2 Situating violence against women with disabilities

2.1 Understanding disability

Defining disability has been a contentious issue and, until the rise of disability movements, has rarely reflected the perspective of people with disabilities (Government of Canada 2003; Smith and Hutchison 2004; Snyder and Mitchell 2006; Thomson 1997; WWDA 2007b; Gallagher 2002). Until recently, disability has been largely understood in the context of the medical model, locating disability as a problem within the person that required medical intervention to address the individual's 'pathology'.

The Victorian Women with Disabilities Network and others have adopted the social model of disability, which understands disability as a social construct. Within the social model, 'disability' is not seen just as the person's 'condition', it is the result of disabling social structures, attitudes and behaviours that create disabling environments in which we are all embedded.

A new approach to understanding disability, which is a further development of both the social and medical models, is referred to as the biopsychosocial model. Developed from the United Nation's World Health Organisation's 2001 International Classification of Functioning, Disability and Health (ICF), it acknowledges disability *not* as a special condition of the few but as indicative of human variation. This approach acknowledges the prevalence of disability in the context of aging world populations, the disproportionate concentration of disability among people in poverty, those social groups lacking access to preventative measures and interventions, and the emergence of new disabilities (related to socioeconomic status and 'lifestyle risks'). [7]

Disabling environments prevent people with disabilities from accessing human services, transport, housing, work opportunities and education. This, then, is the context in which women with disabilities who experience violence are 'triply disadvantaged' - as women, with a disability, experiencing violence (Jennings 2003).

In terms of the family violence response system, it is important to note that women with disabilities experiencing violence are not 'all the same'. Women with disabilities experience a multiplicity of different functional impairments and the concomitant myths and social attitudes relevant to each specific impairment. Furthermore, most people with disabilities live with impairments that are multi-faceted, which defy a single categorisation such as 'physical', 'sensory', 'cognitive' and 'mental health'. This research encompasses all of these functional impairments as part of its conceptualisation of disability. As the Victorian Office for Disability notes,

[7] See Accessing Safety Initiative of the Vera Institute of Justice and the US Department of Justice for a discussion of this new approach: available: www.accessingsafety.org [accessed 12/5/08]; ICF Australian user guide (2003) available: www.aihw.gov.au/publications/index.cfm/title/9329.

> *Disability is complex and multi-dimensional. Disabilities may be apparent or hidden, severe or mild, singular or multiple, stable or degenerative, chronic or intermittent. They can be congenital, or occur as a result of accident, illness or ageing* (Office for Disability 2008: 3).

An individual woman's specific functional needs, her gender, sexuality, race, ethnicity, cultural background, economic status, and the expectations of self and family, all determine her experience of disability. Similarly, responses from service systems to violence against women with disabilities have a bearing on a woman's experience of violence.

The term 'disability' is used in different contexts to apply to impairment alone or the impairment and the concomitant impact of disabling social structures. This research refers to disability as both impairment and the concomitant impact of disabling social structures.

Finally, Australia's Commonwealth *Disability Discrimination Act 1992* understands disability as something that anyone might experience at some stage in their life. At the same time, international opinion seeks to ensure the civil, political, economic, social and cultural rights of people with disabilities through the ratification of the *UN Convention on the Rights of Persons with Disabilities* and the Optional Protocol – a landmark development not only in understanding disability but in empowering people with disabilities and according to them the respect that all population groups should have the right to enjoy. The sum result is an understanding that recognises that people with disabilities must be empowered to fully participate in and contribute to society - and must be engaged with as full participants and contributors to society.

2.2 Incidence and nature of violence against women with disabilities

Worldwide, an estimated one in three to one in five women experience sexual assault and/or domestic violence at some stage in their lives (UNIFEM 2005; Mouzos & Makkai 2004; ABS 2005).

One in five Australian people (over 3 million, or 20% of the population) report having disabilities, of whom approximately half are women (ABS 2004: 3); the proportion is similar for Victorians.[8] Of these, 7% experience specific restrictions in core activities of self care, mobility, communication, or their ability to participate in schooling or employment. VWDN AIS estimates that 89,000 women with disabilities in Victoria experience violence.

Considerations in measuring violence against women with disabilities

We do not know the full extent of the prevalence of violence against women with disabilities, given the dearth of research about the issue, the fact that data on disability is not systematically collected in Australia or elsewhere, and the fact that family violence and sexual assault are under-reported crimes (VLRC 2003: Heenan & Murray 2006; Howe 1999; WWDA 2007b: 40-41, 43; Chang et al 2003; Copel 2006). When statistics about disability and violence are collected, the

[8] The ABS survey defined disability as "*any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities*" (ABS 2004: 3).

data is not always robust, timely or disaggregated, making it difficult to engage in comparative analyses.

Methodological problems include:

- The lack of consensus about what constitutes 'violence' as it relates to women with disabilities. The literature on violence against people with disabilities uses a number of terms, including: domestic or family violence, sexual assault, abuse, victimisation, intimate partner violence, hate crimes, neglect and so on. Women With Disabilities Australia notes how the reclassification of violent crimes against people with disabilities, particularly those occurring within service or institutional environments, are given euphemisms such as "'*abuse'*, *'misconduct'*, *'neglect'*, *'maltreatment' and 'incidents*'" (WWDA 2007b: 15; see also Sobsey 1994).

- Some research examines specific types of violence (such as sexual violence) but not other forms.

- Some research focuses on violence committed by certain types of perpetrators, for example, an intimate partner, to the exclusion of other persons, such as carers. The impact of not measuring non-partner carer violence is that it might under-represent women with the most severe disabilities.

- Some research uses "*convenience samples*" rather than representative community samples (Martin et al 2006: 825; see also Brownridge 2006: 817 and Nosek et al 2005c for shortcomings in research).

- Research uses different categories and definitions of disability; in particular, the inclusion or exclusion of women with mental health problems is contentious.

What we know of the incidence of violence against women with disabilities

There is, however, a substantial body of literature indicating that women with disabilities are at much greater risk of domestic violence and sexual assault than women without, and are more vulnerable to institutionalised forms of violence (Brownridge 2006; Sobsey 1994; Chenoweth 1996[9]; Martin et al 2006; Curry, Hassouneh-Phillips and Johnston-Silverberg 2001; Hassouneh-Phillips and McNeff 2005; Nosek et al 2001; Nannini 2006; Frohmader 2005; Milberger et al 2002; Barile 2002; Grattet & Jenness 2001; Urbis Keys Young 2004).[10]

Few studies of violence against people with disabilities include comparisons with people without disabilities. In one of the few large-scale studies that does, Brownridge (2006) analysed 7,027 Canadian women's experiences of partner violence. He found that women with disabilities had 40% greater likelihood of experiencing violence in the previous five years than women without disabilities. Further, he found that these women were at particular risk of severe violence.

Martin et al (2006) examined data from 5,326 women collected by the North Carolina Behavioural Risk Factor Surveillance System in 2000 and 2001.[11] The

[9] Chenoweth (1996) cites several earlier studies from the 1980s and early 1990s.
[10] By comparison, there is very little Australian or international research that looks at the experiences of children and young people with disabilities and violence, although child abuse often occurs alongside family violence (see Baldry et al 2006)
[11] This is a telephone-based, household survey of a representative sample of non-institutionalised adults that collects health and socio-demographic data for the Centres for

questionnaire surveyed women for the presence of disability and experiences of physical and sexual assault within the preceding year. Of the total women surveyed, 26% had some type of disability: of these, 68% reported having a physical, mental or emotional limitation on their activities; 61% self-identified as having a disability; 42% reported having trouble learning, remembering or concentrating; and 26% reported using some type of special equipment such as a cane, wheelchair or special telephone. The study found that women with disabilities were more than four times more likely to have been sexually assaulted within the past year compared to women without, but were at similar risk of physical assault compared to women without. As it did not include women with disabilities living in institutionalised settings, it is possible the prevalence rate of violence against women with disabilities is under-represented in the findings.

One of the largest Australian studies of violence of all types against women with disabilities was undertaken by Cockram (2003) in Western Australia and is worth reporting on at length although it did not involve a comparison with women without disabilities or include women with disabilities living in institutionalised settings.

Cockram analysed questionnaire responses gathered from 107 agencies from which an estimated 709 women with disabilities experiencing domestic violence had sought help in the two years preceding the research. Of these, 145 or 20% of the women were from a culturally and linguistically diverse background and 201 or 28% were Indigenous. She found that 270 or 38% had disabilities that were a consequence of family violence used against them (Cockram 2003: 3).

The agencies reported that women with disabilities, like women without, typically experienced more than one type of violence. The most common was emotional, (experienced by 513 or 72% of the women) followed by: controlling behaviours involving restricting access to family, friends, phone calls and removing or controlling communication aids (395 women or 55%); sexual violence, including rape and sexual harassment (360 women or 58%); physical violence (355 women or 50%); stalking (275 women or 39%); threats to third parties such as children (230 women or 32%); threats to withdraw care (205 women or 29%); discriminatory practices, including withholding or forcing medicine, removing or disabling a wheelchair, criticisms relating directly to a disability (190 women or 27%); and spiritual deprivation (70 women or 9%).

Cockram's study, along with others, show that women with disabilities experience the same kinds of violence as non-disabled women, with the same consequences, but are also at risk of experiencing types of violence that are specifically related to their disabilities, such as: withholding orthotic equipment (wheelchairs, braces) and medications; forced and involuntary sterilisation or termination of pregnancy; withholding transportation, or essential assistance with personal tasks such as dressing or getting out of bed (Curry et al 2001; Nosek et al 2001; WWDA 2007b; Frohmader 2005; Howe & Frohmader 2001; Dowse & Frohmader 2001). [12] In one study, participants with disabilities were more likely to identify restraint and control as abusive in comparison to those without disabilities (Gilson et al 2001a).

Disease Control and Prevention and administered by the North Carolina State Centre for Health Statistics in Raleigh (Martin et al 2006: 826).

[12] See Appendix 1 for an information sheet about the nature of violence experienced by women with disabilities developed from Frohmader (2005) for use during this project.

The nature of the disability

The literature indicates that vulnerability to violence varies with the nature of the functional impairment.

Given the incidence of violence against women with cognitive disabilities, much of the literature focuses on sexual assault and notes very high rates of assault. However, Carlson notes qualitative studies suggest domestic violence amongst people with intellectual disabilities is congruent with findings of sexual assault amongst people with intellectual disabilities (Carlson 1997).

In Cockram's study, agencies reported that women often had more than one type of disability. The most prevalent disability reported was psychiatric (391 women or 55%) followed by physical (230 women or 32%); intellectual (210 or 30%); neurological, including acquired brain injury (115 or 16%); and sensory, including hearing and sight impairments (75 or 10%) (Cockram 2003: 4).

Drawing on data from a national survey on sexuality in the US, Young, Nosek, Howland & Rintala (1997) compared 421 women without disabilities to 439 women with physical disabilities. They found that both groups of women had equally high lifetime prevalence of physical, sexual or emotional abuse (62% of both groups had experienced some type of abuse during their lives) and 13% of women with physical disabilities had experienced physical or sexual abuse during the previous year. Other studies have found that women with disabilities experience violence at similar or higher prevalence rates (see Nosek et al 2001; Murray & Powell in press; Chenoweth 1996).

Young et al (1997) also found that women with physical disabilities experienced physical or sexual abuse for a longer period of time than women without. This accords with other research which indicates that women with disabilities are more likely to experience more severe violence, for longer periods of time, and more frequently than non-disabled women (Swedlund and Nosek 2000; Nosek et al 2001; Frantz et al 2006).

Perpetrators

Women with disabilities experience violence at the hands of a greater number of perpetrators. Perpetrators have been found to be family members, personal assistants, support staff, service providers, medical staff, transportation staff, foster parents, and peers (Frantz et al 2006).

It appears that family members, who may also undertake care tasks, are most commonly identified as the key perpetrator group (Murray & Powell, in press; Martin et al 2006) but, as discussed earlier, this may be indicative of methodological constraints. Cockram found that 309 (43%) experienced violence against them by their male spouse or live-in partner. A further 80 women (11%) experienced violence by a female partner; 105 (15%) experienced violence from a parent; 60 (8%) experienced violence from another relative; 55 (7%) experienced violence from a child; 45 (6%) experienced violence from someone else, such as a neighbour; 30 (4%) experienced violence from a carer. Work mates, health professionals, housemates and clergy were also reported in smaller proportions. In addition, 165 (23%) of the women had experienced family and domestic violence for more than six years.

Sobsey and Doe (1991) studied sexual violence against 116 people with disabilities (82% of whom were women and 77% of whom had intellectual, neurological or learning impairments). They found in 56% of instances the

perpetrators had a relationship to the victim similar to that found among victims without disabilities. However, in 44% of instances, the perpetrator had a relationship with the victim that appeared to be specifically related to the victim's disability – a disability service provider (27.7%), specialised transport provider (5.4%), specialised foster parent (4.3%) and clients of a disability service (6.5%)

It has long been recognised that there is a chronic culture of institutional violence against people with disabilities by carers involved in intimate tasks (that is, against people with disabilities living in group homes, hospitals, residential schools, day support programs, respite care settings, and prisons) but less attention has been given to the perpetration of violence by carers and personal assistants in non-institutional settings (WWDA 2007b: 23-24, 36). However, carers and personal assistants working in both institutional and private residential settings are a significant potential perpetrator group (for discussions in the US on the incidence of abuse by personal assistants, see Powers et al 2002; Saxton et al 2001; Sobsey 1994; Strand et al 2004).

A current national UK research project into the service needs of women with physical and sensory disabilities experiencing abuse from partners, other family members or personal assistants, has found that violence from personal assistants is a key form of abuse experienced by women who participated in their consultations. They also found that the dynamics of abuse perpetrated by a carer or helper is experienced as "*complex and particularly distressing*" (Hague et al 2007: 46). In a small, non-randomised study of 84 adults with disabilities who received personal assistance from family members, informal providers or agency staff in the US, more than 60 % of the respondents reported "*mistreatment*". Most commonly, "*primary providers*" engaged in verbal and physical abuse, theft or extortion (reported by 30% of respondents); and "*other providers*" engaged in verbal abuse, neglect, poor care and theft (Oktay & Tompkins 2004). Whilst the authors recognised methodological constraints, they nonetheless reported their findings were similar to other research on abuse rates (Oktay & Tompkins 2004: 185).

Why women with disabilities are more vulnerable to violence

Sobsey and Doe note that "*the indirect effects of disability seem to have a much greater influence on increasing vulnerability... factors which are not specifically a result of disability, but rather* ***result from society's response to disability***" (Sobsey and Doe, 1991: 252) This finding is consistent with Justice and Justice's finding that "*disability is a risk factor in cultures that devalue people with disabilities, but not in cultures that place a higher value on them*" (cited in Sobsey and Doe, 1991: 253).

Brownridge found that *perpetrator-related characteristics alone* accounted for the elevated risk of partner violence amongst women with disabilities**.** Male partners of women with disabilities were 2.5 times more likely to behave in a patriarchal dominating manner and 1.5 times more likely to behave in sexually proprietary ways than were male partners of women without disabilities (Brownridge 2006). Similarly, Oktay & Tompkins found a positive correlation between reports of mistreatment in relation to the characteristics of the care provider (for example, being male and working long hours), not to recipient characteristics (2004: 186).

Studies note women with disabilities have increased vulnerabilities owing to: restricted mobility making it difficult for them to protect themselves from dangerous or violent situations; relying on assistance with personal tasks from the perpetrator; and being identified by predators as easy prey. This also means that women with disabilities have fewer pathways to safety and away from the violence. Women with disabilities who are Indigenous or from culturally and

linguistically diverse backgrounds are potentially at even greater risk of violence, however, we have virtually no available data on disability, gender and cultural background in Australia (WWDA 2007b: 24-25).

In summary, a review of the literature with regard to the nature of violence against women with disabilities suggests a number of key findings.

Women with disabilities:

- Experience violence in similar ways to other women and also experience violence specifically related to their disability;
- Are at greater risk of experiencing violence;
- Experience violence at similar or higher prevalence rates than those without;
- Experience prolonged, severe, frequent violence;
- Experience violence at the hands of a greater number of perpetrators;
- Are not believed when they report experiences of violence;
- Think they will not be believed and so do not report experiences of violence.

These findings suggest a critical need for family violence services and programs to give precedence to responding to violence against women with disabilities and to have the resources necessary to respond effectively. However, a review of the literature on service responses suggests that this is not currently the case.

2.3 Service responses to violence against women with disabilities

Very little research has been undertaken in Australia or overseas about the experiences of women with disabilities in seeking assistance when living with violence (Cockram 2003; Jennings 2003).

Understanding access

Many women with disabilities do not have access to an adequate independent income, information, housing, employment, services (lawyers, GPs, counsellors etc.), and transport (Zweig et al 2002; Olle 2006: 52ff; Frohmader 2005; Jennings 2003: 26). This means the majority do not have access to the resources they need to protect themselves from violence. Meanwhile, family violence and family support services are not equipped to meet the needs of women with diverse disabilities (Jennings 2003; Chang et al 2003). Their facilities may not be physically accessible and their programs may be inappropriate. Services may lack the funding to redevelop their premises to make them physically accessible and staff may lack the confidence and expertise in working with women with disabilities. Similarly, disability services do not adequately understand family violence issues and lack the capacity to identify or respond to abuse (Cattalini 1993; Nosek et al 2001; Chang et al 2003; VLRC 2006).

Clearly, access needs to be understood in the broadest possible sense of the word – where a person not only knows about the service but is able to make use of it and obtain the benefit of its functions. Cattalini (1993: 21ff) provides a helpful classification of elements which determine access, involving: knowledge of the issue, information about services, physical access, appropriateness of services, service philosophy, and community attitudes. For their part, services may be

aware that they are not identifying women with disabilities amongst their clientele but have no insight into how to make their service more accessible.

Understanding violence

As with all women, not all women with disabilities understand that what they are experiencing is violence and that they should not have to endure it (Chenoweth 1996; Keys Young 1998; Jennings 2003: 22; Cattalini 1993; Copel 2006; Hassouneh-Phillips & Curry 2002; WWDA 2007b). There is, however, an additional element to this for women with disabilities who have experienced discrimination *as* women with disabilities and/or are dependent on others for assistance. Murray & Powell (in press) discuss this in relation to sexual assault and adults with a disability. In a study of the perceptions and experiences of women with physical and cognitive disabilities related to abuse by paid and unpaid personal assistance providers, Saxton et al (2001) found confusion in being able to recognise, define and describe 'abuse' (their term) in the relationship between the personal assistant carer and the woman, particularly when the carer was an unpaid family member and/or friend. Others suggest that the internalisation of oppression makes it difficult for women with disabilities to speak about the violence (WWDA 2007b: 41; see also Sobsey 1994; Gilson et al 2001b; Chenoweth 1996).

Making information available

Related to the above, women with disabilities sometimes simply do not know about the existence of services that might be helpful to them in dealing with the violence (WWDA 2007b: 14; Frantz et al 2006). It is not yet common practice for services to make information available - and to communicate - in alternative formats (such as sign interpreters, Braille, audio, plain English, the use of email and telephone access relay services) so that it is suitable for people with diverse disabilities (Jennings 2004). Nor is it common for services to disseminate information that includes the experiences of women with disabilities (Jennings 2004).[13]

Physical access

Physical access to a service depends on being able to reach it and being able to enter and access all essential facilities. For many women with disabilities, the nature of their disability makes it difficult to flee from a violent situation or even to make contact if verbal communication is difficult or if they are dependent on a carer who is the perpetrator (Nosek & Howland 1998; Jennings 2003: 22). Transport is a major impediment to accessing services and crisis services do not typically have accessible transport (Swedlund & Nosek 2000; Chang et al 2003).

These difficulties are further compounded for women with disabilities who have children with disabilities (Baldry et al 2006: 194). Crisis refuges may not be physically accessible to many women – and their children - with disabilities; there may be insufficient space in which to accommodate aids or to house personal carers and assistant dogs. Further, women with disabilities - and women with or without disabilities with *children* with disabilities – may be loath to leave their homes if they have been modified to meet their disability needs (see Breckenridge & Mulroney 2007: 91 for a discussion of women's decisions to remain in the home).

[13] But see DVRCV's new webpage, which is also discussed in Section 8 of this report.

Service agency shortcomings

Lack of skills of service workers and/or agencies in providing appropriate care and support has been noted as a barrier in a number of studies (Chang et al 2003: 704; Trotter et al 2007; Nosek et al 2001; Cockburn 2003; Macklin 2005). Trotter et al (2007: 3) note that women with disabilities face institutional barriers in leaving violent situations when professionals they make contact with fail to ask about violence or make it difficult for women to seek help. This may also discourage or make it difficult for women with disabilities to disclose experiences of violence. The UK's Leeds Inter-Agency project found that women who disclose violence to disability services were told they could not be helped as it was not the organisation's expertise (cited in Trotter et al 2007: 3). The same shortcomings have been found in Australia, where women with disabilities who have sought help have found that workers do not have the skills to provide an appropriate service or have found staff to be discriminatory and not inclusive of them (WWDA 2007b: 42; Jennings 2003: 27; Keys Young 1998: 75). Services also lack the expertise and flexibility to support children with disabilities who have behavioural or communication difficulties. Mothers of these children, who may also have disabilities, often face difficult decisions about the crisis support they accept if it means that moving out of the area will interrupt a child's access to special schooling or therapy (Baldry et al 2006: 194).

Research conducted in Melbourne's Western Metropolitan Region by Jennings reports women with disabilities:

- Frequently felt that neither disability nor family violence services had the "*time or patience to work with them*";
- Felt that staff devalued the trauma of the violence when they disclosed violence;
- Rarely felt confident about having their needs met when requiring crisis accommodation and
- Were often "*diverted to limited and segregated services*" because "*women's services and generic agencies*" were not inclusive of or accessible to women with disabilities (Jennings 2003: 27).

Jennings discusses the challenges of ensuring the safety and empowerment of women with disabilities given the lack of support packages and the lack of affordable, accessible accommodation options for many women with disabilities (Jennings 2003: 28).

Cockram's Western Australian study found that 47 out of 72 disability health and violence response agencies (66 %) reported dissatisfaction with the adequacy of their service in supporting women with disabilities experiencing violence (Cockram 2003: table 10).

Criminal justice services

There are significant implications for the criminal justice response to violent crimes committed against women with disabilities in Australia (French 2007; Murray & Powell in press; VLRC 2006; Goodfellow & Camilleri 2003; Cattalini 1998) and overseas (as noted by several contributors, notably Dubin, Whatley, Sobsey and Sorenson, to the American journal *Impact*'s 2000 special issue on violence and women with developmental or other disabilities and also Zweig et al 2002).

The legal definition of domestic and family violence varies across state and territory jurisdictions in Australia. In recent years, however, there have been

moves to broaden the definition in various states in an attempt to provide protection from violence by carers for people with disabilities who may be living in a range of institutionalised or domestic settings (see VLRC 2006: 110-111; the Victorian *Family Violence Protection Bill 2008*; WWDA 2007b; WWDA nd).[14]

Research indicates that many cases involving crimes committed against women with disabilities are inadequately investigated, remain unsolved or result in minimal sentences (WWDA 2007b: 43). This may be compounded by stereotypical views about women with disabilities held by those in the criminal justice system (for example, that women with cognitive disabilities lie, are sexually promiscuous and not reliable witnesses); and barriers to communication in interview settings that do not take account of the functional needs of women with disabilities (for example, issues with memory, recall and suggestibility may be relevant when interviewing women with cognitive disabilities) (see Keilty & Connelly 2001 and Goodfellow & Camilleri 2003).

More recent Australian studies indicate the difficulties that people with disabilities have in being believed and treated as credible witnesses and complainants (VLRC 2004, 2006: 40; Goodfellow & Camilleri 2003: 54ff; French 2007: 76). In Victoria, the Victorian Law Reform Commission and disability advocacy groups have made a number of recommendations that have resulted in improved protocols for the investigation of family violence by police; for example, encouraging police to consider the use of an Independent Third Person and the use of video and audio taped evidence in appropriate circumstances (Victoria Police 2004; VLRC 2004: 325).

The report on barriers to justice for persons with disabilities in Queensland (French 2007) comprehensively looks at service responses by police, the courts, and corrective and young offender services. With respect to police responses, it notes a number of similar problems to those described by others, some of which include:

- A failure to adequately investigate violent crimes against people with disabilities;
- A tendency not to believe persons with disabilities;
- A reluctance to investigate allegations made by people with disabilities about violence perpetrated against them by family members;
- Failure to act owing to the view that there is no alternative to the abusive situation (French 2007: 62-63).

With regard to the experiences people with disabilities have in accessing the courts and legal services, the report notes the following problems:

- Lack of affordable legal services (and publicly funded legal assistance);
- Negative attitudes towards people with disabilities;
- Refusing to take instruction from a person with a cognitive or psychosocial impairment;
- Lack of expertise in working with people with disabilities, including lack of expertise in communicating with and interviewing people with disabilities and using alternative modes and formats of communication;
- Absence of flexible court procedures and practices to accommodate the needs of people with disabilities, including the use of alternative technology (see French 2007: 76-76 for a fuller discussion).

[14] Development on the Victorian *Family Violence Protection Bill* as it makes its way through the parliamentary process can be monitored through www.legislation.vic.gov.au. The legislation could be subject to change as it passes through Parliament and is not finalised until this process has been completed.

Service philosophy

Services often do not consider the needs of women with disabilities when planning and developing their services. Services sometimes justify their lack of service provision to women with disabilities citing insufficient funding and resources to make their service or programs accessible (Barile 2002). In other words, there is an attitudinal problem and, conceivably, an issue of duty of care, if not discrimination (Cattalini 1993). This can also extend to lack of reporting and cover up of violence in institutional settings (most notably, see Sobsey 1994). As previously discussed, Women With Disabilities Australia cite a number of factors within residential, institutional and service settings in which there is not only a normalisation of violence but a culture of fear amongst staff if they 'whistle blow' (WWDA 2007b: 44).

Cross-sectoral collaboration

Lack of cross-sectoral collaboration has been noted as a significant barrier in responding adequately to women with disabilities experiencing violence (Murray & Powell, in press; Jennings 2003: 26 & 29; Keys Young 1998: 75; Chang et al 2003: 706; Zweig et al 2002: 178; VWDN AIS 2007).

Laing et al (2008) are currently engaged in a project exploring collaboration between the domestic violence and mental health sectors in NSW In a survey of 107 respondents from mental health services (56% of respondents) and domestic violence respondents (44% of respondents), they found 45% of mental health practitioner respondents and 72% of domestic violence respondents considered collaboration with other organisations was insufficient. However, the collaboration between the two sectors indicated that: 76% of mental health respondents had contacted a domestic violence service and 69% had referred a client to a domestic violence service; and 98% of domestic violence respondents had contacted a mental health service and 89% had referred a client to a mental health service. Common significant barriers to collaboration between the two sectors for mental health and domestic violence respondents were high workloads and lack of appropriate community resources.

Alternatively, a number of studies cite positive collaboration as a result of research, reporting the types of services provided, the challenges faced, and strategies used to provide services to women with disabilities at community-based domestic violence programs. For example, in the US state of North Carolina, workshops for advocates to learn how to address the specific needs of women with disabilities were developed. These also had the intention of building cross-agency partnerships (Chang et al 2003: 707). Macklin's examination of an action research project undertaken in a regional NSW community focused on issues of abuse prevention and sexuality for people with cognitive disabilities. It demonstrated positive outcomes of improved collaboration between the disability service and local services, including domestic violence, police, women's health, and the court system. This in turn facilitated greater access to services by clients of the disability organisation. This research shows the importance of sustaining support for cross-sectoral collaboration.

Community/societal attitudes

The literature indicates continuing stereotypes of disability that devalue and marginalise people and in particular, women with disabilities (Thomson 1997; Smith & Hutchinson 2006; Snyder & Mitchell 2006). It is these attitudes which render people with disabilities vulnerable to violence, not the disability itself. As

the Victorian Law Reform Commission's *Review of Family Violence Laws* showed, "*People with disabilities experience forms of violence which are not only often condoned, but to a certain extent institutionalised in our society*" (VLRC 2006: 40). Such attitudes feed social inertia and restrict awareness of the need for access for all (Cattalini 1993; Cockram 2003; Sobsey 1994). It is common for women's and children's disabilities to be used against them by men – with and without disabilities themselves – exercising power and control over them. Patriarchal ideologies and "*disablist attitudes and assumptions*" thus combine to further damage the self-esteem of women living in violent circumstances and a cycle of isolation and powerlessness is perpetuated (Trotter et al 2007: 2).

Reluctance to disclose

In addition, women with disabilities – like women without – may feel shame about the experience of violence and be deterred from disclosure. Some may believe that violence is acceptable if, through experience, the perpetrators of violence against them go unchecked. A woman with disabilities may also be concerned that she simply will not be believed and that her claims will be treated as lies, exaggeration, or evidence of mental impairment (Zweig et al 2002; Murray & Powell, in press). As already noted, Women With Disabilities Australia and others have suggested that "*internalised oppression and silence contributes to an already unresponsive service system*" (WWDA 2007b: 41; see also Gilson et al 2001; Sobsey 1994; Chenoweth 1997).

Accommodation options

Weeks' and Oberin's national survey of women's refuges, shelters, outreach and support services found that demand for accommodation services far exceeded availability (2004). Owing to this and many factors already discussed above, women with disabilities who experience violence face fewer alternative accommodation options than women without and are presumably at greater risk of continuing to live with the perpetrator of the violence. We do not know, however, the true extent of this problem in Australia (or elsewhere). Weeks' and Oberin's survey did not identify accommodation issues for women with disabilities experiencing violence but the recently released Commonwealth Government Green Paper - *Which Way Home? A new approach to homelessness* - provided some (albeit limited) evidence of this by drawing on National Data Collection Agency information. The paper clearly identifies family and domestic violence and mental illness as "*common risk factors [amongst others] that often work together to increase the risk of homelessness*" and that there is a "*high incidence of disability, mental illness and alcoholism…in the majority of older people who experience homelessness*" while receiving income support, particularly disability support payments (Commonwealth of Australia 2008: 15-16). Further, a report by the NSW Ombudsman in 2004 found that people with disabilities (particularly those with 'mental illness', physical and cognitive disabilities) are some of the most significant groups excluded from SAAP programs in NSW (NSW Ombudsman 2004: 8). This report also found that there were high numbers of people with disabilities exiting early from SAAP services or who had difficulty in accessing SAAP services.

2.4 Human rights approach to violence and disability

This section explores principles of equality, human dignity, mutual respect and freedom as essential features of the concept of human rights as articulated in the Universal Declaration of Human Rights and adopted in human rights treaties.
There is evidence that there are many benefits to a human rights approach to disability and the disadvantages that people with disabilities are vulnerable to, including poverty, social exclusion, discrimination, poor health, unemployment and low educational attainment. The Melbourne-based Human Rights Law Resource Centre has argued that these include:

- Empowering marginalised and vulnerable individuals, communities and groups;
- Providing a framework for the development of more effective, efficient and holistic public and social policy,
- Promoting flexible, responsive, respectful and humane public and social services;
- Challenging 'poor treatment' and improving the quality of life of marginalised and disadvantaged individuals and groups;
- Assisting in the development of improved and effective social inclusion and poverty reduction strategies.[15]

Convention on the rights of persons with disabilities

Over time, a social justice and gendered approach has become an increasingly important element in guiding policy, legislation and practice, but the development of *treaty* rights for people with disabilities has lagged behind those for other key population groups. For example, the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) was adopted by the United Nations in 1979 (and ratified by Australia in 1984) but the *Convention on the Rights of Persons with Disabilities* was only adopted by the United Nations in late 2006, was ratified by 20 UN members on 3 April 2008, and came into force 30 days after that date.

The Convention recognises and protects the rights of people with disabilities to participate in social and political life and their rights to education, health, work, adequate living conditions, freedom of movement and equal recognition before the law.

Two key articles are particularly relevant regarding the rights of women with disabilities to be free of violence:

- Article 6: "Women with disabilities", states that "*women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms*" and "*State Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention*".

- Article 16: "Freedom from exploitation, violence and abuse", specifically recognises, amongst other things, that "*persons with disabilities, both*

[15] We are grateful to the Human Rights Law Resource Centre Ltd for giving permission to use material included in their letter to the Attorney-General's Department on the ratification of the *UN Convention on the Rights of Persons with Disabilities* and the Optional Protocol, dated 18th February 2008.

within and outside the home [shall be protected] from all forms of exploitation, violence and abuse, including their gender-based aspects"; that "*State Parties shall take all appropriate measures to promote the…recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse*"; and "*shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted*" (*Convention on the Rights of Persons with Disabilities*).

Australia has signed the Convention and is presently considering the impact of ratifying the *Convention on the Rights of Persons with Disabilities*, although some of its provisions exist in Australia's *Disability Discrimination Act 1992*.[16] Once Australia ratifies the Convention, it is legally bound to ensure that all domestic legislation complies with the treaty's provisions.

Convention on the Elimination of Discrimination against Women (CEDAW)

CEDAW is the major human rights treaty for women and was ratified by Australia in 1983. CEDAW requires signatory states to undertake specific measures to end discrimination against women in all forms, including:

- To incorporate the principle of equality of men and women in their legal system, abolish all discriminatory laws and adopt appropriate ones prohibiting discrimination against women ;
- To establish tribunals and other public institutions to ensure the effective protection of women against discrimination;
- To ensure elimination of all acts of discrimination against women by persons, organisations or enterprises.

The CEDAW convention does not specifically mention women with disabilities. To address this omission a general recommendation (Recommendation 18, 1991) requests States Parties to provide information on women with disabilities in their periodic reports, and on measures taken to deal with their particular situations (WWDA 2008).

The Office for Women has responsibility for monitoring Australia's obligations under CEDAW, including preparation of Australia's report under the Convention (required every four years) and providing advice on new developments relating to CEDAW.

United Nations Development Fund for Women (UNIFEM)

[16] There are nine United Nations human rights treaties, which are the core of the international system of human rights' promotion and protection and are *legally binding* for those States that ratify or accede to them. Each treaty (convention or covenant) has a treaty body, a committee of experts, who monitor the implementation of treaty obligations by its State parties. In addition to the nine core treaties, there are numerous other universal instruments relating to human rights, including declarations, principles, guidelines etc. These latter instruments have no binding legal effect. See Women with Disabilities Australia – human rights webpage: www.wwda.org.au; Human Rights & Equal Opportunity Commission – Human Rights Explained webpage: www.humanrights.gov.au/education/hr_explained.

The United Nations Development Fund for Women (UNIFEM) was established in 1996 by a UN General Assembly Resolution as the United Nations Trust Fund in Support of Actions to Eliminate Violence Against Women. It is the leading global multi-lateral means through which national initiatives aimed at ending violence against women are supported. The United Nations General Assembly mandated the UNIFEM to strengthen activities to eliminate violence against women in order to accelerate implementation of the recommendations set out in the Beijing Declaration and Platform for Action. Outcome 6 of the *UNIFEM Strategic Plan 2008-2011* is to ensure

> *the most marginalized women (including, among others, HIV-positive women, women informal sector workers, migrant women, indigenous women, women survivors of sexual and gender-based violence in conflict situations and women with disabilities) have increased resources, capacities and voice to ensure that their priorities are included in relevant policies, programmes and budgets* (UNIFEM 2007: 15).

The Victorian Human Rights Charter

In January 2008 a new act of parliament, the *Victorian Charter of Human Rights and Responsibilities Act 2006* (the Charter), came into effect. The Charter protects the rights and freedoms of individual Victorians, enshrining a body of civil and political rights derived from the *International Covenant on Civil and Political Rights*.

The Charter requires State and local governments, statutory authorities and other public authorities to take human rights into consideration when making laws, setting policies and providing services. It therefore has important implications for the family violence service response system; for example, requiring services to be inclusive and equipped to work with all clients, including women with disabilities, as well as requiring data collection processes to be inclusive of people with disabilities.

2.5 Policy and legislative context in Australia

This section considers legislation governing the rights of people with disabilities and legislation concerning family and domestic violence as it impacts upon all women and children.

Federal Government and community responses

The most significant legislation regarding people with disabilities at Commonwealth level is the *Disability Discrimination Act 1992*, which makes it illegal to discriminate against people with disabilities and draws on two international human rights declarations: the *Declaration on the Rights of Disabled Persons* and *Declaration on the Rights of Mentally Retarded Persons*.

The Commonwealth policy response to family and domestic violence from 1997 to 2003 was through the *Partnerships Against Domestic Violence* (PADV) initiative. The initiative funded:

- The Australian Domestic and Family Violence Clearinghouse
- 'Violence Against Women, Australia Says No' media campaign
- Prevention and early intervention with children
- Projects addressing violence in Indigenous communities
- The development of men's behaviour change (perpetrator) programs (see Phillips 2006).

Recently, the Federal Government's changes to Family Law have introduced mandatory Family Dispute Resolution for all separating couples with children and the establishment of Family Relationship Centres (Kirkwood 2007: 19). Concerns have been raised if Family Dispute Resolution is used in cases where family violence exists or has occurred.

With the change of government in 2008, an initiative of the Federal Government is the newly established National Council to Reduce Violence Against Women and Children, which met for its first quarterly meeting in Melbourne in June 2008. The aim of the Council will be to oversee the Government's commitment to establish the *National Plan to Reduce Violence Against Women and Children*. Coordinated by the Office for Women, the work of the Council will be supported by the Australian Domestic and Family Violence Clearinghouse and the Australian Centre for the Study of Sexual Assault. There is no representation of women with disabilities on the Council.

The *National Plan to Reduce Violence Against Women and Children* is in keeping with one of the key strategies of UNIFEM, which is to "*establish baselines and monitor progress, by regularly collecting information on: …the existence and quality of national plans of action for gender equality and for ending violence against women*" (UNIFEM 2007: 12).

Violence against people with disabilities, and in particular women and children with disabilities, has not had a strong profile on the Commonwealth family violence agenda, although there are three significant developments.

In 2001, a National Disability Abuse and Neglect Hotline was established as an Australia-wide telephone hotline for reporting abuse and neglect of people with disabilities using government funded services. This service is fully funded by the Australian Government's Department of Families, Housing, Community Services and Indigenous Affairs.

Secondly, an important outcome for women with disabilities was the publication of *It's not ok – it's violence: information about domestic violence and women with disabilities,* funded through the PADV program, and recently updated and re-published as part of WWDA's *Violence Against Women with Disabilities Resource Manual* (WWDA 2007b).[17]

Finally, a significant community response was the holding of a national forum called *Diverse and Inclusive Practice: Redrawing the Boundaries – Domestic Violence, Disability and Cultural Safety 2007*. Hosted by the Australian Domestic and Family Violence Clearinghouse in November 2007, a number of recommendations were made. In broad terms, they were concerned with: the implications of signing the UN Convention on the Rights of Persons with Disabilities; recommendations to the Human Rights and Equal Opportunity Commission; safety and protection issues (including a national audit of refuges to establish service gaps in regard to emergency housing for women and children with disabilities and establishing a fund to provide emergency care for women with disabilities when their caregiver has been violent, and increasing emergency housing options); data collection; training and professional development; organisational policy issues; community education and other issues (see Wilcox 2007). It was also recommended that a national working party be established to oversee the implementation of recommendations relating to the above.

[17] Four booklets make up this manual: *A Life Like Mine! Narratives from women with disabilities who experience violence; Forgotten Sisters: A global review of violence against women with disabilities; It's Not OK – It's Violence: Information about domestic violence and women with disabilities;* and *More Than Just a Ramp: A guide for women's refuges to develop Disability Discrimination Act action plans*. Available via: www.wwda.org.au

Victorian State Government and community responses

Discussion of family violence and sexual assault strategies in Victoria's social policy, *A Fairer Victoria,* makes no specific reference to violence against women with disabilities. It commits generally to improving access to public services for people with disabilities through the development of disability action plans for each department.

The Office for Disability in the Department of Planning and Community Development is responsible for a whole-of-government approach to policy and programs for people with disabilities and is responsible for supporting community and health services in developing Disability Action Plans over the next two years. This has significance for the development of Disability Action Plans in the family violence sector (discussed later in this report).

Three further legislative and policy documents address disability but not specifically violence against women with disabilities:[18]

- The *Victorian State Disability Plan 2002-2012*, seeks to ensure access to appropriate support for people with a disability who have experienced, or are at risk of experiencing, physical, emotional or sexual assault or sexual harassment; and improve the response of the criminal justice system to the needs of people with disabilities. This involves building closer links between the Department of Human Services and justice agencies (police, courts, corrections and others).
- The *Disability Act 2006* (operational in July 2007) articulates a whole-of-government approach to enabling people with disabilities to more actively participate in the community. It is guided by human rights principles, including the right to live free from abuse, neglect and exploitation.[19]
- The Victorian *Equal Opportunity Act 1995* (along with the *Commonwealth Disability Discrimination Act 1992*) makes it unlawful to discriminate against a person because they have a disability and requires that people with a disability be given equal opportunity to participate in and contribute to the full range of public life, including having access to goods, services and facilities provided by government departments.

Finally, whilst the *Victorian Charter of Human Rights and Responsibilities Act 2006* (discussed above) does not specifically address disability and violence against women with disabilities, it has important implications for the fundamental rights to non-discrimination, equality before the law, the rights to privacy, liberty and security of person for women with disabilities experiencing violence and for the family violence response system. The Victorian Charter is intended to ensure that human rights are taken into account when developing, interpreting and applying Victorian law and policy and seeks to do so through a number of mechanisms that involve the legislature, the executive (including public authorities in the family violence response system) and the courts.

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[18] Discussion draws on VWDN AIS' *A Framework for Influencing Change: Responding to Violence against Women with Disabilities 2007-2009.*

[19] These clearly inform the Victorian Government's resource guide for disability service providers, prepared by the Department of Human Services, called *Understanding the Quality Framework for Disability Services in Victoria (2007)*. Whilst guided by human rights principles, it is not, however, informed by a gendered approach. This may have implications for building the capacity of the sector to engage with violence against women and children with disabilities and for cross-sectoral collaboration with the family violence sector. However, DHS has developed a policy to assist disability services to respond to physical and sexual assault and some disability agencies provide training to staff regarding sexual assault, which are all indicative of positive developments regarding other forms of violence against women with disabilities in the future.

Family violence reforms

A number of significant family violence reforms in recent years are clearly guided by a human rights and gendered perspective on family violence (see Statewide Steering Committee to Reduce Family Violence 2005: 10).

The reforms aim to improve the safety of women and children, prevent family violence and ensure that men who use violence are held accountable. In 2005, the Government allocated $35.1 million over four years across police, courts and support services; in 2007, a further $14.5 million was allocated; and in 2008, $24.7 million.

The broad family violence policy framework documented in the *Women's Safety Strategy 2002-2007* and the *Women's Safety Strategy II 2008-2013* will guide future efforts on addressing violence against women.

In 2005, the Victorian Government released several key policy documents, which committed it to a new approach to family violence:

- *A Fairer Victoria* (the government's overall social policy)
- *Reforming the Family Violence System in Victoria*
- *Changing Lives: A new approach to family violence in Victoria*.

A central feature of the new approach is to develop an integrated family violence service system involving better coordination of the three main entry points into it: family violence services (case management, practical support and counselling, housing, peer support, healing centres, Indigenous family violence initiatives, and men's behaviour change programs), legal and statutory bodies (police, child protection, courts, corrections), and mainstream services (disability and mental health services, healthcare, public housing, family support services, legal services, education) (DVC 2007: 9).

Key leadership structures were established to guide the reform process:

- The Family Violence Ministers Group.
- The Family Violence Interdepartmental Committee.
- The Statewide Steering Committee to Reduce Family Violence.
- Integrated Family Violence Committees at regional and sub-regional levels, with links to the Regional Indigenous Family Violence Action Group.
- Regional Family Violence Leadership Positions with responsibility for developing cross-sector, cross-agency partnerships (Marcus 2008).

Key reforms include:

- Strengthening the police response (Victoria Police 2004);
- Developing complimentary codes of practice by key agencies involved in responding to family violence;
- Strengthening the legislative response by repealing the *Crimes (Family Violence) Act 1987* and replacing it with a new *Family Violence Act* (at present in Bill form)[20];
- Establishing a specialised court response (Stewart 2005; Stubbs 2004; Marcus 2008);
- An Indigenous family violence strategy (Kirkwood 2006);
- The development of a family violence common risk assessment tool for use by all agencies in the family violence integrated system (DVC 2007 and see section 6 of this report).

[20] Whilst not only concerned with family violence, a related policy is the *Child, Youth and Families Act 200*5, which introduces Child FIRST, a new service stream for children based on a network of services across the state. An important element in this service response is to provide support to children and youths who have experienced family violence.

All of these key reforms have potential implications for how services identify and respond to women with disabilities experiencing violence.

In its 2008-09 budget the government announced plans to develop a Family Violence Prevention Plan. Based on the Victorian Health Promotion Foundation evidence based framework to guide government activity in violence prevention, the Government will develop a State Prevention Plan to prevent violence against women which will also build on existing programs (OWP, 2008).

In 2007, the VWDN AIS launched *A Framework for Influencing Change: Responding to Violence against Women with Disabilities 2007-2009*. VWDN AIS' focus in prioritising violence against women with disabilities is to ensure the issue is on the agenda of the family violence response system. The Framework thus seeks to:

- Influence the family violence sector to be inclusive of women with disabilities;
- Influence the disability sector to prioritise gender issues, such as violence against women with disabilities;
- Support the leadership and education skills amongst women with disabilities;
- Influence government policy and legislation.

In the 2008-09 state budget, funding to assist in the implementation of this framework was made available.

2.6 Recommendations

This overview of current research and current policy suggests the need for the following initiatives to address gaps in research and to monitor the implementation of family violence reform:

1. That a statewide research project be undertaken in order to understand the help-seeking experiences of women with disabilities living with violence and the experiences of family violence workers in supporting women with disabilities across metropolitan, rural and remote areas.

2. That statewide research be undertaken in order to ascertain the prevalence and extent of violence against women and children with disabilities in the full range of residential settings.

3. That monitoring and evaluation of the impact of the Victorian family violence reform initiatives on supporting women with disabilities experiencing violence be undertaken, as part of the SAFER Research Program.

4. That women with disabilities are prioritised in the development of the Victorian Family Violence Prevention Plan and in its implementation at policy and practice levels.