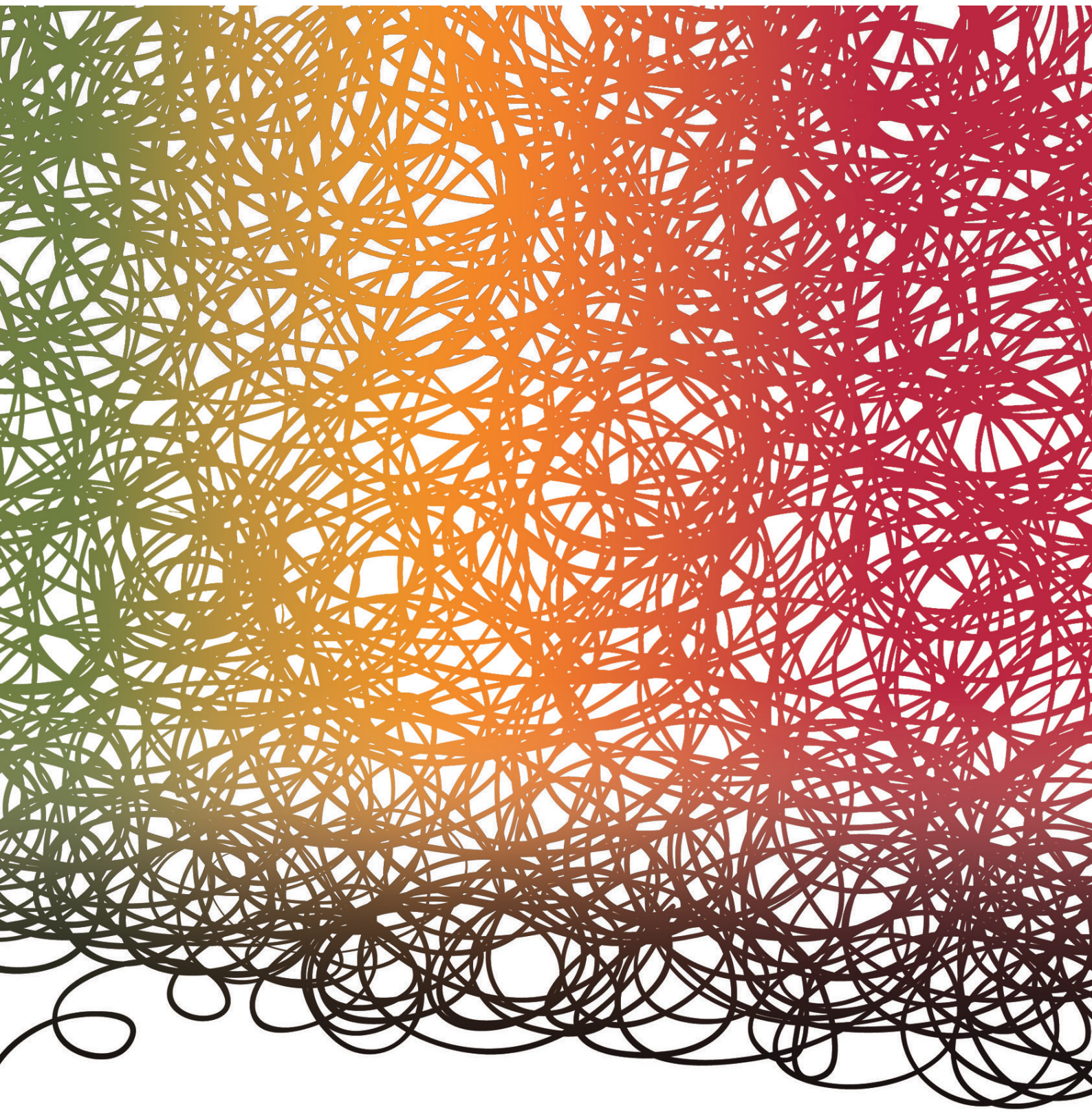


Access to Specialised Victim Support Services for Women with Disabilities who have experienced Violence

Final Short Report



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Ludwig Boltzmann Institute of Human Rights

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Abbreviations

DPOs	Disabled People Organisations
NAP	National Action Plans
PDOs	Pro Disability Organisations
SVSSs	Specialised Victim Support Services
ULOs	User-led Organisations of disabled people
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VAW	Violence against women

A note about language

The term, “Women with disabilities,” is used when referring internationally to policy and legislation, or the general title of the project across the EU. Many women with impairments prefer the term, “Disabled women”, which is used throughout this report, to refer to women who are disabled by the barriers, discrimination and negative attitudes they face when trying to access information, services or equality of employment and life chances. This is consistent with understanding promoted through the social model of disability, which explains how people are disabled by society.

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Introduction

This summary encompasses the main findings of the Daphne III project: *Access to Specialised Victim Support Services for Women with Disabilities who have experienced Violence*. The comparative EU project (from 2013 to 2015) has been carried out by four European countries including Austria, Germany, Iceland and the United Kingdom. In Austria the Ludwig Boltzmann Institute of Human Rights (project coordinator) together with the organisations Queraum (cultural and social research institute) and NINLIL (association for empowerment and counselling for women with disabilities) were responsible for the implementation. In Germany, the University of Giessen, in Iceland, the University of Iceland and in United Kingdom, the Universities of Leeds and Glasgow were the three other project partners.

A literature review on the interplay between violence, gender and disability was conducted. It revealed a clear absence of data, particularly with regards to how disabled women experience violence and their access to specialised victim support services.¹ Among the very few studies, Schröttle et al.² (2012) have published the only representative study on the extent of violence against disabled women in Germany. The study revealed that women with disabilities have experienced violence two to three times more often than women in the average population. In relation to the access of women with disability exposed to violence and getting support at

service providers, Swedlund/Nosek (2000)³ pointed out, for example, that the majority of shelters, helplines, counselling services, etc. seldom explicitly include services for disabled women in their service philosophies, policies, planning and programming.

Therefore the project aimed to assess the range of different experiences of violence against disabled women and their use of support structures. In addition specialised victim support services were interviewed about their experiences and capabilities in terms of counselling and accommodating disabled women.

The project focused on three components:

1. assessing the legal and policy framework,
2. generating extensive empirical data by surveying disabled or Deaf women (focus group discussions, in-depth-interviews) and service providers (online-survey, interviews with staff members) and
3. developing good-practice-examples and recommendations.

For each component national reports and an associated comparative report was prepared, identifying the most prominent issues including the commonalities and differences between the four countries issues. The main findings of the projects (including the final short report, recommendations for service providers and a brochure for disabled women) are available to access in easy language, sign language and audio files. All products are available on the project website: <http://women-disabilities-violence.humanrights.at/publications>

1 The term 'mainstream services' refers to services such as shelters, women's counselling services, helplines, intervention centres for women's survivor of domestic violence, etc.

2 Schröttle, Monika/Hornberg, Claudia: "Lebenssituation und Belastungen von Frauen mit Beeinträchtigungen und Behinderungen in Deutschland", University of Bielefeld on behalf of the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, 2012, online: Short Report, 62 pages, online: <http://www.bmfsfj.de/RedaktionBMFSFJ/Broschuerenstelle/Pdf-Anlagen/Lebenssituation-und-Belastungen-von-Frauen-mit-Behinderungen-Kurzfassung,property=pdf,bereich=bmfsfj,sprache=de,rwb=true.pdf> [<http://tinyurl.com/o6lmp22>]

3 Swedlund, N.P/Nosek, M.A.: An exploratory study on the work of independent living centers to address abuse of women with disabilities, 2000, *Journal of Rehabilitation* 66(4):57-64. WHO 2013.

Executive Summary

The legal and policy framework

At national level, all four countries (Austria, Germany, Iceland and the United Kingdom) have a broad range of legislation in place. Common ground in all four countries is that existing law therefore covers both the issue of violence against women and the issue of protecting disabled people, although there are significant gaps in relation to protecting disabled women if they are exposed to violence.

In addition to the legal gaps, the evidence suggests that disabled women face further obstacles in obtaining access to justice. Some of these obstacles prevent women from seeking help at all. Disabled women may grow up feeling that they are not able to ask for help or advice. Additionally, the reports show that disabled people are often regarded as less credible and less believed by those in authority. The criminal justice system and social workers often hold judgmental attitudes about disabled women's sexuality, for example. If cases do go to Court, women are often not provided with necessary accessible information and knowledge. The gap between the numbers of disabled women who have experienced violence and those who do not have access to justice is significant.

Findings about violence from disabled women

These findings reflect the experiences and views of disabled women stemming from the empirical research: 106 women participating in focus group discussions and in-depth-interviews carried out with 59 women.

Experiences of Violence

Women reported a great variety of different forms of violence experienced during their childhood, adolescence and adulthood, including psychological, emotional, physical, sexual violence and institutional abuse. One woman stated: “[...] *there is no place where violence could not take place [...]*”. A majority of women experienced domestic violence and for the minority of women still living or who had lived in institutions violence and discrimination is/was omnipresent.

Disabled women, like non-disabled women, are at risk to a wide range of different forms of violence. However given their particular situations, the nature of the abuse

is likely to be more complex, especially if they are dependent on individuals, institutions and services for the support they need. This significantly increases the risk of being violated and being kept from seeking support.

Psychological violence featured very frequently in women's accounts. In all countries women spoke of being treated with contempt, threats, oppression and of being frightened. For women living in their own homes, depending on a partner who was at the same time their care person, isolation, manipulation and control were very often huge issues. A common manifestation of abuse was emotional violence and prejudice. In childhood, many women, especially those with learning difficulties and sensory impairments, emphasised that they were exposed to bullying in schools and residential care homes. In addition, some women experienced harassment at their work places or reported about stalking, mainly by people they knew. Furthermore, women who were disabled since childhood and youth often experienced psychological violence by parents which increased the risk of violence during their later life.

Physical violence was also a common experience shared by most of the women, illustrated by examples that ranged from being hit, spat on, punched and kicked. Physical violence was severe, to the extent of being choked or attempted murder by suffocation. Impairment-specific physical violence included, being denied assistance and coercion to undergo forced sterilisation. Being less able to defend oneself, being isolated or having fewer opportunities was often correlated with increased violence.

Sexual violence was among the most frequently experienced types of violence. Disabled women had been exposed to sexual abuse during childhood and adolescence. This ranged from touching genitals, sexual harassment in the public to repeated rape, sometimes sustained over years. The still prevailing view that girls and disabled women are 'asexual' was considered to facilitate and encourage the crossing of boundaries and the perpetrating of sexual violence. Moreover, a lack of sex education may prevent disabled women and girls from knowing about boundaries or being able to identify what is violence, harassment, or unacceptable treatment.

Abuse in institutional settings

Women living in institutions recounted disregard and violation of privacy, neglect, being pressurised to do things they did not want to and being humiliated. Service-related violence was always characterised by control

and domination by staff members, which often led to disregard of their self-determination and autonomy. The life of women in institutions was very often affected by sexual violence and abuse.

Forced marriage is a severe women's rights violation and a relevant experience of some of the disabled women in the UK study. In Iceland, the problem of losing legal capacity was raised in connection with the effect that women were completely hindered from making their own decisions, e.g. relating to the place where they wanted to live. Apart from this, financial dependence on partners, institutions especially in connection with an uncertain legal residence status were mentioned as the source of abusive experiences.

Perpetrators

During childhood and adolescence the perpetrators were most often fathers or to a lesser extent mothers and other family members, such as brothers, uncles, grandfathers, grandmothers, step-fathers, step-mothers, etc. Some were people closely associated with the family or child (teachers, neighbours, caregivers, drivers, therapists, doctors etc.). On the institutional level other residents, service staff, drivers, doctors and therapists are frequently mentioned. While in some cases fathers continued to abuse during adulthood, increasingly partners and spouses became the predominant perpetrators. Rather than the characteristics of perpetrators, it was the positions of power that other people held in relation to disabled women that participants identified as the biggest problem.

What works in support and assistance?

Disabled women discussed what was helpful in tackling the violence and abusive situations they experienced. They identified three main areas: supportive (or unsupportive) relationships with individuals, assistance from services and things that helped them muster personal resources and strength. In all instances and throughout their lives, supportive contact with other people was the factor that disabled women experiencing violence found most helpful.

Supportive relationships with other people

Some women described the importance of family members who helped them to recover from the effects of violence. In some cases, however, women reported a lack of support from family members. That was experienced as having a severe impact, especially in childhood, given

the fact that support or therapeutic services often cannot be reached without family members' assistance. Other people who frequently were mentioned as particularly helpful were relatives and friends, teachers, instructors, doctors, social workers, mobile caretakers, psychologists and psychotherapists.

Assistance from services

Formal and informal support services were also vital sources of support and all the disabled women interviewed agreed that they are important. However, support from services in different countries was experienced in different ways. Disabled women reported not being taken seriously or not receiving adequate assistance due to lack of disability knowledge or the necessary access to resources. In all countries, specialised informal services were particularly helpful included peer counselling, empowerment movements, self-defence classes and self-help-groups. Overall, few women reported the violence to the police and the majority of them were not taken seriously. However, some pointed out that they received positive assistance from individual police officers, judges or other officials.

Personal resources and strength

Quite often a number of small steps were taken towards establishing a violence-free, independent life. Disabled women emphasised the way that the support of others helped them to draw own boundaries concerning acceptable behaviour and to name violence for what it was. Many women used different ways of strengthening their self-confidence by e.g. writing down their thoughts, participating at dancing classes, yoga, relaxation technique training, having animals, educational programmes, getting employment, etc.. Examples of the ways that women took more control of their own lives included getting personal assistance that could replace the abusive care of individual perpetrators or institutions and being more assertive in their dealings with others.

Women's knowledge about rights and use of services

There was a great deal of variation in disabled women's knowledge about their rights. Although a small number were well informed, most had a more limited or partial picture of just one aspect of the law. Most women had used forms of therapy services at some points in their lives; some had spent time in clinics and with private psychologists. A few women in all countries had used

counselling centres and shelters but some women with sensory or physical impairments described barriers to accessing these services. For many women, a lack of knowledge and information was combined with concern about whether the services would be accessible for them. Only a minority of participants stated that the service provision in their area was adequate.

Experiences of Barriers

A formidable array of barriers was identified by disabled women when they tried to secure assistance and a violence-free life. Women were frequently dependent on perpetrators for assistance in their daily lives, both in their homes and in institutional settings. They were often hesitant to report perpetrators in case appropriate alternative assistance was not available. Specialised service providers often created barriers to access. Some women were not believed or were ignored, there was a lack of accessible information, inaccessible services, negative attitudes by service staff or a lack of funding for accessible support.

Power Imbalance

Disabled women were clear that violence stemmed from power imbalances between themselves and perpetrators, but also in society more generally. Power imbalances underpinned violent relationships and for some women violence was reported to be unremitting over long periods of time. Relative powerlessness was identified as stemming from a number of factors, including: the perception that women could not fight back, the degree of control exercised over women (as by residential service providers, for example) and restrictions on reporting, due to fear of losing things that were needed, such as assistance or accessible housing.

Findings from Service Providers

The following results gained from an empirical research encompassed an online survey with 602 service providers⁴ (most organisations were refuges, women's advice centres, women's helplines and intervention centres for women survivor's) and 54 interviews with staff members.

Accessibility for impairment-specific groups of women

Service Providers were asked to complete a self-assessment to identify the accessibility of their services

to women, according to women's impairments. Particularly, women with sensory impairments (including blind, partially sighted or D/deaf women) were barred from access. To a certain extent women with mobility impairments also lacked accessible services: in Austria, Germany, Iceland and the UK there were none, or just a very small number of organisations and services (2% to 13%) and services which were completely accessible for disabled women. Women with the label of learning difficulties were also not served by accessible services, even though the rate of access is a little higher (9% to 13%). The accessibility for women with physical impairments is more positive, however it varies greatly. The percentages in each country study range from 9% (Germany) to 46% (Austria, United Kingdom) and even 66% (Iceland). In all instances, access for women with mental health service need was most frequently reported in the interviews and in the survey (27% to 70%). The participating organisations and services were also asked to what extent they are able to support women who live in inpatient or semi-residential facilities for disabled people and/or people who need care or assistance. The highest rate here was access in Iceland (40%) followed by the UK (29%), with again Austria (13%) and Germany (6%) the lowest percentages.

Measures to ensure accessibility

Service providers were asked about the kinds of measures they had taken to ensure accessibility. Those most commonly described were counselling for women with mental health service need and information in easy language for women with the label of learning difficulty, or services women with chronic ill-health. The lowest percentages (between 0% and 4%) were given for sensory access provision, such as Braille signage or guidance systems for blind women or the use of lights for doorbells.

Access to information and public relations

With the exception of some organisations that focus on actively working with disabled women and providing accessible information, the majority of participating organisations did not engage in accessible activities. Some organisations lacked awareness about promoting existing services and many reported that they do not have enough resources to cope with the "extra" counselling and accommodation needed to protect disabled or Deaf women against violence.

4 Austria: 77 services; Germany: 442 services; United Kingdom: 73 services; Iceland; 10 services (reduced sample due to the smaller overall population size).

Co-operation and networking

A large proportion of service providers had contact with other services (health care organisations, counselling services and other organisations that were in the same or similar sector) and collaborated with them in various ways. The number of contacts were lower with services for disabled people (a third) and for Disabled People's Organisations (DPOs) (a fifth), especially for refuges and helplines. Although disabled women experienced violence from a number of sources, hate crime and institutional violence were largely treated as DPO responsibilities and domestic violence that of women's services.

Challenges of implementing accessibility identified by service providers

In all countries a number of common themes emerged when talking about challenges in implementing accessibility. Service providers spoke about being limited by lack of funds. All said that services experienced lack of capacity, resources and knowledge in order to be able to assist women adequately. Another challenge service providers identified was the far-reaching taboo of the topic of "disabled women who experience violence". Therefore, it seems to be very necessary to focus on specific public relations and awareness-raising activities on a political and social level. Finally, accessibility in a broad sense, was seen by many as something that was not achievable, and this reduced their motivation for starting to change.

Project Methods and Data Overview

Desk Research: Legal and policy framework

The objective of the desk research was to improve the knowledge and understanding of the legal and policy framework as well as the available support structures in the four countries, which was considered as necessary to inform the following empirical research. Legal and policy context concerning protective measures against violence for women in general and their implementation/ applicability for disabled women on the national as well as international level were assessed during the first four months of the project. At the initial workshop, all partners agreed on methodological guidelines with clear definitions and further background information on the key concepts, a clarification of the intended scope, content of the country reports and of issues related to the comparative report. The partners from Austria, Germany, Iceland and Great Britain provided national reports based on the results of these assessments in line with the agreed guidelines and Austria prepared a comparative report that focuses on international standards and strategies.

Empirical Research

This empirical study used a mixed methods approach – qualitative as well as quantitative data was generated during a one-year research process. The empirical

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

Table 1 Overall Summary of Participants by Country

	Austria	Germany	Iceland *	UK	Total
Focus groups of women with disabilities	5 groups in total: 22 participants	6 groups in total: 39 participants	3 groups in total: 16 participants	4 groups in total: 29 participants	106 women
In-depth interviews with women with disabilities	16 women	16 women	11 women	16 women	59 women
Online Survey with service providers	77 services (Response rate 54%)	442 services (Response rate 54%)	10 services (Response rate 100%)	73 services (Response rate 39%)	602 services
Interviews with representatives of service providers	15 participants	15 participants	9 participants	15 participants	54 representatives

A smaller sample size was selected in Iceland due to the smaller overall population.

survey and assessment of the topic of “Accessibility of specialised victim support services for women with disabilities” focused on two target groups: disabled women who have experienced violence on the one hand, and specialised victim support services, Disabled Peoples Organisations (DPOs), User Led Organisations (ULO) and disability organisations on the other hand.

The research started from the premise that disabled women are experts in their own situation and experiences of violence. In each country between 22 and 39 disabled women (except Iceland: 16) aged from 18 to 69 took part in focus groups and 16 women (except Iceland: 11) in individual in-depth interviews. Iceland had a reduced sample due to their smaller overall population size. Additionally, 602 service providers from the four countries (Austria, Germany, Iceland and United Kingdom) participated in an online survey and 54 representatives of the services in individual interviews. However, a systematic survey of all organisations of disabled people and disability organisations was not carried out where it was known that services were not extended to disabled women who have experienced violence.

Disabled and non-disabled women took part in the project as researchers, advisory group members and research participants. Country researchers convened advisory groups at key points in the project: at the outset, after the online survey and focus groups, to review empirical work, etc.

This empirical study is not a representative study, but an attempt – within the project’s scope – to present

tendencies and suggestions regarding the links between women's biographies and experiences of violence and/or use of support structures.

Disabled women

Focus groups with disabled women

Each country aimed to ensure the participation of women with a broad range of impairments and to recruit a diverse sample in terms of for example, age, geographical area (urban/rural and city/small town) marital/family status, ethnicity and experiences of violence and support. Some (but not all) focus groups were organised along impairment lines to make accessibility arrangements more tailored (easy language, sign language interpretation etc.). The interview guide contained questions on the understanding and definition of violence, on places where violence occurred, barriers to accessing support services, suggestions for improvement and good practice examples as well as on the knowledge about the rights of disabled women. It thus focused on support structures and not on the rendering of individual experiences of violence (even though the majority of women mentioned it). Women were not given a definition of either violence or accessibility in advance; instead, they were invited to discuss what they understood by the terms. Some women who took part in the focus groups were later invited to take part in the individual interviews.

In-depth interviews with disabled women who experienced violence

A biographical approach to the guide for interviews was developed, which involved asking women about violence through their lives: childhood, young adulthood and older adulthood. This enabled researchers to gain an insight into the links between different types of violence and its incidence over time in women's lives. Researchers ensured that access to support services was available to participating women if needed. The aim was to be alert to the possibility of violence beyond single incidents experienced by women and to gain a more accurate picture of overall experiences. The individual interviews were carried out with the full consent of those taking part, and at a time and place that was mutually agreed.

Service Providers

Online Survey with service providers

Comprehensive questions were asked of service providers regarding the types of services they provided,

the degree to which women with various impairments used their services, the degree to which their services were accessible and plans for the future. A high degree of interest and support for the work was generated through manifold responses of questions posed in the survey. Following types of services took part in the Online Survey: Refuges/Shelters, Intervention Centers for women survivor's of domestic violence, Advice Centres, Helplines, Counselling Centres for women who have experienced violence, specific contact points for disabled women who experience violence, contact points or counselling for disabled women and disabled people.

Interviews with representatives of service providers

In each country, expert interviewees were recruited through the online survey and also through researchers' contacting of potential participants. Again, a diverse range of services included, for example, refuges / shelters for women, helplines, counselling and information centres and a few User Led Organisations of disabled people that ran violence support services specifically for women.

Good practice and recommendations

Representatives of specialist victim support services and participants of national stakeholder meetings were asked about helpful practices. From this, the national research teams then identified up to five recommendations based on commonly developed guiding principles and criteria for good practice. Disabled and non-disabled women, who worked in different areas of support and services with women after experiencing violence developed this guidance. This included members of the advisory boards and other stakeholders who participated in project meetings.

The recommendations presented here are aimed at improving the quality of support services and facilitating accessibility for disabled women who have experienced violence. Furthermore, the recommendations put forward in different countries are, for the most, the same or addressed very similar issues. This indicates that there are certain key issues that require special attention and focus. The recommendations address different target groups, including EU policy makers, national policy makers, specialised victim support services, disability services and User Led Organisations (ULOs).

All relevant documents and the guidelines for identifying good practices are available at the project website: <http://women-disabilities-violence.humanrights.at/>

Legal and policy framework

The four participating countries of Austria, Germany, Iceland and UK as a first step assessed the legal framework as well as available support structures. The findings regarding the legal and political framework are based on four national reports from Austria, Germany, Iceland and UK concerning the situation of women with disabilities who experienced violence and the countries' responses to it. Research shows that women with disabilities experience violence far more often than women without disabilities.⁵ Although this fact is known, support structures, specifically for women with disabilities who experienced violence, are to a large extent lacking and access to women's support structures is challenging. Women with disabilities seeking support are faced with numerous obstacles and barriers. Women with disabilities are at high risk to fall between two strands of support structures: Women's support mainstream services concerning domestic violence are often inaccessible for women with disabilities. At the same time, specific disability support services are often not prepared or lack awareness concerning gender-based violence. The gap in numbers of women with disabilities who have experienced violence and those having access to the justice system is significant. Only a few women with disabilities are in a position to assert their rights before courts.

Legislation on violence against disabled women and non-disabled women

Several international and regional human rights instruments tackle the issue of violence against disabled women, for example the United Nations Convention on the Rights of Persons with Disabilities and the Council of Europe Convention on preventing and combating violence against women and domestic violence. Monitoring of the implementation of the UN human rights treaties are paying increased attention to women with disabilities. At EU-level, Member States have to ensure that women with disabilities are able to benefit fully from minimum standards on the rights, support and protection of victims of crime.⁶

At national level, all four States have a broad range of legislation in place; common ground in all four States is that the legislation is only to a limited extent meeting the needs of disabled women. In the UK, domestic violence

legislation has been reformed following the Domestic Violence, Crime and Victims Act 2004 and the issue of discrimination is addressed by the Equality and Human Rights Act 2010. In Iceland, the Act on the Protection of Rights of Disabled People aims to support persons with disabilities to protect their rights. Every region of Iceland has to appoint a Rights Protection Officer for Disabled People who monitors the situation and assists persons with disabilities. Austria has similar to Germany bundled the relevant laws in an Act on Protection against Violence. Existing law in these countries therefore covers both, the issue of violence against women and the issue of protecting persons with disabilities, however, leaving significant gaps in protecting women with disabilities if they are exposed to violence, especially if they are living in institutions. For example, the German Act on Protection against Domestic Violence and the possibility of eviction orders are not effective for women living in residential institutions or when the perpetrator is in charge of caring the victim.

Implementation of legislation

For the implementation of international and regional standards as well as national legislation, all four countries are using National Action Plans (NAPs) associated with strategies or working groups. With the exception of Germany, violence against women with disabilities is not at all or only very superficially addressed in such existing national action plans or strategies. In Austria, the recently adopted NAP on violence against women includes the aim to offer support and counselling for women with disabilities, but does not include further detailed measures on how this aim will be achieved. In the UK the NAP does not address the issue of violence against disabled women. In Germany, the issue of violence against women with disabilities was tackled in the 2007 national action plan on violence against women and at regional level, network activities and a governmental working group have been established. However, not all federal states of Germany have a NAP for the implementation of the UNCRPD.

All four countries have a support structure concerning violence against women that encompasses shelters, counselling and/or 24/7-helplines. Initiatives specifically for disabled women are scattered and not systematically established in the participating States. While in Austria and UK at least some sporadic initiatives or NGOs are

5 See for instance EU Fundamental Rights Agency (2014): Violence against Women – An EU-wide survey, p. 186.

6 As set out in in DIR 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA.

focusing on women with disabilities, Germany seems to have initiated a higher degree of activities recently. The national report on Germany indicates the establishment of several helplines and counselling services for women dealing with the issue of violence against women and girls with disabilities, from 2007. Good practice identified in Germany and Austria includes enhanced cooperation between the support structure concerning violence against women and interest groups of women with disabilities. This cooperation is helping to integrate the interests of women with disabilities in policy measures in the area of violence against women. For example, when counselling is necessary, the specialised NGO NINLIL in Austria, which offers empowerment and counselling of women with disabilities, cooperates mutually with different actors of the regular support structure concerning violence against women, like for instance the emergency counselling centre 'notruf.beratung'. In addition, there are specific organisations which support disabled or Deaf women. For instance, 'Deafhope' in the UK supports Deaf women and children who have experienced domestic violence. In Germany, the network 'Weibernetz e.V.' represents the interests of disabled women and works on violence for many years; they are connected with the national network on Frauennotrufen (bff) who have established highly relevant work on better support for women with disabilities.

Applicability of legislation to women with disabilities in practice

Concerning the application of legislation to women with disabilities, two main challenges have been identified: Firstly, the legal structure and its implementation has gaps concerning fulfilling the right of violent free living for women with disabilities. Secondly, due to certain fears and attitudes towards them, women with disabilities are hesitant to report violence to authorities, law enforcement agencies or the judiciary.

There is obviously a lack of legislation protecting women with disabilities from violence. Not mentioning women with disabilities in the context of violence leads to a disregard of their specific needs and realities. Existing systems such as the Austrian system of psycho-social and legal assistance for victims of violence in criminal proceedings are not tailored to the needs of women with disabilities. For example, in Germany, a sexually abused woman who is principally able to express her will, but can not enforce it due to her impairment/disabilities or is unable to describe the way she resisted in the criminal procedure puts the woman in the category of 'unable

to resist'. As a consequence, the maximum punishment would be reduced. In certain cases, legislation to protect women from violence is not applicable to women with disabilities living in institutions or care homes.

In addition to the legal gaps, women with disabilities face further obstacles in their access to justice. Some of these obstacles prevent women from seeking help at all. Many women are brought up with a feeling of inferiority and the sense that they are not able to make any demands. Additionally, the reports show that persons with disabilities are often regarded as less credible and reliable by those in authority. Law enforcement, the judiciary and social workers often hold judgemental attitudes around women with disabilities' sexuality. During court procedures women are often not supported by necessary accessible information and knowledge.

Turning to the issue of fear, the reports on UK, Germany and Austria show that disabled women fear (also due to previous experiences) that their reliability will be doubted by authorities, law enforcement personnel or the judiciary. In UK, there is a definition for a hate crime: a crime that is motivated by a characteristic of the victim, including disability. Although the numbers of reported crimes are increasing, there is still a very high level of non-reporting. Reasons are fear of the police and thinking that the police would not believe them, among other issues. Also in Iceland, women with disabilities only rarely seek assistance from social services in cases of violence. Similarly in Germany, the fear of not being taken seriously prevents many women from reporting acts of violence to the police. The report on the UK demonstrates the attitude of authorities that disabled people are located in policy as 'vulnerable' which leads to an overprotection of the person instead of prosecuting the perpetrator.

Accessibility of specialised victim support structures for disabled women

All the national reports give evidence that there is a major gap concerning the accessibility to specialised victim support services. Support is not accessible for a vast majority of the women and accessible information on counselling services is missing.

Despite a few promising NGO services, specialised accessible victim support services for women with disabilities, tailored to their specific situations, are not available on a nationwide basis. Besides physical inaccessibility to shelters and counselling services, access

to information is very often inaccessible. The services of women's support structures concerning violence against women are limited due to restricted funding. Governments invest only limited resources in adequate support structures for the women affected. Women with disabilities who often are in need of special support structures in terms of accessibility and availability are among the first to suffer from these restrictions. In Germany for instance, there is growing awareness among the support structure but implementation of measures is often limited due to a lack of financial resources. Limited financial resources do not allow for extra-time in counseling sessions. In another example, in Iceland, sign language services for Deaf women are scarce and insufficient due to limited funding of NGOs.

Disabled women in the UK experience 'poor attitudes, impatience, an unwillingness to accept someone would harm a disabled woman and judgemental attitudes around disabled women's sexuality.' Experiences like this prevent disabled women from seeking future support. Other reasons why disabled women do not even seek support are overprotection and inadequate sex and sexual health education, especially for women with intellectual impairments, which leads to difficulties in distinguishing between right and wrong sexual behaviour. Particularly limited possibilities to seek support in case of violence face women living in residential institutions. These women are often unable to seek help outside the institution.

In conclusion, all four participating countries show a lack of adequate attention at political level, with regard to the issue of violence against disabled women. Existing law in these states covers both the issue of violence against women and the issue of protecting persons with disabilities, but does not meet the needs of disabled women if they are exposed to violence. However, all four reports do also show several examples of good practice, such as Iceland's Rights Protection Officers (RPOs) who assist persons with disabilities.

Disabled women

Disabled women's experiences of violence during their life course

This chapter includes the individual experiences of violence of disabled women⁷ who participated in the focus group discussions (106 women) in the in-depth interviews (59 women) and in the four countries. The aim was to get a deeper understanding of their experiences with violence linked to their life biography and to their use of support structures. In particular, in the in-depth interviews women were questioned about their violent experiences during their life course – in their childhood, adolescence and adulthood. All women had experiences of different types of violence during their lives, by different perpetrators and in different contexts, but most women in our study experienced abuse in their homes by partners or family members, either in the private context or if they lived there, in residential institutions. Many women recounted multiple incidents at all stages of life, indicating the pervasiveness of violence. Living in institutions or using care facilities at all ages was associated with violence and discrimination.

Disabled women, like non-disabled women, experience a wide range of different forms of violence. However, given the particular situations of disabled women the nature of their abuse is likely to be more complex, especially due to their dependence on individuals and agencies which significantly increases the risk of being violated and kept from seeking adequate support.

Childhood and Adolescence

Women reported different forms and types of violence mainly in the family context and by intimate partners but also in public contexts, e.g. in schools, especially in boarding schools and residential cares as well as in other institutional settings (institutional violence).

Forms of violence

Almost all women had experienced **psychological** and **emotional violence** including being made to feel guilty, being threatened, humiliated, frightened, neglected and insulted in their childhood and adolescence. Besides that, very often women also recounted experiences of **physical violence**, which was perceived "frequently", "always" and "for every trifle". Many of the incidents described

⁷ Forms of impairments ranging from mobility, sensory impairments, mental health problems to women with learning difficulties and multiple impairments

ranged from very serious, e.g. severe beatings and kicks to slaps in the face, being spit on or pushed. Frequently violence experienced was associated with the women's impairments, as the following examples illustrate:

"[...] my dad also beat me, well, only when I was walking. I limp, you know, and my dad thought if I tried harder, I could walk better. And that's why he once, when we were on our way to see my half-sister, she lived in the region as well, he took a club and wanted to beat my foot." (Example from Germany)

"My grandfather tried to support the only grandchild; I was supposed to be able to hear. Back then I was wearing a hearing aid around the neck, with wires leading to the ears. Once he hit me on the earmold and I started to bleed. It was terrible. And the basement with the hearing tests! I was so scared. This was so scary for me as a small child. And my grandfather dragged me down there." (Example from Austria)

Additionally, **sexual violence** plays a massive role in the young lives of many women, the descriptions range from touching genitals, sexual harassment in public to years of severe sexual violence, including mass rapes, coupled with abortions. Among the perpetrators are most often fathers and other close family members were mentioned, but a few women had been subjected to sexual harassment and rape by neighbours and strangers in the public sphere. *"[...] he just held me down on the bed. I'm crazy from back then, I think this has stayed with me. Eight-legged animals, spiders. I am afraid. And I thought that he had eight arms and held me down on the bed and I tried to fight back and I just couldn't because he had so many arms. And he penetrated me. And I, this is so terrible, but I didn't dare to scream because he covered my mouth and said that he'd hit me if I said something. I didn't dare to say anything."* (Example from Austria)

The still prevailing view of society that disabled women and girls are 'asexual' facilitates and encourages the crossing of boundaries for perpetrators of sexual violence. Moreover, a lack of sex education may lead to girls and women not knowing their own boundaries and having difficulties saying 'no'. For these reasons disabled women are at high risk of being violated by perpetrators who target disabled women to express their power and domination.

Outside the family, there was often evidence of institutional abuse for women who attended residential

schools or apprenticeships and/or used therapeutic services. Bullying in schools by classmates and even by pupils from other classes was very often mentioned in this context.

"When I was in upper secondary school there were always some teenage boys looking at me and saying: "There comes the disabled girl" and you know, calling me names: "There comes the strange disabled girl, let's go somewhere else". You know, I always ended up in something like this." (Example from Iceland)

Many examples from all countries gave evidence on different forms of violence in the context of institutions: experiences of being ostracised by the whole school, not being allowed to play, being locked up, or being held down and forced to eat. Moreover, women recalled being excessively physically manipulated by a therapist, to the extent of bones being broken or having a duvet removed by male staff in the mornings. Furthermore deaf women experienced to high rates sexual violence by deaf boys at schools for deaf pupils.

Adulthood

For some women, childhood violence extended into adulthood and for others who had not experienced violence as children, adulthood marked the beginning of violence. The incidents of violence encompassed all forms and manifestations of violence, including **physical, psychological, sexual** and **structural violence** as well as **discrimination**.

Violence in adulthood could be influenced and the power to resist could be weakened by experiences of violence that occurred in childhood. One woman from Germany defined it as following: *"[...] and then I already had been hit and couldn't, and I didn't defend myself then. I just let it happen to me. Because then this inner child appeared again: you're there for this."*

New forms of violence were also apparent as women entered into adulthood and parenthood. The issue of **control, isolation** and **manipulation by (ex)partners** was often recounted by many women taking part in the study. Over and over again partners or husbands controlled them by placing limits around their movements and contacts with other people or control their finances. Impairment-specific abuse, often not recognised as violence, but a normal part of many lives of women with disabilities, was frequently reported by women. One woman recounted her perpetrator was her sexual partner and at the same

time her carer. He misused his position to control and isolate her: *“He would purposefully give me the strongest painkillers when my friends were coming, and they couldn’t come then obviously because I was asleep.”* (Example from UK)

One interviewee described the nature of the complicated relationship she had with her former partner. He had used this position of dominance against her and forced her to have sex with his friends, who were very harsh and, indeed, raped her. At regular intervals, though, he compensated for his behaviour by giving her presents: *“[...] he was good to me most of the time...but he did things that made me feel uncomfortable.”* (Example from Iceland)

Another woman reported about financial abuse and the fact that she was an easy target because of her impairment: *“[...] men they can see a woman with disabilities and think she’s an easy touch. I used to give money to my boyfriend and I’d give him by bank card. I’d do really crazy things because I loved him so much – or thought I did.”* (Example from UK)

With regards to impairment-specific abuse, the study revealed that violence often increased if women got their impairments after entering a relationship or if the impairment worsened during the relationship. Given the dependence of women with disabilities on their partners, the use of the women’s impairment as part of a violent strategy including isolation was repeatedly observed. Such a situation makes it very difficult for women with disabilities looking for assistance, either informal (among family members and friends) or formal (from service providers). They were very afraid of losing the support they needed to manage their daily life, if they disclosed their depressing secrets.

Abuse in institutional settings such as residential care facilities, day centres for people with disabilities and in the health care system was also commonly reported, especially psychological and physical violence, neglect, coercion and sexual abuse. Several women recounted the imbalance of power between staff members and residents, which weakens the position of women with disabilities particularly in regard to self-determination and autonomy.

One woman said that she had been sexually harassed by a caregiver:

“Before I knew it he was lying in my bed with me. That was one of the caregivers. He had his pager with

him, and it was obvious that he wanted me and I told him to fuck off, he took my hand and said: ‘You’ve never touched a penis, right? You’ve never been with a man, right, and don’t you want to know what it’s like?’” (Example from Austria)

Impairment-specific abuse also included neglect. A woman with a wheelchair told about being left stranded for hours in a hospital:

“They took my chair... when people take my chair away I’m a sitting duck, or a lying duck because I can’t sit up on my own... after about three hours of feeling degraded and abandoned and humiliated – all the feelings that I didn’t want to feel – I decided it was enough, I didn’t want to cope with this. I phoned up a friend and said can you come and help me get dressed and get me out of here.” (Example from UK)

Another important issue was raised in respect to **violation of privacy** in institutional contexts that generally receives little attention. Women said that they often don’t have a choice: for example, they are not given the opportunity to choose who is caring for them (if the person is male or female), or with whom they live. Their stories revealed that, sometimes they even could not lock up their bathrooms, were forced to participate in activities or restricted when to do free time activities or go to sleep etc..

Forced marriage, a severe women’s rights violation, was also an issue of relevance among the women in UK taking part in the study. A black and minority ethnic (BME) women’s focus group discussed forced marriage, where women were coerced into marriage, often with the collusion of family members. While distinct from arranged marriage, it could also be associated with it, as shown in the quote below:

“All my three brothers...they arranged or forced my marriage because my dad had passed away when I was sixteen...I spent in India for ages... my husband wouldn’t let me come back to England. I tried to commit suicide a couple of times and they (the husband’s family) just got fed up and sent me back to England.” (Example from UK)

In few cases in Iceland and Austria women were subjected to **forced sterilisation**. In Iceland this violent act was performed after the removal of their legal capacity. After **losing their legal capacity** women could be hindered in making their own decisions ranging from simple aspects of their daily lives to making decisions

where to live. Women in Iceland without legal capacity expressed their wish to have more control over their lives but until recently they received limited support from their environment and families and have encountered many hindrances in the system.

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

One insight gained out of the interviews was that **motherhood** can be very problematic for women with disabilities, not least because of the societal disquiet reported about mothers with disabilities. Disabled women feared that their children might be taken away and so they were sometimes reticent to report a violent partner. In several countries disabled women stated similarly that they were viewed as incompetent and did not receive the support / assistance they needed or the opportunity to show they could handle motherhood. Some interviewees explained that violence increased during their pregnancy and after their children were born, when more assistance was needed. A few women with intellectual impairments even reported that their babies were taken away directly after birth.

Almost all women taking part in our study were under 65. However, some noted that targeting of violence may change as disabled women age into later adulthood. The greater likelihood of living in an institution for all **older women**, as well as the increased likelihood of financial abuse by family members may well be an issue affecting disabled women in particular ways. This possibility remains an issue for further investigation.

Perpetrators

In childhood and adolescence most frequently perpetrators were fathers and less often mothers, as well as other family members (especially brothers, but also uncles, grandfathers, grandmothers, step-fathers, step-mothers, etc.) and people closely associated with the family or child (teachers, pupils, neighbours, caregivers, drivers, therapists, doctors, etc.). While in some cases fathers continued to abuse during adulthood, increasingly partners and spouses became the predominant perpetrators. On the institutional level service personnel, drivers, doctors and therapists were frequently mentioned.

Women’s experiences also revealed that in the majority of all cases no perpetrators were prosecuted or even sentenced. Few women reported the violent experience to the police, and most of them did not due to various reasons, ranging from “having no support to do so” and “being scared not to be believed” to “being afraid losing the assistance of my carer”, who is often the perpetrator. There is still too little research undertaken in the area of “access to justice” for women with disabilities and obviously needs further investigation.

Facilitating factors and support

Women with disabilities discussed helpful factors (and also commented on less helpful) in terms of three main areas:

1. Supportive relationships with individuals,
2. Formal and informal support services (including experiences with the justice system) assistance from formal services (including the or the justice system and
3. Factors that helped them muster personal resources and strengths.

Supportive relationship with individuals

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

One woman reported getting a new physiotherapist as a teenager who had a dramatically different view of his

role than those who had treated her earlier. He told her that she was the one in control:

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

Another woman reported about a very positive experience she made with a doctor:

“[...] on recommendation I found a great doctor who really built me up. I was sitting in his surgery and was a picture of misery and he built me up and said, hey, we’ll get through this. I’m an experienced doctor and you’re a strong woman, we’ll get through this.” (Example from Austria)

Apart from supportive factors, disabled women also gave examples of people either in their close environment or working in services or the justice system who had been unsupportive in various ways. In some cases, women reported about a lack of support from family members. That was experienced as very severe especially in childhood, given the fact that support or therapeutic services cannot be reached without their assistance. With regard to school, several women recounted they lacked good friends to stick by them. Their impairments were felt to be an isolating factor. Teachers were perceived differently in their role of persons of support, depending on their personal courage and motivation to give substantive support or not.

Formal and informal support services

Formal and informal support services were also vital sources of support and all women with disabilities agreed on their importance. For example, the Austrian national report points out that about half of the women participating had used specialised women’s support services (refuges, helplines and counselling) and all who had done so spoke highly of the support they had got. In some cases (in all countries), however, the support from services was assessed in different ways. Women reported not being taken seriously or not receiving the adequate assistance due to lack of impairment specific knowledge and necessary resources.

In the context of formal support, different therapeutic approaches (e.g. psychotherapy) as valuable sources were mentioned by many women. In Germany, for example, the search for a suitable female therapist with sign language skills was, however, a big challenge.

In general, only few women reported to the **police**, but some of them pointed out that they received positive assistance from police officers and experienced favourable treatment from judges and other officials. Still some women also reported not being believed or their cases were not pursued due to lack of evidence.

In all countries, **specialised informal services** stated as being particularly helpful included peer counselling, empowerment movements, self-defence classes and self-help-groups. Whether as part of the system or independently, disabled women who had experienced violence found value in receiving and giving personal support to others. Of those with access to it, independent peer support and counselling was declared by women as being particularly helpful. Nevertheless, this should not be automatically assumed to be the best for every woman as professional services are highly relevant. Furthermore, one woman found contact with other distressed disabled women stressful. The vast majority however valued contacts with these groups, where they existed, as well as contact with DPOs and the Independent Living Movement. In all countries women described the value to themselves by helping other women in a similar situation to theirs. And some disabled women had completed training as counsellors or taken on other support work for women who had experienced violence. One woman described it as follows:

“I think it makes you feel better to be helping other people, that’s me. I always feel better helping, and that’s what we’ve been allowed to do with this women’s group. We are now helping other people. It just gives you the most amazing boost instead of feeling like oh it’s terrible, even if you’re still going through it, to help someone else makes you feel a little bit better. And that’s what we’ve been allowed to do with this women’s group.” (Example from Great Britain)

Personal Self Reliance

Quite often a number of small steps were taken towards establishing a violence-free, independent life. Disabled women emphasised the way that the support of others helped them to draw boundaries concerning acceptable

behaviour and to name violence for what it was. But often they also developed their own strategies to gain strength and self-confidence. Several women described that writing down thoughts, fears and feelings as part of a kind of “self-therapy” was helpful. Moreover, yoga and tantric exercises, dancing classes and autogenous training were described as helpful for regaining inner balance and strength (examples from Germany). Another woman used competitive sport to compensate for the lack of recognition and to increase her own self-confidence and one woman sought support at a religious community. Also contact with animals was helpful for developing well-being and strength (examples from Austria). By some women education and employment were also seen as good opportunities to leave the abusive environment and gain distance and independence to put on new perspectives how to handle the situation.

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

Women’s knowledge about their rights

There was a great deal of variation in women with disabilities’ knowledge about their rights. Although a **small number** were **well informed**, most had a more limited or partial picture of just one aspect of the law. Participation in legal processes had helped some to become more familiar with aspects of the law and procedure.

Other sources of information were support organisations, such as peer support groups of women in similar situations to their own, contact with DPOs, human rights organisations or employment as well as involvement in education at university.

There were also variations in the depth of knowledge. Some had heard of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) for example but many women were not sure of its exact provisions or of the degree to which it had been implemented in their country. Women highlighted the problem of lack of appropriate information about rights and its accessibility (very often not available e.g. in easy language, sign

language videos, audio files, etc.). Women highlighted that even when information is easily available that it is difficult to know how and where to claim the information and subsequently their rights.

However, lack of access was compounded by the way the law segments rights into those related to gender, disability, race, sexuality etc., making it difficult to tell which rights applied to their situation, as one woman from UK emphasised:

“If the only thing that you can be discriminated for is your gender it’s simple to navigate what you need. Whereas if there’s a lot of things then it’s difficult to know where to go to coordinate the bits. So if I have an issue it could be with my impairment, my gender, my sexuality or all three at once so to get those bits together is difficult at best, and damn right impossible sometime! I don’t think that women get enough protection.” (Example from UK)

The issue of legal capacity was also raised as a particularly acute problem by women in Iceland (as already stated); however legal guardianship is an issue that affects people with disabilities in many European countries. The Icelandic national report notes that legal capacity judgements had been used to remove rights from women with disabilities to make decisions about even very basic things and women felt isolated and externally controlled. Sometimes the law on mental capacity itself limited freedom of movement.

Several women emphasised the concern that there is a lack of political will and resources for the implementation of their rights. From their perception the root problem of prejudice and discrimination sometimes made the law ineffective. Rights on their own were therefore considered to be insufficient.

Knowledge about and use of Services

In all countries, the relationship with support services was not straightforward and overall, specialised services concerned with violence played rather a minor role in women’s lives. Typically two types of services were mentioned – those designed to support women who have experienced violence (particularly domestic violence) and those to support persons with disabilities. Specialised services concerned with violence played a relatively minor role in women’s lives.

Nevertheless, all women agreed that the help services

offered was essential and very necessary for women. Most women had used forms of therapy services at some points in their lives and some had spent time in clinics and with private psychologists. A few women in all countries had used counselling centres and shelters. Some, with sensory or physical impairments, identified issue of inaccessibility as a reason for the low rate of using the services.

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

However, many participants did not have any contact with services at all and a number of reasons were given for this. A particular problem identified by women in Iceland was that there was nowhere to go for women experiencing institutional abuse through care providers. Often the only recourse was through the complaint systems of care providers themselves and this route was clearly unsatisfactory.

For many women a lack of knowledge and information was combined with poor knowledge about who to turn to. As mentioned above, some women in all countries lacked necessary guidance about what constituted violence and unacceptable behaviour. Fear about whether a service might be inaccessible deterred some women, as did the assumption that as disabled women they would not be helped. Gaining access could be problematic in the first instance, and some women reported suspicion from service providers about whether they had a need for a service. Interpretation problems were mentioned by Deaf women.

Experiences of Barriers

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

Access to Information

Problems with lack of accessible information and knowledge have been mentioned already above. Some disabled women did not have access to the internet, which in all countries was the most common way that services provided information. Lack of accessible information applied to specialised victim support services, other support services and the justice system. It was felt by some women that there was insufficient publicity and when there was, it was not clear that the respective services were accessible and would provide adequate support. In turn disabled women were reticent to address to them.

Frequently counselling material, information brochures and counselling itself are often not tailored to the individual needs of disabled women, e.g. there is almost no information provided in easy language, in sign language or in voice output.

Especially women with learning difficulties and Deaf women raised this problem. Even where sign language was available, for example on organisations' websites, this did not mean that signing staff were necessarily employed by an organisation. Confidentiality was a clear cause for concern with worries expressed about involving children as interpreters when reporting violence, to concerns about the discretion of counsellors, where these were needed, in dealing with the personal effects of violence. Some Deaf women reported preferring to not seek help at all because of these problems.

Access to services

In all countries women with disabilities brought up the issue of inaccessible services (including specialised victim support services and the justice system). Amongst other aspects construction related barriers were very often reported. Examples were given where a woman with personal assistance could not be accommodated or where there was no place useable by a woman with mobility impairments. In the same way, women often reported not being able to attend service premises at all, due to physical inaccessibility of the location. One woman, for example, could not find an accessible local female gynaecologist and had to attend a clinic for a male; another could not locate an accessible trauma therapist. Whereas another woman recalled she was informed that a service provider was accessible, but indeed found it was not. Although in some instances services organised external alternative accommodation and services, being seen as an 'inconvenient client' was felt to be embarrassing in some reports. Even if accessibility

is guaranteed e.g. in cases of specialised services for Deaf women/women with hearing impairments, women raised the problem with regard to confidentiality. The fact that there is only a small pool of interpreters in all countries may create barriers to maintaining privacy and confidentiality.

Additionally, participants discussed the nature of the support provided by the specialised victim support services. They debated whether the support was first and foremost tailored to the needs of non-disabled women and whether they could actually adequately meet the needs of disabled women. They pointed out that most services focus their attention on sexual violence and intimate partner violence and doubted that they were in a position to provide advice and support with regards to violence particular to persons with disabilities, such as institutional and service-related violence, emotional violence, financial violence and bullying. Indeed, participants pointed out that women with disabilities, who had been exposed to such violence, received little support. As one woman stated: *“It would be a bit difficult to get help if the one providing assistance knows nothing about disabled [people].”* (Example from Iceland)

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

In regard to access to justice several women reported when addressing to the police they felt a tendency for not being believed; some required particular evidence of violence, which was sometimes not possible to provide. Within the justice system a number of women pointed out that information about the development of their cases was not accessible to them and the procedure and progress were unclear to them.

Living in institutions

Women believed that disabled women face all sorts of barriers in particular within the disability service system. In all countries women stated that power imbalances were prohibitive for women living in institutions, where staff might have almost total control over daily lives. Staff in institutions were said to be often poorly trained and therefore unaware of how to recognise and counter

violence. Because staff did not know how to react, they often referred women on to other services rather than helping them directly. That could cause additional confusion and stress for women concerned.

However, women who experienced violence within the context of care or assistance were confronted with special challenges when seeking help. Due to their isolation in residential facilities, violence that they experienced was not noticed outside as the institution tried to solve the problem internally without reporting to the police. Within the institution, however, the affected women were often not believed, especially if the perpetrators were also work mates of those that the women tried to talk to. In cases where women did not have the opportunity to look for help outside independently (without an assistant) and immediately (because of decision processes and internal rules), it was considered as structural violence by various participants in the study. The situation was exacerbated even further if the woman sees the perpetrator every day in her institution. Additionally, some women reported that in cases where they had been violated by male residents, staff often were helpless in regard to knowing how to react.

Not Being Believed or Being Ignored

In all four countries there were many examples of women’s accounts being dismissed by not being believed or ignored by family members, service staff and the general public. This was especially the case if there were no witnesses to violence. Occupying a marginalised status in society, many disabled women did not seek help on the basis that they were unlikely to be helped, as one woman stated:

“Maybe you exclude yourself. Well, you think: ‘Oh my God, well, it’s my own fault. Now, I’m also disabled and no, it’s better if I don’t call in the first place’, whatever. Because then I might be hurt again. ‘Well, you’re disabled. You should have been more careful’ or whatever, ‘Do you have to go out at night?!’ Whatever. I’d fear such reactions. Even today.”
(Example from Germany)

Family members were sometimes the first people that women turned to for help. However, many of them stated that they were scarcely receptive and in some instances were hostile. Similarly, participants stated that the ‘keep it in the family’ philosophy was usual and this was often considered as barrier to accessing external support. One woman illustrated it as following:

“I think the thing that hurts me the most was probably my parent’s reaction... they must have been thinking do they phone the police, if they do, you know, it’d be a big scandal; it would be in the paper – all this kind of thing. A sort of shameful situation and I remember hearing my mum saying that “she’s young, she’ll just forget about it if we don’t mention it”. And it was just swept under the carpet.” (Example from UK)

Some women with intellectual impairments pointed out that they had been cast by perpetrators as ‘deranged’; as making accusations because of their impairments, and that this made them reticent to bring charges. Such accusations were reportedly often believed and might lead to a woman’s testimony being discounted in court. Physically impaired women stated that they were regarded as “deranged”, “less intelligent” or “not of sound mind”. Often the women’s credibility is damaged, sometimes accompanied by scornful reactions which in turn could lead to violent actions being excused and perpetrators being acquitted.

Public Discourse on Violence and Disability

Participants noted obstacles related to public discussions and discourses on violence and disability. They pointed out that the discourse on violence was often of a negative nature and reflected prejudices against victims who were often judged as being in some way responsible. Women who had been subjected to violence frequently experienced great shame and discussion of this kind could increase their shame and self-doubt.

Additionally, women felt that public awareness about violence against disabled people was limited and that the general discourse reflected poorly the violence that is most common in the lives of many disabled women. There is, for example, little discussion about prejudice and social isolation of disabled people and their subordination and marginalisation at all levels of society. Disabled women have fewer opportunities to take part in public debates and non-disabled people are often insecure and hesitant in interactions with persons with disabilities. Furthermore, media coverage is usually not made accessible for persons with different communication needs. At the same time, these sources of information are very important since education about matters regarding violence for disabled people (including children) is very limited.

Internal Inhibitions

Participants in the study believed that disabled women often gained their knowledge about issues regarding violence mainly from public discussion and the media. Public awareness on violence against disabled women is often influenced by prejudices and this seems not to be helpful promoting positively women’s self-perception. Apart from that, women often had reduced self-confidence from not been listened to and the lack of opportunities to share experiences with disabled and non-disabled women since childhood. Many women who had experienced violence experienced insecurity, fear, feeling guilty and/or being ashamed. Consequently, disabled women often had low self-esteem and self-confidence, which made it difficult for them to stand their ground. Some women stated not wanting to be a burden on anyone when it came to confiding in other people. In particular, women with intellectual impairments emphasised that they sometimes even didn’t know when they were experiencing violence. According to the interviewees this point often has to do with the fact that women, especially with intellectual impairments, never learned about their personal boundaries and limits and when to say “no”. When combined with purposeful strategies used by perpetrators to keep women isolated, this acted as a powerful inhibitor to seeking help.

Finances

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

In Germany, for instance, women reported about a financial barrier to accessing help. Two examples are given in the national report: from a deaf woman who spoke of uncertainties about who was responsible for paying for an interpreter during counselling sessions and another instance where the additional cost of support meant that a woman was not able to stay in a trauma clinic.

Women were often poorly situated with regard to employment. As well as gender based labour market segregation that disadvantaged women, discrimination against persons with disabilities also kept many disabled women out of employment that generated good wages. Worries about whether they might manage financially again kept women from reporting violence.

Power Imbalances and Additional Factors

Violence against disabled women was considered to be higher in all countries than for non-disabled women and to be possible in almost any situation. Certain women such as those with sensory impairments, with intellectual impairments and disabled women from BME communities (especially reported in UK) were considered to be especially at risk. Power imbalances underpinned violent relationships and for some women it was reported to be unremitting over long periods of time. Rather than the characteristics of perpetrators, it was the positions of power that other people held in relation to disabled women that participants identified as the problem. Relative powerlessness was identified as stemming from a number of factors including: the perception that women could not fight back, the degree of control exercised over women (as by residential service providers, for example) and restrictions on reporting imposed on women by themselves due to fear of losing things that were needed, such as assistance or accessible housing. Where women received personal care and assistance they were particularly endangered. In all countries women's impairments were often targeted for violence. For example, mobility aids might be removed or made ineffective or women might be over-medicated, to only mention a few.

Violence was mostly reported to be greater at times when the power imbalance increased, in one case, however, the situation was reversed. In common with all women, disabled women in this study reported increased domestic violence just before and after childbirth. Some disabled women reported that they felt they had no option but to remain in violent households due to their dependence of additional assistance with daily life duties,

faced with the responsibility for young children. For some women, the alternative was to have their children taken away, if it was judged that they were not able to manage on their own without support/assistance. As one mother who had learning difficulties described the situation when she left a violent partner:

“it’s very likely the parent with the learning disability would have their children removed from their care instantly. And I was put in that situation where that did happen but when they did ask him to leave the family home, they didn’t put that support in for me so they moved him back in anyway because he was my support to look after the children.” (Example from UK)

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

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

Figure 1: Type of organisations (Multiple answer set)

	Austria		Germany		Iceland		UK	
	N	%	N	%	N	%	N	%
A refuge service for survivors of violence	17	21.0%	189	26.8%	1	10%	38	23.0%
A women’s advice centre	32	39.5%	141	20.0%	1	10%	22	13.3%
A women’s helpline	5	6.2%	96	13.6%	1	10%	35	21.2%
Intervention Centres for women survivors of domestic violence	6	7.4%	190	27%	4	40	19	11.5
A specific contact point for disabled women who have experienced violence	3	3.7%	8	1.1%	–	–	11	6.7%
A contact point or counselling centre for disabled women	3	3.7%	10	1.4%	–	–	5	3.0%
A contact point or counselling centre for disabled women and men	5	6.2%	4	0.6%	–	–	4	2.4%
Something else	10	12.3%	67	9.5%	3	30%	31	18.8%
Total	81	100.0%	705	100.0%	10	100.0%	165	100.0%

Service Providers

This section presents the findings from the second major element of the study: research with specialised service providers to women who have experienced violence. The description follows the main outcomes of the survey and interviews: the self-assessment results regarding their accessibility towards disabled women, measures they had taken to ensure accessibility, public relations activities and at least networking and co-operation between services to support disabled women as best as possible. On the whole 602 service providers from four countries participated in the online survey and 54 representatives of the services in individual interviews.

Figure 1 shows the self-classification of the organisations and services participating in the online survey:

The organisations that participated in the survey most frequently were:

- refuges (21% in Austria, 27% in Germany, 23% in the UK),
- women’s advice centres (40% in Austria, 20% in Germany),
- women’s helplines (21% in the UK)
- intervention centres for women survivors (20% in Germany, 40% in Iceland).

Specific contact points for disabled women who have experienced violence are rare. However, this is not due to these organisations being less willing to participate in

the survey, but having very few contacts and counselling centres that specialise in the provision of services for the target group of disabled women affected by violence.

The majority of organisations and services is located in urban areas, on the whole 44% are located in a large city, 43% in a medium-sized city/small town and only 13% in rural areas.

Accessibility by impairment

The participating organisations and services were asked to rank accessibility by form of impairment. Figure 2 shows the respondents’ self-assessment, itemised by the seven target groups. In the table the data from Austria, Germany and the United Kingdom show the outcomes of only the women’s refuges, women’s counselling centres, women’s emergency hotlines and intervention centres for women who have experienced violence.

Women with sensory impairments

The figure shows that in all countries, according to the interviewees, women with sensory impairments are particularly likely to encounter barriers when trying to use counselling and specialised victim support offers. Especially blind and visually impaired women are barred from access: in Austria, Germany, Iceland and the UK there are not any or just a small number of organisations and services which are completely accessible for this target group. In addition, only 2% (of the German) to 14% (of the Austrian) organisations and services say that they are completely accessible for deaf and hearing-impaired women.

Figure 2: Accessibility by impairment and country⁸

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

⁸ In the table the data from Austria, Germany and United Kingdom show the outcomes of only the women’s refuges, women’s counselling centres, women’s emergency hotline and intervention centres for women who have experienced violence.

Women with learning difficulties

Another disadvantaged group are women with intellectual disabilities (for example, women with the label of learning difficulty). In Germany only 9% of the services and organisations which filled in the questionnaire assessed themselves as fully accessible for this target group. In the UK one third (34%) of the respondents, in Iceland 4 services and organisations and in Austria 14% said that they were totally accessible. However, in all countries about two third of the services and organisation assessed themselves as partially accessible. Some organisations and services take specific measures for this target group. These mainly consist of collaborating with professional services for their expertise or offer material and counselling in ‘easy language’.

Women with physical impairments

The assessment of accessibility of women with physical impairments is more positive. However, the figure shows clearly that the accessibility levels for these women are still low. About only a half of organisations and services interviewed in Austria, Iceland and the UK state that they are completely accessible for wheelchair users as well as for physically and mobility-impaired women. In comparison to these figures, the inaccessibility of services for disabled women in Germany stands out: just 9-10% of services and organisations are fully accessible for wheelchair users and women with other mobility restrictions. This significant difference might be partly explained by two observations. First, the topic of “accessibility” is currently very strongly discussed in Germany, this might lead to high expectations or high standards concerning services’ own perception on their accessibility. Second, service providers are overstrained and hesitant to welcome a further “target group” due to fear and lack of resources to cope additional workload.

Women with mental health service need

In all instances, women with mental health conditions were the group most frequently reported in the interviews and the survey. In many ways this is not surprising given the effects of violence on women’s health but it may also reflect the degree to which women with other kinds of impairments experienced difficulties accessing services. And accessibility to the surveyed organisations and services seems to be best for women with mental health impairments. Nevertheless, the half of organisations and services interviewed in Austria, Germany and Iceland say they are just partially accessible for women with mental impairment – in the UK a third of the respondents.

Women who live in inpatient or semi-residential facilities for disabled people and/or need care and assistance

In addition, the participating organisations and services were asked to what extent they are able to support women who live in inpatient or semi-residential facilities for persons with disabilities and/or need care or assistance. The highest figure here was for Iceland followed by the UK, with again Austria and Germany showing a very low level of engagement. Almost half of organisations and services in Austria, Germany and the UK say that they are not prepared to support women living in institutions. Support services for women include, above all, outpatient and mobile counselling, the possibility of phone contact, and referring women to other professional services.

Measures to ensure Accessibility

Service providers were asked about the kinds of **measures they had taken** to ensure accessibility. Those most commonly described were counselling for women with mental health conditions and in easy language for women with intellectual disabilities and women with chronic ill-health. Other measures that were mentioned more often were partial accessibility of rooms for women with physical impairments, the provision of legal advice (although it was not stated how this might have been adapted for disabled women or if it was something routinely provided) and assistance that could be given through email. Perhaps unsurprisingly, given the points made above, adjustments had least frequently been made in relation to women with sensory impairments. The lowest percentages (between up to 4%) were given for alterations such as the introduction of Braille signage, the use of lights for doorbells and guidance systems for blind women.

Service providers were also asked about **planned changes** to improve accessibility. The most frequently identified issues were the development of a more accessible web site and information (Austria 13%, Germany 11%, Iceland 29% and UK 15%) and improved counselling support for physically disabled and for chronically ill women. Few improvements were planned for women with sensory impairments, although the UK, Germany and Austria had a slightly higher percentage at around 16% compared with none for Iceland.

Access to Information and Promotions

With the exception of some organisations that focus on actively addressing disabled women and providing

accessible information, the majority of participating organisations do not engage in such activities. Some organisations lack awareness about promoting existing services, many do not have enough resources to cope with the “extra” counselling and accommodation needs for disabled women experiencing violence. Some service providers explicitly stated that this was because of concerns that additional work would be generated and because of lack of time and human resources and provision of additional funds by the government and other funders.

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

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

Co-operation and Networking

A large proportion of organisations had contact with other services (health care organisations, counselling services and other organisations that were in the same or similar sector) and collaborated with them in various ways. Positive working relationships between agencies facilitated the referral of clients between services. The intensity and commitment regarding cooperation on the topic of violence against disabled women vary greatly. Some organisations tend to keep a rather loose, case-related contact, others assemble regularly for meetings, workshops or further training and education and work together on developing accessible material on the topic of violence. Openness and improved awareness were reported by some, enabling the development of individualised solutions to women’s problems in some instances. In each of the countries a small number of organisations worked across the divide and aimed to assist women with disabilities directly. However these were few and far between and often identified more strongly with one group or the other. Some relationships were less effective, for example where they did not

lead to any tangible benefits for women experiencing violence, such as women with more ‘severe/multiple’ impairments and comprehensive personal assistance support. Relationships between agencies were made more difficult by the competition for and shortage of resources. With less money available, statutory services were often unwilling to provide support (e.g. personal assistance) that might be needed.

The number of contacts fell for services for disabled people (a third) and for DPOs or ULOs (a fifth), especially for refuges, helplines etc. However, often there was not much contact between violence against women services and disabled people’s organisations reported. Although disabled women experience violence from a number of sources, hate crime and institutional violence were largely treated as DPO responsibilities and domestic violence that of women’s services. DPOs were generally described by participants as male dominated and lacking an understanding of the gendered nature of violence. Nevertheless, in some countries like Germany, very active DPOs for women with disabilities do exist and are concerned with VAW since many years. They are connected with networks of the support system as well. In general, good co-operation existed but there was notably room for improvement in relationships between specialised services and DPOs and in some instances with services that disabled women needed when escaping from violence.

Challenges of Implementing Accessibility

In all countries a number of common themes emerged when talking about challenges in implementing accessibility. There were however, differences in the degree of difficulties perceived and the extent to which these were considered to be surmountable. The following two barriers to accessibility were the ones most frequently mentioned by service providers interviewed.⁹

Financial barriers and lack of resources

All four countries spoke about accessibility measures being limited by lack of funds. All said that services experienced lack of capacity that has been a continuing problem in most countries and were therefore in the position of having to be selective in terms of the women that they turned away. Most services operated with an ethos of equal treatment for women; nevertheless

⁹ More challenges of each country are described in more detail in the National Empirical Reports. <http://women-disabilities-violence.humanrights.at/publications>

selection was a necessity and from the evidence provided above, it was clear that disabled women were often screened out in one way or another. Service providers in Germany for example expressed a high degree of scepticism about the possibility of fully including women with disabilities. Large scale and costly adaptations were felt to be likely to be needed (and not given by the state institutions), as well as more staff, aspects that might make it “impossible” to include disabled women without any barriers. However, in all countries many service providers showed their good will and understanding that it would be necessary to improve accessibility in their organisation. For some of the surveyed organisations and services, however, it was hard to comply with the requirements for accessibility in its broadest sense. In order to provide complete accessibility they would need a lot of funding, staff and time, none of which were available at the moment. Accessibility was seen by many as something that was not achievable, and this reduced the motivation to actively effect changes.

Stigma and taboo about violence against disabled women and lack of understanding in society

Another challenge is the far-reaching taboo and stigma about violence against disabled women. Therefore, it seems to be highly necessary to focus on specific public relations and awareness-raising activities on a political and social level. Moreover, Icelandic service providers emphasised lack of understanding in society and also prejudiced attitudes in society. They also spoke of the reluctance of disabled women experiencing violence to come forward. Funding shortages were again described, with the suggestion that these made alterations to service provision not possible.

The chapter below is based on the Comparative Report WS 4 – *Good Practice Examples and Recommendations*. The recommendations were incorporated verbatim.¹⁰

Good Practice

As part of the empirical studies, carried out by the national research teams, interviewed disabled women participating in focus group discussions and in-depth interviews, representatives of specialised victim support services and participants of national stakeholder meetings were asked about helpful practices. From all these national good practices the national research teams then identified up to five good practices based on the commonly developed guiding principles and criteria for good practices. It is important to note that none of the practices were deeply evaluated in terms of their effectiveness, impact and sustainability. Therefore the good practices are the result of a common understanding, what a good practice should be able to encompass.

The research teams believe it is highly relevant to exercise caution when making any claims about the success of practices. There are no uncontested principles for ‘good’ or ‘best’ practices and in this report no such claim is made. The terms ‘good’ practices are used when describing support that has proven successful in certain situations. It is, however, important to emphasise that when considering transferability of ‘good practices’ most activities will need to be changed and adapted when moved from one (country) context to another, especially when considering a highly heterogeneous group like disabled women.

Description of guiding principles and criteria for good practice

The guidelines and criteria were jointly developed by the participating research teams in collaboration with stakeholders and advisory group members.

The guidelines aim to assist in identifying and developing good practice examples in the area of specialised support services for disabled women who have experienced violence.

It is essential that the support of services should be grounded in the CRPD and other human rights standards and offered to all women including disabled women. Herewith it is important that they have a social model understanding of disability and knowledge about violence against disabled women and related issues. Another fundamental guideline is that accessibility should be ensured by service providers. A safe space,

¹⁰ Good Practice Examples and Recommendations. Comparative Report. University of Iceland, The Centre for Disabilities Studies. October, 2014; Download under Project Website: <http://women-disabilities-violence.humanrights.at/?q=publications>

defined by the disabled woman, should be provided according to the understanding of the woman including confidentiality and respect for privacy. The recognition of the diversity within the population of disabled women is considered another key guiding principle. Here it is fundamental to recognise that women with disabilities are not heterogeneous and, depending on their individual situations and the interdependence with other categories such as e.g. age, sexuality, nationality, self-definition (e.g. women living with autism, Deaf women) are relevant in their lives. Consequently an individual approach should be followed when giving support to women with different impairments and purposeful measures for all women should be provided. It is crucial that women are listened to and that what they report is believed. Service representatives have to respect the self-determination of disabled women and respect the preferences of the women. Self-empowerment should play a key role when building up strengths of disabled women. The employment of disabled women on all organisational levels and the partnership with disabled women are vital parameters.

The criteria for the identification of **'good practice'** in the provision of specialised support services for disabled women were elaborated specifying the outlined guiding principles.

One very important criterion is **accessibility**, meaning being within reach for the wide range of disabled women and providing information which is accessible to their needs, adapting and adjusting the offered service in a flexible way to welcome disabled women acknowledging their diversity.

Knowledge and awareness about different forms of violence particular to disabled women and the specific social situation of disabled women is a further crucial criterion. It also encompasses the promotion of disability awareness, on-going training and limiting respectively decreasing social structures and conditions discriminating against disabled women.

The **participation** of disabled women as employees on all levels, as cooperation partners, as representatives from User-led organisations, interest groups etc. and their involvement when introducing new services is understood as additional criterion for the selection of a good practice. **Self-empowerment** and **diversity** as described in the guiding principles are noted as two more relevant criteria.

Additionally the following criteria for the **access to justice** were identified in general and from the perspective of specialised support services.

General criteria take in, among others, the existence of formal complaint mechanisms and the entitlement of free legal assistance prior and during criminal proceedings as well as ensuring the access to existing schemes of legal assistance for women with disabilities. Furthermore, training of police officers, lawyers, prosecutors and judges and the institutionalised communication between police and service providers are components of general criteria. The acceptance of alternative methods and ways of communication is regarded as one more crucial criterion.

From the perspective of specialised support service providers central criteria are if women with disabilities receive training about their rights and the dynamics of violence. Additionally legal counselling for women with disabilities and support in gaining access to justice through reporting the crime to the police, courts or formal complaint mechanisms and training for co-workers in the services concerning issues related to violence against disabled women and legal topics are also elements of these criteria.

Examples of good practice

Disabled women stated that several actions or programmes provided by support services, other organisations or individuals as helpful. Among many others some were highlighted and brief examples are mentioned here. More details can be found in the Comparative Report *Good Practice Examples and Recommendations* as well as in the four National Empirical Reports (see project website: <http://women-disabilities-violence.humanrights.at/publications>).

Disabled women emphasised peer-counselling either as a specific offer or within mainstream support services as very helpful when seeking support as survivors of violence but also for many other issues linked to their lives, like self-determined living, education, partnership, housing etc. A women's representative in institutions (e.g. residential cares for people with disabilities, day care centres, etc.) was stated as another supportive practice aiming to improve the situation of disabled women. Organisations/support services that show flexibility, non-judgement, empathy, anonymity, understanding, good attitude and who proactively advocate for the rights of disabled women and explaining about their situations

were also considered as good practices. Non-formal organisations that treat disabled women with respect and offered helpful support and self-development in form of self-defence classes, or peer-support groups were pointed out as positive examples.

Besides that it is crucial that disabled women who have experienced violence have the same rights like other women to get professional support. Some examples of good practice to implement this are shown below.

Moreover further education for non-disabled persons aiming at enhancing their understanding of the situation of disabled women and violence related topics were brought up as good practice.

Recommendations

Many recommendations regarding ways to improve support services and facilitate access to support for disabled women surfaced in the project. The recommendations were suggested by the women with disabilities who participated in the focus groups and interviews, representatives from support organisations that were interviewed, members of advisory boards that consulted with researchers and other stakeholders who participated in project meetings. Each national research team listed up to five recommendation themes in their national reports, and in this chapter they were combined. In most cases the recommendations formulated by the different groups of participants overlapped. Furthermore, the recommendations put forward in different countries were, for the most part, the same or addressed very similar issues. This indicates that there are certain key issues that require special attention and focus.

Recommendations for EU policy

Emphasise barrier free access to information

Findings of the project highlight a lack of accessible information about violence against disabled women or accessible support options for survivors of violence. It is important that information is made available in barrier free formats for disabled women. The EU should promote the provision of accessible information for women with disabilities. It should fund projects that include creating and disseminating accessible information about violence against disabled women and the support options accessible to them.

Address access to justice for disabled women

Participants in the project called for improved access to information about the rights of disabled women and facilitated access to legal assistance. It is important that information about legal procedures is made more readily available and accessible to disabled women. The EU should take measures to facilitate access to legal assistance for disabled women and promote barrier free information about rights, for example by requiring legislation and policies in EU Member States.

Promote awareness-raising about violence against disabled women

The findings showed that when disabled women speak up about violence they have experienced, they are very often not believed. The EU should promote and fund

awareness-raising campaigns that tackle discrimination and prejudice against disabled women.

Focus on disabled women

Violence perpetrated against disabled women is intrinsically connected to their marginalisation, exclusion in society and their overall societal status. The EU should be increasingly engaged in the participation and inclusion of disabled women and should promote and fund projects that address their marginal status and exclusion (as well as strengthening their position and value in civil society).

Recommendations for national policy

Make a commitment to improve access to support for disabled women

Politicians can improve access to support for disabled women. As article 16 of the CRPD outlines, States should take all appropriate measures to promote the recovery of disabled people who have become victims of violence. It is important that States make a commitment, prioritise this issue and fund the implementation necessary to facilitate access to support. States should make law reforms or put in place legislation and policies to ensure adequate, accessible support and information for disabled women who have experienced violence.

Increase funds to specialist services to promote access and support for disabled women

Many specialist victim support or women's services fail to provide accessible support to disabled women. Many participants in the project reported inadequate funding and financial difficulties as the main reasons for limited access. Funds to these services should be increased, and special attention and resources focussed on projects that address support with disabled women. Specific funds should be provided to organisations facilitating access, support and information for disabled or Deaf women after violence.

Increase funds to user led support

The findings of the empirical reports show that many disabled women value self-help groups and peer support, led and controlled by disabled women and survivors themselves. It is important to promote the establishment of such support options, actively support those organisations and provide them with on-going funding.

Promote support in rural areas

Disabled women who live in rural areas generally have less access to resources and support. States should emphasise access to support and information for disabled women in rural areas.

Improve access to information

Information about violence and support should be made accessible. States should ensure access to information for disabled women about how to recognise violence and about accessible support options. Such information should be provided in accessible formats (e.g. easy words and pictures, Braille, sign language videos and audio format). It should and be made available in public spaces and through different mediums to reach a larger population of disabled women (e.g. through radio, television and in print media). They should organise and fund projects where disabled women who have survived violence play a key role in planning, designing and broadcasting information through various media outlets. It is important that all measures to promote information should be developed in collaboration with disabled or Deaf women to enhance the relevance, efficiency and expertise of the projects.

Promote sex education

States should ensure the quality of sex education for disabled girls and women in schools and in institutions where disabled women live, study and work. It is important that information about sexual and reproductive rights of disabled women is integrated into school and other curricula. Such education should also promote self-empowerment and help women distinguish inappropriate, neglectful, violent or abusive behaviour.

Promote awareness-raising about violence against disabled women

It is important that the issue of violence is openly discussed and embedded in a broader discourse stressing the necessity of inclusion and equality of disabled people. In accordance with article 8 of the CRPD, States should undertake measures to raise awareness about societal perceptions of disabled people and violence against them. Such awareness-raising should aim to reduce the prejudice and discrimination experienced by disabled or Deaf women who speak up about the violence they experience.

Promote knowledge among professionals

It is important that professionals who work with disabled women or in support services receive training about violence against disabled women, access and support requirements. Disability equality training should also be integrated into vocational training of professionals within the health care and rehabilitation sectors, education, disability services, specialised victim services and criminal justice systems. This training should aim to address discrimination and provide a deeper understanding about the barriers faced by disabled or Deaf women. Those training activities should be carried out by or in collaboration with disabled women who have experienced violence.

Promote the participation of disabled or Deaf women

Participants in the study stressed the importance of measures to promote the social and political status of disabled women. States/governments/municipalities should take measures to combat common stereotypes by promoting projects and initiatives where disabled or Deaf women are in the forefront and represented in civil society and media. Disability equality training and standards for media representatives should be organised and supported, preferably by or in collaboration with disabled or Deaf women.

Endorse independent living and guarantee safety in institutions

Disabled women who are dependent upon support services are more at risk of violence and abuse. Services provided for disabled women must promote their empowerment and support them to exercise their self-determination. States/governments/municipalities should promote, fund and execute projects that promote and deliver independent living, supporting the individual self-determination of disabled or Deaf women. Where women do not have capacity to make decisions, advocates should be appointed to act in their best interests. For women living still in institutions, a safe and violence-free life must be guaranteed through comprehensive mechanisms and measures to fully protect and support women who experience violence.

Improve access to justice

Many participants, both disabled women and support service providers, stressed the importance of improving access to legal assistance. States need to develop and disseminate accessible information about the rights of

disabled women and facilitate their access to legal aid. States should review or amend legislation to facilitate the safe participation of disabled women in legal proceedings. They should furthermore establish laws that make the exclusion of perpetrators from the home possible, rather than requiring the woman to leave; this can be particularly important in cases when refuges are inaccessible for disabled or Deaf women. States should ensure that the justice sector is supportive of disabled women and provide disability equality training and education about violence against disabled women and their rights to lawyers, judges, victim support services and police officers. In addition, anti-discrimination laws and support measures should be more accessible and provided routinely for disabled or Deaf women.

Recommendations for disability services

Actively engage in the fight against violence

Participants in the project called for increased involvement of disability service providers in the engagement in tackling violence against disabled women. It is important that disability service providers recognise that disabled women are at greater risk, especially of sexual violence, abuse and neglect and that they find ways to address that in the organisation of their services. Disability service providers should develop protocols for the identification of situations of violence and address risk factors in their services. They should furthermore make reforms aimed at eliminating discrimination against service users and promote their independent living and self-determination.

Improve access to information

Disability service providers are in a unique position and could have an important role in providing information about accessible support to disabled women who use their services. Disability service providers could therefore participate in outreach projects in collaboration with disabled women who are survivors, specialist services, DPOs and ULOs. They should disseminate barrier free information about violence and provide details of accessible support for disabled women who have experienced violence. Furthermore, disability service providers should take measures to improve access to information about the rights of disabled women and facilitate their access to legal assistance.

Promote awareness-raising

Disability services should emphasise awareness-raising

about the rights of disabled people, discrimination and violence against them. They should participate in projects that increase awareness among general public as well as among specific professional groups who work with disabled women. Disability service providers should collaborate with victim support services, ULOs and DPOs. Furthermore, it is important that all measures on awareness be developed in collaboration with disabled women and with the movement for violence against women to enhance the relevance of the projects.

Endorse independent living

Participants in the project emphasised how being dependent upon services and assistance disempowered them and limited their choices. Disability service providers should promote the empowerment of disabled women and discontinue institutions and service arrangements that cultivate and sustain power imbalances between disabled service users and non-disabled service providers. Disability services should promote, fund and execute projects that involve independent living and empowerment strategies such as workshops for disabled women. It is important that empowerment measures be developed in collaboration with disabled women.

Develop clear strategies

It is important that disability service providers address the fact that violence happens within the service system. Preventing violence should systematically be implemented in the practices and activities of the services. Service providers should develop protocols or obligatory policies and guidelines to ensure that all instances of violence, reports or cases are identified and investigated. Such guidelines would encourage staff to intervene and be an important effort to improve users' safety. It is paramount that management levels support the implementation of such guidelines actively. When establishing concrete intervention strategies, users of the services and survivors should be involved.

Promote knowledge among staff and other professionals

Disability service providers should promote an attitudinal change within the services and make staff more sensitive about the topic of violence against disabled women. This should be done by providing training about violence against disabled women and accessible support options to all staff who work with disabled women. It is imperative that staff receive training about the rights of disabled people, the social model of disability and

the CRPD. Training should promote a critical reflection of participants about violence related to power and to what extent dependencies can foster violence and abuse. All training activities should be carried out by or in collaboration with disabled women, survivors and the support system.

Recommendations for specialised victim support services

Be prepared and willing to support disabled women

Support services need to define disabled women as a relevant target group and orient and organise their services so that they address gaps and barriers. Organisations have to be willing to undertake necessary changes in order to provide successful and barrier free support to disabled women. Services should be disability-inclusive and designed and implemented in a manner that ensures accessibility for disabled women.

Tackle attitudinal barriers and provide disability equality training to counsellors

Many participants in the research, disabled women and service providers alike, agreed that there is a general lack of awareness and knowledge among non-disabled counsellors who are currently providing support. Counsellors must have skills necessary to adapt their support to the needs of disabled women and be made aware of issues of power imbalances. Raised awareness of counsellors decreases attitudinal barriers which is a common hindrance for disabled women who seek support. Victim and women's services need to promote disability equality training on a regular basis for the counsellors, preferably in collaboration with disabled women survivors, DPOs or ULOs. The training should address the specific situation of disabled women, the different manifestations of violence perpetrated against them and social model understanding of disability.

Provide accessible support

The empirical reports revealed a lack of accessibility in most support service organisations. Victim support and women's services should assess their services to see to what degree they still have barriers for disabled women and acquaint themselves with ways to promote accessible and successful support. Facilities of organisations need to be physically accessible, as well as providing communication for D/deaf women and such with cognitive impairments. Furthermore pro-active support out of the counselling room has to be extended,

for example in outreach activities in institutions. Also, the services of organisations need to be flexible and counsellors knowledgeable about ways to meet the different needs of disabled women. Furthermore, support services have to address access for Deaf women especially and ensure the presence of Deaf staff and volunteers, as well as members who can sign.

Employ disabled women

It is important that victim support and women's organisations have a clear strategy of employment of disabled women and their career progression. Support services should emphasise the participation of disabled women in leadership and management and see to it that they are involved in decision-making. This is an important way of ensuring that support to disabled women is grounded in their experiences.

Provide services that are successful according to disabled women

Many of the women who participated in the study called for increased peer support and peer counselling. Victim support and women's organisations should recognise disabled women as experts of their own lives and experiences and promote support options that are valued by them. They should promote peer support and form discussion forums and a safe space for disabled survivors and victims, where they can meet and discuss their common experiences and the barriers they face in everyday life and services. They should make sure the support for disabled women is always on the terms of the disabled women and not organised based on the views and experiences of the non-disabled counsellors or professionals.

Provide accessible information about the services

Disabled women in this study pointed to a lack of information about accessible support services. Victim support and women's services should ensure that information about the counselling and support be made barrier free, e.g. in easy language, video clips in sign language and audio files. It is important that organisations indicate clearly in what ways their services are accessible.

Actively engage in the discussions of violence against disabled women

Participants pointed out that public discussion about violence usually does not reflect the experiences of

disabled women and does not take into consideration the disparity and imbalance of power that they experience. Victims support services and women's organisations should acknowledge oppressive processes of social structures that work against disabled people. They should publically take a stance with disabled women and take part in awareness-raising about violence against them. Support services and women's organisations should participate in awareness raising and projects that increase awareness among general public and specific professional groups and that address violence and stereotypes. Furthermore they should participate in the training of professional groups who work within disability services to promote the knowledge of different manifestations of violence and the proper reactions when such cases arise.

Find ways to reach out to disabled women

Findings revealed a notable lack of connection between the disabled women and specialised women's or victim services. They should take measures to bridge the gap between disabled women who need help and support services. They should engage in proactive projects that aim to reach women who need help, preferably in collaboration with other DPOs, ULOs or disability service providers.

Collaborate with other organisations

Support services should work in collaboration with DPOs and ULOs, promote a network of organisations engaged in the fight against violence against disabled women, preferably making a single accessible point of contact.

Recommendations for DPOs and ULOs

Participate in the fight against gendered violence

Several disabled women who participated in the project felt that DPOs and ULOs do not address gender based violence adequately. It is important that DPOs and ULOs recognise and advocate for the right of women with disability to live a life free from exploitation, violence and abuse, as articulated in Art.16 of the CRPD. DPOs and ULOs should participate in projects that address awareness-raising and preventative measures.

Collaborate with organisations that provide support to disabled women that have experienced violence

DPOs and ULOs should actively engage in collaboration

with victim support services and other organisations that offer support to disabled women who have experienced violence. For example, DPOs could provide support services with disability equality training and help support organisations address necessary accessibility issues. Such collaboration between organisations could promote barrier free access to victim support and women's services for disabled women. A united effort would also make for a more coordinated lobbying for implementation and funding.

Promote information about accessible services for survivors of violence

While many DPOs and ULOs do not have the resources to take on specific aspects of support, they could have an important role in providing information and directing disabled women to accessible support services. DPOs and ULOs should have barrier free information about the different manifestations about violence and accessible support services and disseminate this information to disabled women. Participants in the project stressed that a collaboration between DPOs, ULOs and organisations of support would help bridge the gap disabled women who have experienced violence as ULOs and DPOs could have an important role in directing women to accessible help.

Conclusion

The seriousness of the violence faced by disabled women was made very clear by all participants. The **violence took many forms**, was often experienced over the life course in different places and from different perpetrators. Violence was also closely associated with living in institutions and with carers, whether paid to assist or informal family carers. In institutions violence by inhabitants was frequent as well. Frequently violence that took place where people lived and associated with those who women were close to: partners, spouses and family members. Violence against disabled women was considered to be higher in all countries than for non-disabled women. Women with sensory impairments (Deaf or blind women), women with the label of learning difficulty and migrant or BME women (especially reported in UK) were considered to be especially at risk. Power imbalances were seen as suppressive mechanisms to expose violence against women and especially against disabled women. Relative powerlessness was identified as stemming from a number of factors, including: the perception that women could not fight back, the degree of control exercised over women (as by residential service providers, for example). In all countries women's access needs were exploited during violence. For example, mobility aids were removed or made ineffective or women were over-medicated.

The **prevalence of sexual violence in childhood and in adulthood** was marked and is cause for particular concern. The still prevailing view of society that disabled women and girls, in particular women with the label of learning difficulty, are 'asexual' facilitates and encourages the crossing of boundaries and the perpetrating of sexual violence. Lack of sex education in childhood was reported by some disabled women in all countries. Because of that some women reported that they had difficulties understanding about sexual boundaries and recognising sexual abuse. Some women only recognised the abuse later in their lives, and their lack of knowledge can only have exacerbated their powerlessness in the eyes of perpetrators.

Consequences of violence are very severe. The effects of violence on mental health were catastrophic, but violence was a major cause of other physical and cognitive impairments as well. With regard to impairment-specific abuse, the study revealed that if women acquired their impairments after being in the relationship or the impairment had worsened during the relationship,

violence often increased. Given the dependence of disabled women without support on their partners, the use of women's impairment as part of a violent strategy including isolation was repeatedly observed. Such a situation makes it very difficult for disabled women to look for assistance either informal among family members and friends or service providers. They were very afraid losing the support they need to manage their daily life, if they disclosed their situation.

Disabled women did not have access to proper help, for two reasons. First, they often did not have access to specialised women's services or accessible information during or after violence. Apart from physical access problems, professionals pointed out that they have not enough financial resources and did not feel well enough equipped to tackle this issue or create provision. Some did not have enough knowledge about the target group and their needs, for some others it was argued that their service or refuge would perhaps not be suitable for some groups of disabled or Deaf women. For disabled women, the type of support offered by women's organisations or refuges did not always meet their needs, because many experienced violence from several different sources. Impairment-specific forms of neglect, abuse and violence may not be recognised by victim support or womens services.

Therefore a **pressing need is for disabled women to have safe spaces** where their experiences will be recognised for what they are and where women can receive practical and emotional assistance. Summing up the importance of knowledgeable, personal support from individuals should not be underestimated, especially at pivotal points in women's lives, such as during the process of escaping violent perpetrators. In this context, assistance through obtaining information about the respective services from a trusted person played a vital role. Several women described the moment when they felt, for the very first time, that they were being taken seriously and that someone believed them as extremely positive.

An important step towards the improvement of the support system for women affected by violence, according to the advisory group and many representatives of specialised victim support services, is the **comprehensive and multi-layered networking between relevant services**. The reality in most of the countries however is that a gulf exists between DPOs and specialised women's

services, and disabled women often receive no help from either party. Most DPOs often lack recognition of gender-based aspects of violence and specialised services are inaccessible to disabled women. Nevertheless, in the gap there are a few organisations in each country specifically concerned with addressing the needs of disabled women who have experienced violence. This work needs supporting and funding.

An important aspect of this project was also to develop **recommendations regarding ways to improve services and facilitate access to supports for disabled women who have experienced violence**, as well as to identify preventive measures. Interestingly, and despite the fact that the recommendations came from a diverse group of participants, there were significant overlaps and similarities, indicating key areas that need attention in addressing how to improve policies and various support services and programmes for disabled women who have experienced violence. In conclusion, a main finding of this project is that successful policy making, planning, developing, implementing and monitoring of initiatives regarding violence against disabled women requires **active and meaningful participation of disabled women and survivors themselves at all levels and in all areas**.

Although in all countries laws focusing on violence against women and protecting the rights of disabled people are in place, an evident gap emerged when it comes to disabled women exposed to violence. Consequently, a **political response is needed**. Mainstreaming (improving accessibility in services for all women) and targeted (assistance specifically directed at disabled women) approaches are both necessary. **Sufficient funding** needs to be made available to specialised services to tackle the problem with its associated emotional, human and financial costs.

In the light of the conclusions of the national reports apparently two areas of concern are identified. There is the need for **further investigation into institutional abuse, when women are living in residential care facilities and access to justice for disabled women**. There are indications from all the countries that problems exist in these areas but information on the exact issues is still patchy, except in Germany where recently a study¹¹ on violence against women living in institutions has been published. Given the research so far, especially in institutional settings, the possible imbalance of power

11 Schröttle/Hornberg: Violence against women living in institutions, 2014. Online: <http://www.gwi-boell.de/de/2014/10/27/studie-zu-gewalterfahrungen-von-einrichtungen-lebenden-frauen-mit-behinderungen> (20th of November 2014) [<http://tinyurl.com/nejrwd>]

between staff members and residents weakens the position of women in terms of self-determination and autonomy and increases the risk of being violated. Examples of the ways that women took more control of their own lives was through gaining personal assistance that could replace the abusive care experienced when living in institutions and being more assertive in their dealings with others. Relating to the issue of “access to justice” women’s experiences also revealed that in the majority of all cases no perpetrators were prosecuted or even sentenced. Few women reported their violent experience to the police, most of them didn’t due to various reasons, ranging from “having no support to do so” and “being scared not to be believed” to “being afraid losing the assistance of my carer”, who is often the perpetrator. In particular the concern of “being not believed, dismissed or ignored” is a high relevant problem raised by all women in all countries.

In summary, it can be said that prevention, the improvement of the situation of disabled women affected by violence and access to support measures can only succeed if in the future disabled or Deaf women

and girls are treated equally on all levels – in schools, workplaces, in public and within their families. **All women who were interviewed aimed to and wished to live in an inclusive society in which ‘being disabled’ or ‘being a woman’ were not a barrier to access, safety or life chances anymore.** In order to achieve that aim, it is the task and the duty of policy makers to implement adequate measures to fulfil all rights of disabled women, especially guaranteeing a violence-free life.

Finally, the project also showed that the interviewed women affected by violence were not just (helpless) victims or prisoners of comprehensive dynamics of violence, but women with strength and power who, despite experiencing discrimination and violence throughout their lives, were able to save themselves by their own efforts – sometimes even from seemingly severe and hopeless situations. This is exactly where measures should try to connect with the strengths and the self-determined decisions of disabled women. Ultimately, a joint support network with disabled women should be set up that lives up to the rights and goals ‘equality’ and ‘self-determination’.

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