarding financial security, access to affordable housing, access to food for adequate nutrition, cost of living and levels of unmet need would similarly be met by nation-wide research (p. 31).

The right to participate in political and public life

The research required in this category would involve gathering statistical data regarding the percentage of women with disabilities' participation in representative political and self-

> "Lack of recognition of their needs and experiences constitutes a serious form of disrespect which compounds lack of self-esteem and self-worth, and contributes to the ongoing neglect and pervasive denial of their rights and fundamental freedoms." (p. 7)

representing structures, percentage of women with disabilities applying for and being accepted for positions on company, government, sport, rural and community boards; and the existence of funding programs aimed at supporting women with disabilities undertaking leadership, representative and management roles. National research is required, Frohmader argues, into women with disabilities' understanding of political participation, opportunity to participate in all forms of political processes, barriers to undertaking leadership roles and access to training designed to improve leadership and decision-making skills (p. 33). All three of these sections refer to the National Plan's *strategy 1.3* regarding *gender equality* as forming the domestic policy context. Immediate national initiatives listed in the National Plan to address this strategy include the development and implementation of measures designed to increase women's economic security and leadership opportunities (COAG 2011, p. 21).

The right to health

Frohmader states that key quantitative research and data required, regarding assessing women with disabilities' right to health, include: life expectancy, cause of death, diseases, health risks such as tobacco use and obesity, utilisation of health services and extensive analysis of state and national health related data sets. This information would be complemented by national research examining barriers to health services, factors impacting upon health status, sexual and reproductive health, access to various forms of therapy and healthy ageing (Frohmader 2011, p. 35). As in the "freedom from exploitation, violence and abuse" section, *strategies 4.1, 4.2* and *4.3* are used to contextualise the need for action.

The right to education

This section calls for research into the percentage of women and girls with disabilities participating in all forms of post year ten education, the percentage disaggregated by the school sector, the existence of gender and disability training available to teachers and reports of discrimination in the education system; as well as a national study of the experience of women with disabilities of educational support services, barriers to accessing higher education and making the transition from study to employment (Frohmader 2011, p. 37). This section again cites *strategy 4.2: support specialist domestic violence and sexual assault services to deliver responses that meet needs* (COAG 2011, p. 27).

The right to access to justice and the right to equal recognition before the law

This section lists the identification of the existence and number of training modules dealing with gender and disability in the justice sector, the percentage of women with disabilities appearing before the court as victims of crime or offenders; percentage being assisted by legal aid; and reported incidences of abuse of women with disabilities which resulted in investigations and convictions, as key pieces of empirical data required. Additionally, national research covering women with disabilities' experience with pre-court proceedings, dealings with police, access to legal representation, barriers, attitudes and stereotyping was similarly identified as necessary (Frohmader 2011, p. 39). The context is again provided by *strategies 4.1, 4.2* and *4.3*; as well as: *Strategy 5.1: Improve access to justice for women and their children*; and *Strategy 5.2: Strengthen leadership across justice systems* (COAG 2011, p. 30). These strategies emphasise the vital role the justice system has to play in reducing violence against women and the need for all elements of the system to work effectively together (COAG 2011, p. 30).

Overall, this WWDA policy paper provides an extremely comprehensive list of the wide range of data, research and information required for a detailed assessment of the current situation facing women and girls with disabilities in Australia. The need for this assessment has not only been identified by women with disabilities themselves, but is, the paper argues, a key legal obligation required of the Australian Government as a signatory to several human rights treaties, including CEDAW and CRPD. The paper further contextualises this imperative through a discussion of the intersection of gender and disability, and a concise summary of the main human rights treaties and instruments, of which Australia is a signatory. The framework for such an assessment is also provided through the provision of the domestic policy context in which the research and analysis would take place.

From a domestic violence advocacy perspective, the linking of each of the fundamental human rights requiring research to the National Plan to Reduce Violence against Women and their Children 2010-2022, highlights the significance of broadening the definition of what constitutes violence against women; as well as making some important connections between strategies designed to keep women and children safe from violence in Australia and Australia's responsibilities to uphold human rights conventions in a global context.

The complete Policy Paper can be found at http://www.wwda.org.au/confpaps2011.htm

References

Council of Australian Governments (COAG) 2011, *National plan to reduce violence against women and their children 2010-2022*, Commonwealth of Australia, Canberra.

Frohmader C 2011, *Assessing the situation of women with disabilities in Australia: a human rights approach*, Women With Disabilities Australia, Rosny Park.

Frohmader C & Meekosha H [forthcoming], 'Recognition, respect and rights: women with disabilities in a globalised world' in Goodley, D, Hughes, B & Davis, L (eds), *Disability and social theory*, Palgrave Macmillan, London.

At the coalface ...

Jody performing at the IFVP Forum 2010.

Jody Saxton-Barney is a deaf Aboriginal woman, a mother and grandmother living in Victoria. She owns her own business *Deaf Indigenous Community Consultancy* and has just completed a Bachelor of Applied Management Studies with the University of Ballarat. Her business works at all levels of engagement from the individual - to community services, organisations and departments on the rights of deaf and hard of hearing Aboriginal and Torres Strait Islander people. Jody has been involved with family violence awareness for women with disabilities for nearly 25 years and has lived experiences of family violence as a survivor of an abusive relationship. She is now in a non-violent relationship, in a non-violent home and works with communities to ensure safety, accessibility and human rights are protected for all members.

CDFVR recently spoke to Jody about her role and work as a community leader:

What are some of the accomplishments in your role and some of the challenges?

I have received the Emerging Leader Fellowship with the Victorian Indigenous Fellowship for 2010/11, which helps me to continue my work with Aboriginal women with disabilities. I am able to speak publicly about things of interest to them, including their plight to stop family and domestic violence. One of the challenges I have encountered has been working with organisations - being Deaf has communication complications and many don't take note of the barriers in communication for women with disabilities who experience violence. Also, many find that the word 'disability' is not used in community as it's another label we do not want to define ourselves by. Many community accomplishments are awareness raising, partnerships for advocacy, training and reconciliation; and disability action plans prepared in a culturally safe way. The greatest challenge is to have Aboriginal women with a disability recognised as active participants in the community and the opportunity to share knowledge about their own history and plight to stop violence. Many are never given the opportunity to speak up or work in the industry. An additional challenge is seeing many other women, who do not have a disability and who are not Aboriginal or Torres Strait Islander, doing the talking for us.

What type of skills do you think are necessary for workers in the domestic violence/sexual assault arena who provide service to women with disabilities?

I believe that anyone who works with women with disabilities needs to be trained in both awareness of cultural diversity and disability awareness. This is tricky, as many women with disabilities do not link into services easily. Training must be provided to enable women to explain their need, what their barriers are and how they want problems solved - the women can only do that themselves. Whilst many are not forthright, they do have the right to have a say. Service providers shouldn't presume that they are dealing with only the family violence – they need to deal with the disability as well. This is equally relevant for agencies that are providing service for the disability component only. What is needed is a dual support network.

What, in your view, is the most important quality anyone who works with people with disabilities should have?

Respectful relationships with others; having a professional rapport and empathy; the ability to work with the client and be client centred; a strong understanding of the barriers faced by the client; the ability to advocate for the rights of people with disabilities. Workers need training to heighten their awareness of barriers so they are able to engage effectively and honestly. They need to be able to provide self-determination opportunities to their clients and to share ideas and skills with others to grow their own professional awareness. Most importantly they need to be genuine and honest. If they don't know about something to do with people with disabilities - find out - ask someone.

Do you find that most women with disabilities know about domestic violence/sexual assault services in their communities?

Many Aboriginal women with disabilities aren't aware of services that are available and when they do enter a service they find that it is not equipped to deal with their needs. Many have expressed that they are aware of what violence is, but they tend not to seek supports until it is at crisis stage. Many stay in violent situations because of the need to be "cared" for, so they aren't reporting the violence. Whilst many in the community feel they are loved, they have limited understanding of the lateral and emotional violence, mental abuse and isolation that is enforced upon them. The community try to share care their responsibilities for women with disabilities and many feel they are overwhelmed by the intensity of the need. Women themselves who disclose violence tend to be removed from that home and put with other family and never speak of the violence again. They sometimes see being sent away as a punishment and are unaware of the safety factor. Women with disabilities are easy targets; many try and stay away from making reports to police or seeking help as they don't want to bring shame or attention on themselves.

What resources and services do you recommend for women who have a disability and are also subjected to domestic and family violence or sexual assault?

There are not many services or resources that cater for women with disabilities that are also culturally appropriate. The services that are available are already over-stretched. It would be better if mainstream services had a more inclusive policy which works on developing stronger pathways to support women with disabilities. There needs to be strong alliance and partnership in the delivery of holistic service and a framework to meet women's needs before they come in the door.

What do you think are some of the reasons women with disabilities would not use a domestic violence or sexual assault service?

There are hundreds of reasons why women with disabilities won't access services. Firstly there is the accessibility issue, such as not providing interpreters for deaf women; the service not being accessible for women to enter; and not providing appropriately trained staff who can secure a safe place for the women to disclose their stories. Additionally there is the fear of not being believed; feeling that they are not being listened to; shame brought on the family who abuse them; small town mindset; payback, isolation or being stranded if they report. Many women with disabilities do not have strong self-esteem or awareness of what is appropriate. Some are never given any type of education on their rights to sexual health and safety; therefore they don't know that what they are experiencing is violence or abuse. Some women don't feel they are valued members of the community.

What could encourage women with disabilities to use services?

- That the service is universally accessible for women with disabilities.
- That they can be provided with the same opportunities as non-disabled women to attend information sessions, awareness days, pamper days and sister days out with support workers or interpreters.
- That women are given the opportunity to take the time to tell their stories in a cultural safe environment without being subjected to timeframes (many take longer to disclose their stories).
- Services demonstrating to community that they have a commitment to stop violence for all women regardless of race, age, sexual orientation, disability and socio-economic background.
- That women know that they can use a service and have their information protected by law.

To what extent do organisational policies, procedures and protocols hinder or promote the particular needs of women with disabilities who are also subjected to domestic violence or sexual assault?

Many organisations have very little understanding of the need to support women with disabilities. There are policies to ensure safety and privacy for women with disabilities, but these are not always adhered to. Many service providers speak to the carer or the family member instead of the client, seemingly unaware that the carer or family members could be the perpetrator and therefore putting the woman at greater risk. Policies and procedures prevent them from referring onto other agencies because it's not their job role. It's important to maintain transparency in their work plans and activities and look at the development of outcome-based assessments and successes. Many workers, over the years, have stated that they feel that paperwork ties them down and hinder the healing and supportive process in ensuring women with disabilities are safe from violence. Many suggest that, whilst policies are in place and workplace practices are viewed in supervision, most of the work done in management doesn't reflect the need at the coalface. Many state that they cannot 'deal' with disability AND violence, that they can only focus on what they are paid to do. It is one or the other. Those who speak about Memorandums of Understanding say that 'they are not worth the paper they are written on' as they are not providing the workers with the cross cultural training and therefore they are prevented from delivering appropriate services.

What relationships currently held between service providers and the disability sector could be fostered to better serve women with disabilities who are subjected to domestic violence?

I haven't seen any that are truly successful. Many that I have visited and seen have a lot of work to do, and many are underfunded and have no time to keep up with demands. Those who try are struggling to deal with the cultural issues of clients being abused, being Aboriginal and having a disability. The uniqueness of this target group is that they are entwined and are not separated based on race, gender or disability. They are and must be seen as a whole. This leads to specialised trained people who can work on improving access and provide training to develop stronger alliances, partnerships and policies to cover the needs of these amazing strong women. I would be offended if a deaf service told me to concentrate on the deaf issue; or a women's organisation told me it's a gender issue; or an Aboriginal services told me to stay with my mob. You cannot separate any women like that. In the morning, I wake up as a woman, I also wake up as an Aboriginal woman and I wake up as a woman who is deaf. However, I DON'T have to wake up to violence. It takes time, energy, money and a passion to stop violence and support women with disabilities.

The intersection of domestic violence and disability

by Renette Viljoen, CDFVR

In the 1990s the Australian government passed two pieces of legislation that had a major impact on the disabilities rights movement and the domestic and family violence movement in Australia.

The *Disability Discrimination Act* was passed in 1992 to eliminate, as far as possible, discrimination against persons on the ground of disability in all areas of life and to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community; and to promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community (Commonwealth of Australia 2005).

The *Domestic and Family Violence Protection Act* was passed in 1989 to provide safety and protection for people in domestic relationships who are experiencing domestic and family violence by allowing a court to make a domestic violence order to prevent domestic and family violence from occurring within a domestic relationship by restricting the behaviour of the person committing the abuse (the respondent)" (State of Queensland 2010).

However, the multiple oppressions of being female, having a disability and being abused leave this sample of the population vulnerable to intimate partners and caregivers (Erwin 2008; Nosek & Howland 1998; Powers, Hughes & Lund 2009). All of the barriers faced by women without disabilities who are experiencing domestic violence are simply compounded by the disability as well as the paucity of services available. Women with disabilities are subjected to further forms of violence, which may include but are not limited to (Attard & Price-Kelly 2010):

- physical violence such as deprivation of food, water or heat; forced restraint; and withholding of disability-related equipment, medication or support and care services;
- sexual violence such as demands for sexual activity in return for assistance; inappropriate touching during personal care-giving; and reproductive control; and
- emotional violence such as forced social isolation; denial of disability and threats to withdraw services or inflict other punishments.

Given the high rate of violence against women in general, the question arises: What about women with disabilities? According to the Australian Bureau of Statistics (2009), almost four million Australians (18.5%) had a disability in 2009 and over a million Australians had a profound or severe core activity limitation (5.8%). Disabilities are diverse, can be visible or hidden, and range from impaired mental capacity to being wheelchair bound, from being sight-impaired to having total hearing loss. Disabilities can be chronic or temporary and they can be present from birth or acquired later in life.

Although considerable research has been conducted on the problem of domestic and family violence in Australia, there is a paucity of research undertaken on the extent and nature of domestic and family violence amongst women with disabilities who access services (Cockram 2003). What has been determined, nationally and internationally, is that women who identify as having a disability:

- experience abuse at a much greater rate than the rest of the population (Jennings 2004);
- who sought help, had acquired a disability due to the abuse they suffered and experience worse consequences than women without disabilities (incl. greater levels of poverty, social isolation, discrimination, stereotyping, low self-esteem, increased health problems (Cockram 2003); and
- tend to experience abuse for longer periods of time and have fewer escape options because of their greater economic dependence, their need for assistance, environmental barriers and social isolation (Cockram 2003; Jennings 2004).

Disabilities affect every segment of our population, regardless of class, race, gender, sexuality or other facets of identity. Disability has implications for both the complexity of survivors' experiences of violence and different needs in accessing help, as well as for the recognition of the abuse of women with disabilities as a pressing social issue. This issue continues to gain prominence in government strategy and community consciousness as evidenced in the current Council of Australian Government's 12 year National Plan to Reduce Violence against Women and their Children 2010-2022. A specific strategy listed in the first three-year action plan as an immediate national initiative is "investigate and promote ways to improve access and responses to services for women with disabilities" (Commonwealth of Australia 2011). Women should continue to work together to shift the position of women with disabilities from one of marginalization to one of inclusion in women's broader agendas.

References

Attard M & Price-Kelly S 2010, Accommodating Violence: The experience of domestic viol*ence of people with disability living in licensed boarding houses*.

Cockram J 2003, *Silent Voices: Women with Disabilities and Family and Domestic Violence*, People with Disabilities (WA) Inc.

Commonwealth of Australia 2011, *National Plan to reduce Violence against Women and their Children*, Canberra.

Erwin P 2008, *Violence Against Women with Disabilities, Battered Women's Justice Project-Criminal Justice Office*.

Jennings C 2004, 'At Greater Risk', *Parity Council to Homeless Persons, vol. 17*, no. 4.

Nosek M & Howland C 1998, *Abuse and women with disabilities*, Violence Against Women Online Resources.

Powers L, Hughes R & Lund E 2009, *Interpersonal Violence and Women With Disabilities: A Research Update*.

What about the carer?

by Renette Viljoen, CDFVR

As outlined earlier in this edition of the Re@der, women with disabilities are more likely to experience domestic violence and for longer periods of time; women with disabilities who are experiencing domestic violence also face a multitude of barriers when attempting to seek help; and sometimes the perpetrator is also the primary carer of a woman with a disability. However, 96% of carers are not perpetrators (DVRCV 2011) but still face their own set of barriers.

One in three primary carers believe the caring role strengthens their relationship with the person they care for (Buchanan 2006), but carers also report negative health and wellbeing impacts associated with caring. Of the 2.6 million informal carers in Australia (more than 770 000 are primary carers), 58% report that their physical health had been adversely affected; a third said that they had sustained a physical injury as a result of being a carer and over half reported depression, anxiety, high levels of stress and other detrimental effects on their own mental health (ABS 2009).

Over and above the impact of the caring role on both the care giver and the care receiver, not much attention is paid to carers of women with disabilities who seek help because they are experiencing domestic violence. Are the carers included in a domestic violence protection order (DVPO)? Are the refuges accessible to both the women with disabilities and their carers?

The *Domestic and Family Violence Protection Act 1989* provides for the relatives or associates of the aggrieved to be named on a domestic violence order, if the respondent has committed or threatened to commit an act of domestic violence against them. Being named on an order provides the relatives or associates of the aggrieved, such as the carer, with the same standard of protection as granted to the aggrieved. Although some protection is provided to the carer of a woman with a disability who wishes to leave a domestic violence situation, the need still exists for domestic violence services and disability services to develop a more holistic and collaborative approach to supporting both the woman and their carer. A preferable long term solution for cases where the women have their own primary carer, protected by the DVO, is to provide purpose-built structures which ensure that all refuges are fully accessible and responsive to meet the specific needs of women with disabilities and their carers.

References

Buchanan J 2006, *Who cares for the carers?*, http://www.livingnow.com.au/advertise/articles/20-issues/459-who-cares-for-the-carers.html.

DVRCV 2011, Domestic violence and women with disabilities fact sheet, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Domestic_violence_and_women_with_disabilities.

Training

Course in Responding to Domestic and Family Violence, Course Code: 30949QLD

	Cairns	Brisbane
Unit 1	6-8 December 2011	23-25 November 2011
Unit 2	21-22 February 2012	7-8 February 2012
Unit 3	23-24 February 2012 9am - 4pm each day	9-10 February 2012 9am - 4pm each day
Costs (incl. catering, learner guides)	Total amount payable for full 7 days $1 100 + GST $110. Cost per individual unit $320 + GST $32.	Total amount payable for full 7 days $950 + GST $90. Cost per individual unit $320 + GST.
Venue:	Novotel Oasis Resort 122 Lake St, Cairns.	University of Queensland Staff Club 41 Staff House Rd, St Lucia, Brisbane.

For more information and to obtain a copy of the registration form, visit www.tavan.com.au

Train the Trainer Day
Wednesday, 19th October 2011 from 9am-5pm
Whitsunday Police Station, Cannonvale, QLD
RSVP 12th October 2011 - **leah@whitsundayccs.com.au** or **49462999**
No cost involved - Tea and coffee will be provided. Please bring own lunch.

Contact Us

Queensland Centre for Domestic and
Family Violence Research
CQUniversity Mackay
P.O. Box 5606
Mackay MC Qld 4741

Telephone: 07 4940 7834
Fax: 07 4940 7839
Email: enquiries@noviolence.com.au
Website: www.noviolence.com.au

Staff

Director	Heather Nancarrow
Education Officer	Annie Webster
Education Officer	Renette Viljoen
Multimedia Officer	Clinton Rawsthorne
Research Assistant	Terese Kingston
Administration Officer	Sue Atto

We encourage readers to contribute to the CDFVRe@der. If you have any information or articles you wish to publish, please contact Centre staff.

HAVE YOUR CONTACT DETAILS CHANGED?

We have become aware that some recipients of the CDFVRe@der have relocated or changed contact details, including email address. To enable us to update our records and ensure that you receive our quarterly publication, please contact us at the listed phone, fax or email address with your change of details. Please be assured that the Centre does not release your details to any third parties without your permission.

If you would like to be included on, or removed from, the Centre's mailing list, please ring us on (07) 4940 7834.

CDFVR

ISSN 1836-9847 (Print)
ISSN 1836-9855 (Online)

The Queensland Centre for Domestic and Family Violence Research (CDFVR) is located within the Institute for Health and Social Science Research, in the Academic and Research Division at CQUniversity. It is physically located at CQUniversity's Mackay Campus.

Queensland Government

The Queensland Centre for Domestic and Family Violence Research receives defined term funding from the Queensland Department of Communities to undertake research and develop educational resources pertaining to domestic and family violence in Queensland.