

Voices Against Violence



Paper Two:
Current Issues in Understanding and Responding to Violence
against Women with Disabilities

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Privacy note:

The case studies in this paper have been de-identified to protect people's privacy. All the names used are pseudonyms and identifying details (such as people's nationalities) have been changed.

Content note:

Please be aware that the material contained in this paper may be distressing to some readers.

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About the research project team

Women with Disabilities Victoria

Women with Disabilities Victoria (WDV) is an organisation run by women with disabilities for women with disabilities. Its members, board and staff have a range of disabilities, backgrounds, lifestyles and ages. It is united in working towards its vision of a world where all women are respected and can fully experience life. Using a gender perspective allows the organisation to focus on areas of inequity of particular concern to women with disabilities, including women's access to health services, parenting rights and safety from gender-based violence. WDV undertakes research, advocacy and professional education and provides information, leadership and empowerment programs for women with disabilities. It has dedicated particular attention to the issue of male violence against women with disabilities, due to its gravity and high rate of occurrence.

Office of the Public Advocate

The **Office of the Public Advocate (OPA)** is an independent statutory body established by the Victorian State Government. Working within a human rights framework, its mission is to promote and protect the rights and interests of people with disabilities and to work to eliminate abuse, neglect and exploitation. It provides various services that work towards achieving those goals including an Advocate/Guardian Program, a Community Visitors Program, an Independent Third Person Program, and an Advice Service. It also advocates for systemic changes in the lives of people with disabilities by undertaking research, policy advocacy and community education. The Public Advocate is strongly committed to tackling violence against people with disabilities, particularly women, who make up the largest proportion of victims of violence.

Domestic Violence Resource Centre Victoria

The **Domestic Violence Resource Centre Victoria (DVRCV)** aims to prevent violence in intimate and family relationships and promotes non-violent and respectful behaviour. It works within a feminist framework with an understanding of the gendered nature of family violence and in partnership with other organisations with similar aims. DVRCV receives core funding from the Victorian Department of Human Services with additional funding from a variety of government and philanthropic organisations. It provides training, publications, websites, policy advice and advocacy, as well as initial support and referral for women experiencing violence.

The Voices Against Violence Research Project

The Voices Against Violence Research Project was a cross-sectoral partnership, undertaken between WDV, OPA and DVRCV. The project investigated the circumstances of women with disabilities of any kind (including physical, sensory and cognitive impairments and mental ill-health) who have experienced violence.

The need for the project arose when our organisations recognised the lack of available information regarding violence against women with disabilities. We knew that women with disabilities experience higher rates of violence than women in the general community. We also knew that they can encounter significant barriers to accessing appropriate support services and justice outcomes. In spite of this, there was a lack of data about the nature and extent of violence against women with disabilities in Victoria.

There was also a lack of information and knowledge about what we can do to respond to this problem and prevent it from occurring. This project addresses some of these omissions. We have done this by conducting an extensive fact-finding mission relating to violence against women with disabilities, which included:

- a paper outlining current issues in understanding and responding to violence against women with disabilities
- a review of the legislative protections available to women with disabilities in Victoria who have experienced violence
- a review of OPA's records of violence against women with disabilities
- interviews with staff and volunteers from OPA's major program areas
- in-depth interviews with women with disabilities who have experienced violence
- consultations with women with disabilities
- engaging with the disability, family violence, sexual assault, legal and other service sectors.

This data has been used to devise evidence-based recommendations for legal, policy and service sector reform.

This project built on previous work undertaken by the organisations, including *Building the Evidence: a report on the status of policy and practice in responding to violence against women with disabilities in Victoria* by Lucy Healey, Keran Howe, Cathy Humphreys and Felicity Julien for WDV, DVRCV and the University of Melbourne; *Violence Against People with Cognitive Impairments* by Janine Dillon for OPA; and *Getting Safe Against the Odds* by Chris Jennings for the DVRCV.

Reference group

The project benefited from the expert advice of a reference group comprising the following representatives:

- Maree Willis, representative of women with disabilities
- Beverley Williams, representative of women with disabilities
- Chris Jennings, consultant
- Marita Nyhuis, Department of Human Services
- Philippa Bailey, DVRCV
- Chris Atmore, Federation of Community Legal Centres Victoria
- Marg Camilleri, Federation University Australia
- Christine Chong, inTouch Multicultural Centre Against Family Violence
- Patsie Frawley, La Trobe University
- Sarah Fordyce, National Disability Services
- John Chesterman, OPA
- Bianca Truman, Safe Futures Foundation
- Dagmar Jenkins, South Eastern Centre Against Sexual Assault
- Cheryl Sullivan, Women and Mental Health Network
- Lucy Healey, The University of Melbourne
- Jen Hargrave, WDV

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What the project explored

The overarching research question for the Voices Against Violence Research Project was to investigate the nature of violence against women with disabilities in Victoria. As part of this investigation, the project explored issues such as:

- the impacts of violence against women with disabilities in Victoria
- the help-seeking behaviour of women with disabilities who have experienced violence
- the legal context and social services responses to women with disabilities who have experienced violence.

The research papers

This paper is one of a series of publications for the Voices Against Violence Research Project.

The papers for this project are:

1. *Voices Against Violence, Paper One: Summary Report and Recommendations*
2. *Voices Against Violence, Paper Two: Current Issues in Understanding and Responding to Violence against Women with Disabilities*
3. *Voices Against Violence, Paper Three: A Review of the Legislative Protections Available to Women with Disabilities who have Experienced Violence in Victoria*
4. *Voices Against Violence, Paper Four: A Review of the Office of the Public Advocate's Records on Violence against Women*
5. *Voices Against Violence, Paper Five: Interviews with Staff and Volunteers from the Office of the Public Advocate*
6. *Voices Against Violence, Paper Six: Raising Our Voices – Hearing from Women with Disabilities*
7. *Voices Against Violence, Paper Seven: Summary Report and Recommendations in Easy English.¹*

¹ To access the papers, refer to the research partners' websites:

Women with Disabilities Victoria www.wdv.org.au/publications.htm

Office of the Public Advocate www.publicadvocate.vic.gov.au/research/255/

Domestic Violence Resource Centre Victoria www.dvrcv.org.au/publications/books-and-reports/

These papers have been written by different authors over a period of time, reflecting different language and definitions. In this period, the complexity of dealing with violence in different contexts – which employ different understandings of disability and different understandings of violence – has become evident. Grappling with this complexity has been a valuable learning and the thinking of the project team has evolved through the life of the project. We have endeavoured to standardise the language across papers as far as possible.

Underlying premises of the project

- Violence is a gendered issue. The majority of victims of violence are women and the greatest numbers of perpetrators are men.
- Violence is about power and control. Perpetrators (who are usually men) use violence in order to intentionally control or dominate other people (usually women).
- Violence against women is a human rights issue. Therefore, a human rights framework needs to inform our understandings of, and responses to, violence.
- Women with disabilities experience multiple and intersecting forms of discrimination. Violence against women with disabilities is the result of the intersection of gender-based discrimination, disability-based discrimination and other forms of subordination.
- Women with disabilities experience violence at a higher rate and for longer periods of time than women in the general population. They also encounter significant barriers to receiving appropriate services and justice responses to their experiences of violence.
- Violence against women is preventable. There is considerable scope for governments and communities to prevent violence before it occurs.
- Disability is created by discriminatory practices and attitudes that have built up over time. Disability is preventable and can be addressed through government policy and regulation.

Working definitions

It was important for this project to be based on an understanding of the terms 'disability' and 'violence against women'. The Project team drew on extensive literature to inform its own working definitions.²

In defining 'violence against women with disabilities' the project team took account of the numerous ways power and control is exercised and the various forms of violence in which it is manifest.

In defining 'disability' the team took account of the common practice of using 'disability' and 'impairment' interchangeably. However, it was important for the project team to make explicit its understanding of the structural underpinnings of disability (noted in the Underlying premises above).

Below are definitions that will assist the reader to better understand how abuse and violence can and does affect women with disabilities.

Disability is a social construct and stems from the interaction of a person's functional impairment with a disabling environment. Disabling environments create structural, attitudinal and behavioural barriers; for example, by preventing people with functional impairments from accessing housing, education, work opportunities, transport. A specific type of disability arises from the interaction of a specific impairment with an environment that creates barriers. Some barriers are specific to that impairment; for example, a physical or sensory or cognitive disability arises from the interaction of a physical, sensory or cognitive impairment with an environment that creates barriers for the particular impairment. In addition, some barriers develop regardless of the particular impairment; for example, negative stereotyping of 'people with disabilities'.³

Violence against women with disabilities is a human rights violation resulting from the interaction of systemic gender-based discrimination against women and disability-based discrimination against people with disabilities. It includes family violence, sexual assault and disability-based violence. A range of behaviours are associated with these forms of violence, including emotional, verbal, social, economic, psychological, spiritual, physical and sexual abuses. These may be perpetrated against women with disabilities by multiple perpetrators, including intimate partners and other family members, and those providing personal and other care in the home or in institutional, public or service settings.

² This paper provides a detailed discussion of these and other relevant terms and problems associated with recognising the complexity of violence against women with disabilities.

³ The social model of disability was first conceptualised by Mike Oliver. For a further exploration of the concept, see for example, Mike Oliver (1983) *Social Work With Disabled People*, London, Macmillan

Summary

This paper examines the nature and extent of violence against women with disabilities and the barriers to services faced by women with disabilities who have experienced violence. It also explores promising initiatives being run in Victoria that may help repair the harm and prevent the injustice of violence in the first place. The intersections of gender, violence, disability and structural disadvantage are central to understanding violence against women with disabilities.

On all measures of social and economic participation, people with disabilities are significantly disadvantaged and can experience the violation of their human rights. This is particularly acute for women with disabilities due to gender discrimination, heightened by the risks of poverty and violence.

This paper builds on work undertaken by the participating organisations and draws on recent research on violence against women with disabilities in order to highlight the need for Victoria's disability sector to better understand the gendered dynamic of violence and for the family violence–sexual assault sector (including criminal justice services) to better understand disability-based violence. It advocates for sustained, multi-sectoral engagement across Victoria's human and justice services to support prevention initiatives and improved identification of, and responses to, women with disabilities who experience violence regardless of whether they live in the community or in institutions.

This work is based on the critical need to give attention to gender and disability and other layers of disadvantage when analysing, preventing and responding to violence. Without this multi-layered focus, women with disabilities will continue to live with an increased risk of experiencing violence and experiencing barriers to justice and community services.

Section 1: Background

The Voices Against Violence Research Project is about women with disabilities living in Victoria who experience or are at risk of experiencing violence perpetrated against them.⁴ It includes adult women with physical, sensory, cognitive impairments and/or mental ill health.⁵ It relates to all types of violence that women with disabilities may experience within the context of intimate and family relationships and in disability care-related relationships and diverse living settings.

The project was based on three important premises. Firstly, that violence against women with disabilities is understood to be the result of complex, interlocking systems of gender-based discrimination, disability-based discrimination and other forms of exclusion and domination.

Secondly, the project is informed by a human rights approach, within which violence is understood to be the result of historically unequal power relations in which women and girls with disabilities are “subject to multiple discrimination” (*Convention on the Rights of Persons With a Disability*, 2008, Article 6) and where

...the pervasiveness of violence against women across the boundaries of nation, culture, race, class and religion points to its roots in patriarchy – the systemic domination of women by men. The many forms and manifestations of violence and women's differing experiences of violence point to the intersection between gender-based subordination and other forms of subordination experienced by women in specific contexts (United Nations General Assembly, 2006, para 69).

Thirdly, while violence against women is endemic through time and place, there is significant evidence to demonstrate that it is preventable (Fergus, 2012; WHO, 2010) but that, in relation to women with disabilities, it requires a moral obligation on the part of states to take

...all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects... [and] all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, *inter alia*, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognise and report instances of exploitation, violence and abuse... [and] ensure that protection services are age, gender and disability sensitive (*Convention on the Rights of Persons With a Disability*, 2008, Article 16).

4 This paper focuses on women, not girls with disabilities. We acknowledge that many of the issues raised in this paper are relevant to girls and young children with disabilities, but there are additional issues relating to them that do not fall within the scope of this current project.

5 Cognitive impairments include intellectual disability, acquired brain injury (ABI) and dementia.

This paper presents current issues in order to advance progress in identifying and responding to women with disabilities who have experienced violence and to prevent or reduce the risks of future violence.

Scope and outline of the paper

This paper grew out of years of feminist and disability advocacy in Victoria, and Australia more broadly (Chenoweth, 1996; Howe, 1999, 2007; Women With Disabilities Australia [WWDA], 2007; Jennings, 2003). From 2008, several significant projects were undertaken that explored the extent and nature of violence against women with disabilities. The advocacy that stemmed from earlier research, *Building the Evidence: a report on the status of policy and practice in responding to violence against women with disabilities in Victoria* and from several subsequent forums has resulted in important, positive developments in Victoria. However, many of the recommendations from these projects still remain to be addressed (respectively, Healey; Howe; Humphreys; Jennings; Julian, 2008; Dillon, 2010; Greenland, 2009).

Drawing on international and national research,⁶ this paper calls on new sources of knowledge in order to update and extend the previous research projects undertaken by the research organisations. It focuses on:

- the nature and extent of violence against women with disabilities
- the barriers to services for women with disabilities experiencing violence
- promising initiatives in Victoria that aim to prevent or respond to violence against women with disabilities.

It aligns with (but does not replicate) research and evidence presented in the accompanying Voices Against Violence Research Project papers.

This paper also aligns with WDV's *Position Paper on Violence Against Women with Disabilities* (2014) which provides a summary of current disability policy and violence against women policy and identifies opportunities to improve service and justice responses to women with disabilities who experience violence.

⁶ Academic electronic databases were searched from 2008 to the present. These included Ebsco, Informit, JSTOR, ProQuest, Elsevier, Web of Knowledge and Google Scholar, using the search terms 'violence' and 'women with disabilities' (and related key terms). Key websites were searched, including the National Online Resource Centre for Violence Against Women, the Centre for Women Policy Studies, the New Zealand Family Violence Clearinghouse, the Australian Domestic and Family Violence Clearinghouse and the Minnesota Center Against Violence and Abuse, as were key journals, including *Violence Against Women*, *Violence and Victims*, *Journal of Interpersonal Violence and Disability and Society*. Grey literature is also included in this review.

Section 2: Disadvantage in the context of gender, disability and violence

Many international agreements recognise the fundamental human right for women to life free from violence, the most significant of which is the United Nations Declaration on the Elimination of Violence Against Women (DEVAW). Yet the lived experiences of women with disabilities have often been disregarded. When the 2006 *UN Convention on the Rights of Persons With Disabilities* (CRPD) came into force, the same fundamental right was made explicit for people with disabilities, with Article 6 specifically recognising discrimination on the grounds of gender and disability.

Yet, as many reports indicate, including the first World Health Organization *World Report on Disability* (WHO, 2011), women and girls with disabilities are significantly disadvantaged on all measures of social and economic participation, including in relation to men and boys with disabilities. Further, the likelihood of women with disabilities experiencing violence and abuse is considerably heightened (Australian Government, 2009; Office of the United Nations High Commissioner (OHCHR), 2012; WHO, 2013; Frohmader, 2011).

Definitions

Defining disability and violence against women is widely recognised as a contentious issue in policy, practice and research (see ALRC, 2010; Nixon, 2009a). Both have been defined in international, national and state legislation, policy and research.⁷ Later in this section of the paper, the terms we use are explored and problematised in more detail, but for the moment we set out the understanding of key terms that are used in the Voices Against Violence Research Project.

Disability

The social model of disability underpins the Voices Against Violence Research Project.

The social model of disability understands disability to be a result of the interaction between a person's impairment and disabling environment (Mays, 2006; Nixon, 2009a).

⁷ For example, see the *National Plan to Reduce Violence Against Women and Their Children 2010–2020* (a joint responsibility of Commonwealth and State Governments), the *2012 Action Plan to Address Violence Against Women and Children – Everyone has a Responsibility to Act, the Victorian Government's Strong Culture, Strong Peoples, Strong Families. Towards a Safer Future for Indigenous Families and Communities: 10 year plan*, the *National Disability Strategy 2010–2020* (an initiative of the Council of Australian Governments from the previous Labour government), the *Coalition's Policy for Disability and Carers*, August 2013 (which includes an ongoing commitment to the National Disability Insurance Scheme's roll-out), the *Disability Discrimination Act 1992* (Cth), and the *Victorian State Disability Plan 2013–2016*.

The terminology of preference in Australia is to 'put the person before the disability', hence this project uses the term 'women with disabilities'.

Disabling environments prevent people with disabilities from accessing the built environment, human, health and justice services, transport, housing, employment, education and social networks (Australian Government, 2009). The social model views disability as a social construct stemming from disabling social systems based on behaviours and attitudes creating barriers that separate – and thus discriminate against – people with impairments. Disability thus stems from the interaction of the disabling environment with individual impairment. This view is in contrast to the medical model that prevailed until recently and is still evident in some areas, which locates disability within the person who requires interventions to address individual 'pathology'.

This does not mean that functional characteristics of impairments are unimportant. They, like other identity forming characteristics (such as gender, sexuality, race, ethnicity, socioeconomic status, citizenship status and so on), shape life experiences.

This project is about adult women with disabilities in all their diversity, irrespective of the nature of their disability. It also highlights how the marginalisation of people in society according to their social identity creates the conditions within which violence against them flourishes.

Violence against women with disabilities

Article 1 of the United Nations DEVAW provides the normative basis of a gender-based definition of violence against women as

any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UN DEVAW, 1993).

Interpersonal violence is a profoundly gendered phenomenon. While men and boys are obviously victims of violence, the type differs from violence against women and girls. Males are more likely to be victims of physical assault perpetrated by a male acquaintance or a stranger, rather than by someone with whom they are in an intimate or family relationship and perpetrators of sexual abuse of boys are less likely to be a family member; whereas, females are more likely to be victims of male intimate partner violence and sexual assault by family and kin (ABS, 2006; Atmore, 2001; Marcus and Braaf, 2007).

The Voices Against Violence Research Project was founded on the understanding that there is a similarly gendered pattern to violence against women with disabilities.⁸ Thus, perpetrators are most likely to be men in an intimate or family-like relationship or who are providing disability-related care and are repeatedly using abuse, coercion and violence or threatening to do so (Clark and Fileborn, 2011; McLain, 2011; Pence, 2010; The National Council to Reduce Violence Against Women and Their Children, 2009; WWDA, 2007).

Violence against women with disabilities is a human rights violation resulting from the interaction of systemic gender-based discrimination against women and disability-based discrimination against people with disabilities. The violence that ensues is a manifestation of the historically unequal power relations between women with disabilities in relation to others in public and private life. Relations of power and control in the context of a prevailing culture of unequal power between women and men, adherence to rigid gender stereotypes and notions of male dominance, superiority and entitlement over women are thus central motivating forces underpinning violence against women with disabilities (see UN General Assembly, 2006; OHCHR, 2012).

The above boxed text paraphrases the UN Secretary-General's feminist and human rights perspective on the context and causes of violence against women but extends it to apply specifically to the situation of women with disabilities (UN General Assembly, 2006, p. 27ff). The UN's thematic study also clearly stipulates the need to analyse violence against women with disabilities in the context of the "overall subordination of women within a patriarchal system" (OHCHR, 2012, p. 3).

The terms used in this project broadly align with those used within the family violence–sexual assault sector and government policy in Victoria and Australia. These are premised on a gendered understanding of violence in which some of the violence is considered to be criminal, and some not.⁹

Importantly, however, this project extends the gendered understanding of violence to argue for the need to understand its intersection with disability-based violence (McLain, 2011).

8 The basis of this premise is discussed in Section 3 of the paper where the higher prevalence of violence against women with disabilities is compared to men with disabilities and women without disabilities.

9 For example, see the *National Plan to Reduce Violence Against Women and Their Children 2010–2022*, Victoria's *Family Violence Protection Act 2008*, the Australian Law Reform Commission's recommendations (ALRC, 2012) and sector standards, such as the *Code of Practice for Specialist Family Violence Services for Women and Children* (DV Vic, 2006). The legislative definition of family violence in the *Family Violence Protection Act 2008* (Vic) has been proposed as a model for other Australian state and territory family violence legislation (ALRC, 2010, 176, Proposal 4–1).

In comparison to the general population, people with disabilities are at an elevated risk of experiencing violence. Women with disabilities – particularly those with intellectual disabilities who are most excluded from social and economic participation – are at especially heightened risk of experiencing violence. When we listen to what women with disabilities say about their experiences of violence, it is clear that gender-based and disability-based discrimination exacerbate the risk of violence for women with disabilities (Hague, Thiara, Mullender, 2011a; Healey, Humphreys, Howe et al, 2008; Walter-Brice, Cox, Priest, Thompson, 2012).

The Voices Against Violence Research Project uses the following terms in relation to violence against women with disabilities while recognising that these are variously described within state and federal legislation and policy arenas (as indicated in footnotes 9-11):

- Sexual assault – unwanted behaviour or activity of a sexual nature directed towards a woman that makes her feel uncomfortable, distressed, frightened or threatened or which causes harm or injury to her to which she has not, or is unable to, give consent; behaviour that involves coercive physical, emotional, psychological or verbal behaviour against her in a single incident or part of an ongoing pattern of assault; and behaviour that includes sexual harassment, stalking, forced or deceptive sexual exploitation (such as images being taken and distributed without consent), indecent assault and rape (The National Council to Reduce Violence Against Women and Their Children, 2009).¹⁰
- Family violence – the use of ongoing, coercive power and control overwhelmingly by males against female partners or ex-partners, but also in family-like arrangements and communities that may involve elder abuse, abuse of siblings, abuse by care providers, same-sex violence and violence by adolescents against parents. It includes emotional, verbal, social, economic, psychological, spiritual, physical and sexual violence (ABS, 2013; The National Council to Reduce Violence Against Women and their Children, 2009).¹¹

10 In Victoria the *Crimes Act 1958* (Vic) defines sexual offences to include rape and assault with intent to rape, indecent assault, incest, administering drugs to enable sexual penetration, sexual offences against young people and offences against people with impaired mental functioning. This Act does not therefore include sexual harassment, however, in some circumstances it is unlawful. For example, sexual harassment in the workplace is against the law under the *Equal Opportunity Act 2010* (Vic) and the *Sex Discrimination Act 1984* (Cth). Sexual harassment describes a wide range of unwelcome behaviour of a sexual nature, which could reasonably be expected to make a person feel offended, humiliated or intimidated (www.business.vic.gov.au/operating-a-business/employing-and-managing-people/employer-responsibilities/equal-opportunity/sexual-harassment).

11 In Victoria, the *Family Violence Protection Act 2008* defines ‘family violence’ as behaviour that is physically or sexually abusive, emotionally or psychologically abusive, threatening or coercive or in any way controls or dominates the family member and causes that family member to fear for his or her safety or well-being or for the safety or well-being of another person. Importantly, it includes behaviour by a person that causes a child to hear, witness or otherwise be exposed to the effects of family violence. This can include violence against women with disabilities where they are in a ‘family-like’ relationship. In defining the meaning of a ‘family member’, the *Family Violence Protection Act 2008*, Section 8(3)(i) includes the following example: “A relationship between a person with a disability and the person’s carer may over time have come to approximate the type of relationship that would exist between family members.”

- Disability-based violence – involves a diverse range of behaviours that, in addition to sexual assault and family violence as outlined above, includes being a target of impairment-related violence and abuse, hate crimes, ongoing neglect, the use of constraint or restrictive practices and institutional violence (rigid regimes, poor quality care, unethical or unauthorised practices in response to challenging behaviours and mental ill health needs and breaches of professional boundaries by staff). The violence is often experienced over long periods of time and inflicted by multiple perpetrators, including those providing personal care in the context of an intimate relationship in the privacy of their home or in the provision of care or services in institutional, public or service settings (International Network of Women With Disabilities, 2010; Saxton, Curry, Powers, Maley, Eckels, Gross, 2001; Hague, Thiara, Magowan, Mullender, 2008; Women With Disabilities Australia, 2007). Disability-based violence is experienced differently by girls, boys, women and men with disabilities and is thus gendered and intersects with other forms of discrimination including race, sexuality and class.¹²

As the following forms of violence were particularly apparent in the lives of the women covered by this project, we provide a further brief outline of each:

- Emotional or psychological violence – emotional or psychological violence constitutes behaviour that torments, intimidates, harasses or is offensive. Examples of this behaviour range from yelling abuse and name calling, to mind games, and threats to kill/to harm and/or to commit suicide. Withholding medication and preventing a person from keeping connections with their family, friends and culture can also be considered emotional or psychological abuse.
- Economic abuse – economic abuse involves behaviours that “control a woman’s ability to acquire, use, and maintain economic resources, thus threatening her economic security and potential for self-sufficiency” (Adams et. al. in Corrie and McGuire 2013, p.1). These behaviours can include a perpetrator controlling the woman’s finances, denying her access to her property, abusing his authority under a financial Power of Attorney, or exploiting a woman sexually in return for money (Corrie and McGuire 2013).
- Physical violence – physical violence is an assault that causes physical injury, and/or the use of the body to threaten injury. There are ranges of behaviours that can constitute physical abuse including hitting, choking, burning, and restraining. It can also cover physical intimidation, such as the use of body language to threaten someone, i.e. standing over someone to cause fear.

¹² *The Disability Discrimination Act 1992* (Cth) and the *Equal Opportunity Act 1995* (Vic) make it unlawful to discriminate against a person because they have a disability and require that people with a disability be given equal opportunity to participate in and contribute to the full range of public life, including access to goods, services and facilities provided by government departments. *The Disability Act 2006* (Vic) provides the basis for the state’s disability services to ensure the right for people with disabilities to a life free from ‘abuse, neglect and exploitation’.

Victoria's population of women with disabilities¹³

Victoria's population of approximately one million people with disabilities represents 18 per cent of the overall state population of 5.4 million. Of those Victorians with disabilities, 338,200 (six per cent) live with a profound or serious disability. Overall, there is little difference in the rates of disability between females and males. There are, however, a higher estimated number of females with a disability across age ranges, except for the 0–4 and 5–14 year old age groups. As expected, given the onset of age-related impairments, the prevalence of disability rises significantly after the age of 50 years, for example, from 20 per cent in the 45–54 age group to more than 80 per cent among people aged 85 years or over.

The rate of disability for Victoria's culturally and linguistically diverse population is only slightly higher than other Victorians, for example, 22 per cent compared with 18 per cent in the general population.

The rate of disability for Aboriginal Victorians aged 15 years or more (46.3 per cent in 2008) was more than double that of the total Victorian population in 2009.

The proportion of Victorians with a disability is higher in rural and regional Victoria than in the major cities (for example 22 per cent compared to 17 per cent). We might speculate that this may be due to lower housing costs and/or the higher percentage of older Victorians in rural areas. Of those requiring assistance for a core activity, five per cent were residing in rural and regional Victoria compared to 4.3 per cent in metropolitan Melbourne.

There is no reliable data for the rate of homelessness among Victorians with a disability because of the narrow criteria used to identify those with disabilities. The National Homelessness Research Agenda, however, found that the prevalence for homelessness is greater for Australians with a disability than the general population (Homelessness Australia cited in State of Victoria, 2011).

¹³ Statistics in this section, unless otherwise indicated, are drawn from the *Victorian State Disability Plan 2013–2016* (State of Victoria, 2012, pp. 6–34), which in turn are based on ABS data, specifically: *Disability, Ageing and Carers, Australia: State Tables for Victoria 2009*, the *Census of Population and Housing 2006*, the *General Social Survey 2010* and *Disability Australia 2009*.

National home ownership data indicates that an estimated 36 per cent of all people with a disability own homes with a mortgage, compared to 45 per cent of people without a disability. There is no housing data available that disaggregates by gender and disability, however, in 2009, Victorians with disabilities were living in the following types of premises:

- 1 per cent of people with disabilities lived in a non-private dwelling such as a group home
- 28 per cent of people with disabilities lived in private rented accommodation, compared with 25 per cent of people without a disability
- 7 per cent of Victorians with disabilities rented from a state housing authority compared with one per cent of people without a disability
- 12 per cent of Victorians with a profound core activity limitation lived as boarders, compared with five per cent of people without a disability
- 18 per cent of Victorians with a disability lived rent free compared with eight per cent of people without a disability (State of Victoria, 2012, p. 18).

The above data on homelessness and housing is seen in an even starker light when we take into account research that shows how different types of disability lead to different housing situations. In comparison to the ‘housing careers’ of people with other types of impairments, those with mental ill health experience the greatest housing instability, moving more frequently than people with other impairments. This is owing to the episodic nature of mental ill health and periods of unemployment, which are more likely to lead to living in insecure forms of accommodation, including caravan parks and boarding houses (Beer and Faulkner, 2009).¹⁴

People with developmental impairments move infrequently, whereas people who are profoundly deaf tend to live in the private rental market as they are unable to secure public housing or afford their own home given their limited employment options, which limits their capacity to afford mortgage payments.

People with mobility impairments since birth are more likely to spend long periods living with their parents. They are under-represented in home ownership figures (unlike those who acquired mobility impairments, perhaps as a consequence of an accident) and tend to eventually reside in public rental housing. Those people who acquired mobility impairments and received insurance compensation have housing careers similar to the rest of the population although, having modified their dwelling, they are likely to occupy it into old age (Beer and Faulkner, 2009).

¹⁴ See also the NSW study of the experiences of domestic violence of people with disabilities, particularly the heightened risk for women with disabilities living in licensed boarding houses in NSW (Price-Kelly & Attard, 2010).

Not surprisingly, this research found that households where people with disabilities and care providers reside together experience greater housing stress compared to households where there is no disability (Beer and Faulkner, 2009).

Data from correctional settings indicate that there is an over-representation of people with disabilities in the justice system in comparison to population estimates. For example, it has been estimated that there may be between 1.3 per cent and 2.5 per cent of Victoria's prison population with an intellectual disability and up to 42 per cent of male prisoners and 33 per cent of female prisoners with cognitive impairments, such as an acquired brain injury – ABI (State of Victoria, 2012, p. 24).

Another major index of inclusion and disadvantage is that of economic security, measured in terms of employment and income. Significantly fewer Victorians aged 15 to 64 with a disability (48 per cent) were employed in 2009 compared with those without disabilities (78 per cent), constituting a 30 per cent disparity, and fewer women with disabilities (44 per cent) were employed compared to men with disabilities (53 per cent) (State of Victoria, 2012, pp. 26–27).

In terms of income, people with disabilities earned lower wages, for example, the estimated median income of Victorians with a disability is \$305 gross per week, compared with \$592 for people without a disability. Income estimates indicate that Victorians with disabilities are over-represented (at the rate of 28 per cent) in the lowest household income quintile and an estimated 57 per cent reported receiving a government pension or allowance as their main source of income, compared with 15 per cent of those without disabilities (State of Victoria, 2012, p. 27).

The data demonstrates that most Victorians with disabilities live with varying degrees of autonomy in the community. It also illustrates the geographic, gendered and racialised pattern of poverty and disadvantage. As women with disabilities are more likely than men with disabilities to have lower standards of living given the discriminatory access to mainstream services and public resources, they are more likely to be at risk of violence. This risk is significantly greater for Indigenous women with disabilities (OHCHR, 2012).

Conceptualising the problem: disability, gender and violence

The terms that we use to represent an issue or a social problem are crucial, as governments and the legislation they pass to drive policy and practice have particular ways of problematising issues. These “competing understandings of social issues” have been called “problem representations” (Bacchi, 1999, 2012). We therefore need to be clear about what we mean by the problem of violence against women with disabilities, how we name it, analyse it and respond to it in order to reshape public awareness and influence public policy (Bacchi, 2012). The voices of women and girls with disabilities speaking out against violence are central to the cultural shift that needs to occur in the ways in which society thinks about disability, violence and gender.

Different bodies have different stakes and purposes in defining ‘violence’ and ‘disability’. As a result, the problems of violence against people with disabilities and of violence against women with disabilities, more specifically, are tackled by different systems and agencies with poorly integrated engagement. This is reflected in the lack of consensus about how to name ‘violence’ in legislation, government policy, research and service providers’ remit in Victoria and across Australia.

To illustrate, disability researchers tend to highlight the unacceptably high levels of ‘abuse’ against ‘people’ with disabilities, particularly the most ‘vulnerable’(identified as those with intellectual impairments), and researchers of older people talk of ‘elder abuse’, but are less skilled in recognising family violence or sexual assault or in taking appropriate action when it is disclosed.

Meanwhile, researchers in the family violence–sexual assault arena highlight unacceptably high levels of ‘violence against women’ with the emphasis on the gender of victim–survivors and relegate women with disabilities – like Indigenous, immigrant and lesbian women, those identifying as intersexed or transgendered, rural and older women – to a subset of ‘all women’. The result of this dissonance is that violence against women with disabilities is not well understood in the disability sector and violence against people with disabilities is not well understood by family violence–sexual assault services.¹⁵

Consequences for justice for women with disabilities

The experiences of women with disabilities (particularly those with communication barriers and cognitive disabilities) in the justice and welfare services indicate that current policies and legislation that supposedly apply to all women in order to protect them from violence do not necessarily afford them the same protection.¹⁶

15 The Victorian Government’s current Policy and Action Plan, *Victoria’s Action Plan to Address Violence Against Women and Children: Everyone Has a Responsibility to Act 2012–2015*, has provided funding to WDV to address the problem, in part, through the development of the *Gender and Disability Workforce Development Program* (discussed in Section 5: Promising practice).

16 This is discussed further in other papers in this series.

To illustrate further, Victorian family violence legislation is framed around ‘family-like relationships’ for the purposes of protecting women with disabilities from family violence but, in that it only provides illustrative examples of family violence, it does not sufficiently reveal the targeting of women in uniquely disability-related ways in all their diverse identities. Similarly, disability legislation fails to recognise that violence, abuse and neglect are experienced in gendered and sexualised ways. As recent reports from Victoria’s OPA and the media indicate, there are gross failures in identifying disability-based violence, let alone responding to it (Bedson, 2012; Dillon, 2010).¹⁷

Lack of consensus about how to define disability also has significant implications for determining access to disability entitlements in the interests of governments struggling to balance competing interests and financial commitments. For example, during the pilot period of the National Disability Insurance Scheme (NDIS) people with disabilities who are less than 65 years of age will be eligible, but those seeking assistance after the age of 65 will not be, at a time when health and disability-related costs might be expected to increase.

Similarly, Victoria’s Disability and Family Violence Crisis Response Initiative (enabling women with disabilities or women with a child with disabilities to access crisis support of various kinds) is based on the definition of disability provided in the *Victorian Disability Act 2006* (Vic). This is a narrow definition (in comparison to the Disability Discrimination Act (Cth) in that it does not include women with mental illness.¹⁸ Yet research indicates that women with disabilities, particularly those with mental ill health and intellectual disabilities, experience numerous forms of violence and abuse in institutional and community settings (Clark and Fileborn, 2011; Disability Services Commissioner, 2012; French, Dardel, Price-Kelly, 2009; Murray and Powell, 2008).

The failure of disability, mental health, family violence and sexual assault services to align in advocating against violence has resulted in a significant policy failure (Dillon, 2010). The consequences of poor legislation and justice responses for individual women with disabilities living in disadvantaged and isolated situations that expose them to heightened risk of violence seems far from just for a population group that has had more than its fair share of discrimination.

¹⁷ For example, see media coverage by Richard Baker and Nick McKenzie into alleged sexual assaults occurring in supported residential accommodation: ‘Host of problems at home in crisis’, *The Age*, 29 July 2013, p. 3; and ‘Love of life affirmed in the blessing of a fisherman’, *The Age*, 16 August 2013, www.theage.com.au/victoria/love-of-life-affirmed-in-the-blessing-of-the-fisherman-20130815-2rzk8.html and coverage into sexual and physical assaults in aged care facilities by Julia Medew: ‘Assaults against elderly increase in nursing homes’, *The Saturday Age*, 5 February 2011, p. 3.

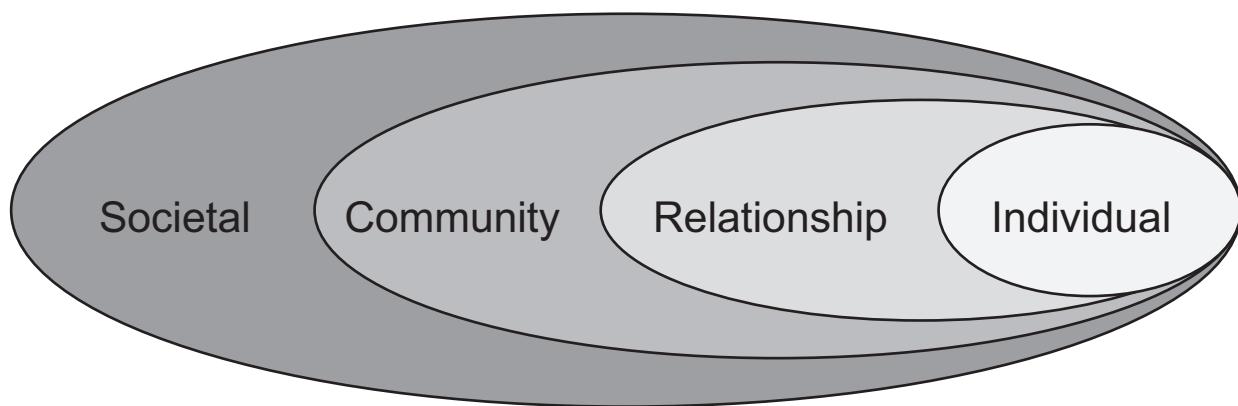
¹⁸ The *Disability Act 2006* (Vic) says that people with physical, sensory or neurological impairment, an ABI, intellectual disability or developmental delay may access disability services. An evaluation has been undertaken by the Department of Human Services (DHS) and while this is not yet publicly available, media reports indicate the initiative is to be continued following positive evaluation.

There is an ongoing challenge to the normative and legislative understanding of family violence and sexual assault when we listen to what women with disabilities have to say about their experiences of violence. Women with disabilities, particularly those with cognitive impairments and mental ill health experience numerous forms of violence in the community and institutional settings, often for exceedingly long periods of time and at the hands of numerous perpetrators (discussed in more detail in the following section). Yet Victoria's legislation, justice system (including law enforcement, courts and corrections) and policies have so far had little success in ensuring safety or achieving justice for those who have experienced violence in institutional settings (Clark and Fileborn, 2011; Murray and Powell, 2008; Success Works, 2011). A full analysis of the Victorian legislation related to violence against women can be found in *Voices Against Violence Research Project, Paper Three: A Review of the Legislative Protections Available to Women with Disabilities who have Experienced Violence in Victoria*.

Institutional violence: an ecological approach to violence

Institutional violence is well documented in disability literature on violence, abuse, neglect and exploitation against people with disabilities (Brown, 2011; Cambridge, Beadle-Brown, Milne, Mansell, Whelton; 2006, 2011; French, Dardel, Price-Kelly; 2009; Robinson, 2012; Sobsey, 1994). Much of this literature is informed by a rights-based 'ecological model' that understands violence and abuse as stemming from interactions occurring on the level of the individual, relationships, the community and societal (see Figure 1). The development of an ecological model for understanding violence against women and girls has emerged within the field of public health and been most influential in developing prevention strategies that address gender and other forms of discrimination and domination (Fergus, 2012).

Figure 1: An ecological model approach to understanding violence



Source: World Report on Violence and Health, 2002, World Health Organization, Geneva

Dick Sobsey's work is an important contribution to highlighting violence and abuse against people with disabilities in institutions developed from an 'integrated ecological model of abuse' within disability studies.¹⁹ In his 1994 publication, he identified four characteristics of 'institutional abuse' (his term) against people with disabilities. Firstly, extreme power inequalities exist between staff and residents. Secondly, the prevailing subculture of violence is such that abuse is typically collective by nature with more than one perpetrator and more than one victim involved. Thirdly, there is overt and subtle covering up of the abuse that includes rationalisations of its use amongst residents with 'behaviours of concern' and the devaluation of violence through euphemistic descriptions of 'misconduct', 'maltreatment' and 'incidents'. Lastly, the cultural practices of the violence are remarkably similar across geographically dispersed institutions (discussed in different ways in Michel Foucault's work in 1977 and Erving Goffman's work in 1966 on disciplinary regimes and asylums).

A number of conditions may account for replicated environmental conditions, including inadequately resourced or regulated care within which unmotivated or overwhelmed staff are employed; rigid regimes; overcrowding and insufficient privacy for residents leading to abusive behaviours; and inappropriate sharing of space, including mixed gender residences and health units (Brown, 2011; French, Dardel, Price-Kelly, 2009; Victorian Women and Mental Health Network, 2009, 2008; Victorian Mental Illness Awareness Council, 2013).²⁰

These insights into the disabled conditions in institutions in which people with and without disabilities live and work have been vital. However, they provide limited insight into how discriminatory or gender stereotyping and disabled stereotyping dynamics (at the heart of causes of violence) interact in different ways on women and men with disabilities and, indeed, the rest of society. For this reason, the Voices Against Violence Research Project team suggests that an intersectional theoretical approach to violence provides a more useful way of explaining gendered violence in the context of disability and other sources of discrimination based on race, ethnicity, class, rurality and so on.

19 Drawing on Urie Bronfenbrenner's ecological model, Sobsey integrates elements of the 'counter control' and 'social learning theory' models of abuse, modifying in order to highlight the interactive relationship and power differentials between victim–offender for the purposes of proposing violence prevention strategies (Sobsey, 1994). Another prominent researcher of violence against people with disabilities working in the disability field is Nancy Fitzsimons, who also uses the integrated ecological model (Fitzsimons, 2009). Dr Patsie Frawley's work in this field builds on these models with a more gender nuanced use of the model in her work on peer education relating to sexuality, intimacy and relationships for people with an intellectual disability (for example, see Frawley, Barrett & Dyson, 2012).

20 We need to be prepared for violence-induced disability in women and girls held in our detention centres as well as for the exacerbation of disabilities that, if not pre-existing, have been the result of sexual and other gender-based violence in the context of war and conflict. As recently observed, the boundaries between public and intimate violence are "blurred by the fact that, for many refugee women, violence at the most intimate level has been utilised for political purposes" (Zannettino, 2013: 6).

Gender, violence and disability: an intersectional approach to violence

An analysis that only focuses on gender – and the “‘default’ position” of adult male perpetrator and adult female victim in an intimate relationship – needs to be disentangled when it comes to understanding the continuum of violence as experienced by women with disabilities in all their diversity (Atmore, 2001, p. 9).

Further, violence perpetrated by carers or service providers who are women against women with disabilities indicates that gendered power is not the whole explanation for such violence. Indeed, it may well be that not all women with disabilities identify gender as the only source of oppression in their lives and many may be hard-pressed to identify whether they are positioned ‘on the margins’ because of any single or particular source of oppression (Nixon and Humphreys, 2010).

There is a growing body of work that draws on the concept of intersectionality in order to understand the interacting or interlocking systems and relations of disadvantage and oppression that we are embedded in, depending on our identities as individuals or members of social groups. An intersectional approach to violence against women with disabilities seems a potentially useful way of understanding how interacting systems of disadvantage based on sexism and racism (to focus on just two possible systems) shape the lives of women with disabilities.

The concept was coined by Kimberley Crenshaw, who sought to expose the racial and gender discrimination experienced by black women at a structural level with a particular focus on the legal system in the US (1991). The idea is that single category explanations (for example, a focus on ‘gender’) or additive explanations (for example, ‘gender + race = double oppression’) are inadequate, but Crenshaw – and those following – sought to find a way to study how different oppressions intersect (or interact, interlock or create multiple jeopardy to produce something that is ‘unique and distinct’ and so much more than the sum of its parts (Dhamoon, 2011, p. 231).

We can follow on from Crenshaw’s problematisation of oppression when looking at violence against women with disabilities by using her metaphor of intersecting roads. Each road represents a different explanatory axis, for example, racism, sexism, sexism and so on. It is where these metaphorical roads collide that “multiple axes of differentiation intersect – economic, political, cultural, psychic, subjective and experiential... in historically specific contexts” (Brah and Phoenix, 2004, p. 76, quoted in Dhamoon, 2011, p. 231).

An intersectional approach to analysis can involve focusing on up to four interacting modalities: on *identities* of individuals and *social groups* (e.g. a lesbian with a disability or an Aboriginal woman with a hearing impairment), on *categories of difference* (such as race, gender, sexuality and disability), on *processes of differentiation* (expressed in terms of racialising, gendering and disabling processes) and on *systems of domination* (racism, colonialism, sexism, patriarchy, homophobia, ableism, war and so on). This is a “framework of intersectionality... [that] provides a multidimensional analysis of how power operates and its effects on different levels of political life” (Dhamoon, 2011, p. 233).

When we consider the diversity of women with disabilities who experience violence – women with sensory, physical, cognitive impairments and/or mental ill health, women who are Indigenous or from immigrant, refugee or asylum seeker backgrounds or who are lesbian, transgender or intersex or who live in poverty or in rural or remote communities – deeper insights into processes of discrimination and differentiation, systems of domination and the nature of the ensuing power differentials in relationships become possible.

Theorists, policymakers and practitioners (for diverse examples see Cramer and Plummer, 2009; Davaki, Marzo, Narminio, Arvanitidou, 2013; Gray and Bradford, 2005; Nixon, 2009b; Ortoleva and Lewis, 2012; Thiara, Hague, Mullender, 2011) discuss the interactions of disability-based and gender-based violence. They open up a space in which we might better understand the complex enmeshment of violence, gender and disability, but there is still much work to be done.

Section 3: The extent and nature of violence against women with disabilities

There is an estimated one billion (or 15 per cent) of adults worldwide with disabilities. As a population, they are at a greater risk of violence than their non-disabled counterparts, with women with disabilities being at particularly greater risk of violence in comparison to men with disabilities (Hughes, Bellis, Jones et al, 2012; OHCHR, 2012).²¹

In Australia, family violence, including sexual assault by a family member, is the most common form of violence against women. More than half of the country's women have experienced some form of physical or sexual violence in their lifetime and just over a third of women who have ever had an intimate partner report experiencing at least one form of violence during their lifetime from a male partner (Mouzos and Makkai, 2004, p. 2 & p. 65).

Important sources of Australian prevalence data come from two national surveys, the national *Women's Safety Survey* (ABS, 1996) and the *Personal Safety Survey* (ABS, 2006), and the Australian component of the *International Violence Against Women Survey*, conducted in 2002–2003 (Mouzos and Makkai, 2004). The findings from these surveys relate to women's experiences of physical or sexual violence, mostly from a current or previous partner, as summarised in Table 1.

²¹ These estimations are based on mostly high income countries as data from middle and low income countries is lacking (but see Astbury, Walji, 2013, and Spratt, 2013, for Cambodia and Pacific countries).

Table 1: Australian findings on the prevalence of intimate partner violence against women regardless of disability

Author(s)	Methodology and sample	Key Findings
Women's Safety Survey (ABS, 1996)	The survey recorded the prevalence of physical and sexual violence experienced by women (including relationship to perpetrator (male and female), where the violence occurred and injuries sustained) during last 12 months and since the age of 15 in an Australian population representative sample. Conducted in 1996	<ul style="list-style-type: none"> • 23 per cent of Australian women currently in an intimate relationship, or previously in one, had experienced physical or sexual violence from their partner.
Personal Safety Survey (ABS, 2006)	National survey of 16,400 adults in Australia aged 18 and over recorded the data on lifetime experiences of physical or sexual assault since the age of 15 (including current or previous partners, boyfriend/girlfriend or date, other known man or woman and stranger, where the violence occurred and what action was taken for the most recent incident). Conducted in 2006	<ul style="list-style-type: none"> • Approximately one in five women (19 per cent) has experienced sexual violence since the age of 15. • Nearly one in three women (29 per cent) has experienced physical violence since the age of 15. • Nearly one in six women (16 per cent) has experienced violence by a partner or previous partner in their lifetime.
International Violence Against Women Survey (Mouzos, Makkai, 2004)	The Australian component was conducted by the Australian Institute of Criminology and was a national survey of 6,677 women aged 18–69. Conducted in 2002–2003	<ul style="list-style-type: none"> • 34 per cent of Australian women aged between 18 and 69 had experienced some form of violence by a current or previous partner.

But of greater significance for our examination of violence against women with disabilities is the study that measured the impact of intimate partner violence (IPV) on the health of Victorian women (see Table 3), which concluded that '...future research should concentrate on evaluating effective interventions to prevent women being exposed to violence and identifying the most appropriate mental health care for victims to reduce short- and long-term disability' (Vos, Astbury, Piers et al, 2006, p. 739).

Despite this, and despite the concern about the heightened risk of violence for women with disabilities, there is no systematic collection of data in Australia or within the states and territories that enables the determination of the prevalence of violence against women with disabilities (Frohmader, 2011; Healey, Humphreys, Howe et al, 2008). Nor has there been any national scale research into the prevalence of violence against women and girls with disabilities, to date.²²

For reasons discussed below, information about the extent and nature of violence against women with disabilities has to draw on qualitative studies and be extrapolated from quantitative studies that are not always comparable. The current knowledge base has established the following.

1. Most interpersonal violence (including family violence, sexual assault and what we know from qualitative studies about disability-specific violence) is perpetrated by men towards women with disabilities, although we cannot be sure if this dominant gendered pattern exists to the same degree in violence perpetrated against women with disabilities in institutional settings as no large-scale research has included women who are institutionalised.
2. Women with disabilities are at greater risk of experiencing violence compared with both men with disabilities and women without disabilities.
3. Women with intellectual disabilities are at a considerably heightened risk of experiencing sexual assault compared with other women with disabilities.

²² However, a national project, *Stop The Violence Project (STVP)* involving Women With Disabilities Australia, People With Disability Australia and the University of NSW, is currently underway and reiterates the need for standardised data collection across sectors and jurisdictions in its recommendations (see Section 1: Background, the discussion paper for the National Symposium on Violence Against Women and Girls with Disabilities). Women with disabilities have been included in the forthcoming *Personal Safety Survey* to be undertaken by ABS.

There is a lack of robust quantitative data on the extent of violence against women with disabilities globally and nationally. This is due, firstly, to the problem of defining the terms 'disability' and 'violence', which leads to different studies measuring different metrics. For example, some studies look at particular disabilities only, some look at sexual assault, some at sexual and physical assault or IPV. Secondly, in many studies it is hard to identify who the perpetrators are, whether they are non-partner care providers or opportunistic perpetrators of sexual or physical assault. Thirdly, very few studies differentiate between 'violence-induced disability' (occurring in utero, infancy or later) as opposed to the perpetrator choosing to target a woman with a disability and yet we do not collect data in a systematic way that links violence to impacts on pregnancy and infancy, even though there is growing understanding of violence as a cause of disability in children (Baldry, Bratel, Breckenridge, 2006; Olle, 2006).

This 'data gap' has significant implications for the ways in which government policy and funding continues to support the siloed delivery of disability, mental health, family violence and sexual assault services with little shared knowledge of the provisions made for women and children with disabilities.²³ Fourthly, population-based studies that draw on representative samples are difficult to compare because some focus on women with and without disabilities, some on violence against people with disabilities, disaggregating on variables such as gender, race, ethnicity and age, and others compare violence against people with and without disabilities but give no gender disaggregated data. For insights into the diverse circumstances in which violence is perpetrated against women with disabilities, we must often turn to qualitative studies.

There have been a number of significant review studies conducted in recent years that have employed different methodologies that examine research into prevalence, violence and disability (Hughes, Bellis, Jones et al, 2012; Hughes, Lund, Gabrielli, Powers, Curry, 2011; Khalifeh, Howard, Osborn, Moran, Johnson, 2013; Plummer and Findley, 2012). All, in different ways, attempt to address gaps in what can be known about the prevalence²⁴ and risk of violence for adults with disabilities. Not all of the reviews make comparisons by gender, however, this information can be extracted by accessing the studies under review. It is important to note that these studies looked at the extent of violence against non-institutionalised women with disabilities, so we know even less about the extent of violence against women living within institutional settings.

The most significant findings extrapolated in relation to women with disabilities are summarised in Tables 2 and 3.

²³ It should be noted that the Victorian Government's integrated family violence and sexual assault reforms initiated from 2004 have gone some way to improving coordinated responses to victims of family violence and sexual assault by developing better links with disability and mental health policies and services.

²⁴ Prevalence refers to the estimated measurement of the extent of victimisation experienced within the community and is defined as the number of people in the relevant population who have experienced violence at least once within a specific time period (ABS, 2013, p. 13).

Table 2: Findings from international studies on the extent of violence against women with disabilities

Author(s)	Methodology and sample	Key Findings
Hughes, Lund, Gabrielli et al, 2011	Review of empirical literature reported in 22 studies conducted in the US and Canada relating to IPV for WWD ²⁵ living in the community.	<p>Prevalence of any type of IPV for WWD ranged from:</p> <ul style="list-style-type: none"> • 26 per cent to 90 per cent for lifetime • 4.9 per cent to 29.1 per cent over the past five years • 2 per cent to seven per cent over the past year.
Khalifeh, Howard, Osborn, Moran, Johnson, 2013	Analysis of 2009–2010 British Crime Survey data of 44,398 adults living in private residences, of whom 1,256 (2.4 per cent) had one or more disabilities (excluding mental ill health) and 7,781 (13.9 per cent) had one or more disabilities, including mental ill health.	<ul style="list-style-type: none"> • PWD at increased risk of experiencing interpersonal violence and of experiencing mental ill health problems compared to those without disabilities. • Approximately 80 per cent of violence perpetrated by men; 10 per cent by women; 10 per cent by women and men. • Regardless of disability, men were more likely to be victims of physical and non-domestic violence (53 per cent and 58 per cent of victims, respectively), but women were more likely to be victims of sexual and domestic violence (83 per cent and 71 per cent of victims, respectively). • Sexual and domestic violence was more prevalent than other forms of violence for women regardless of disability.
Plummer, Findley, 2012	An American literature review of 24 studies on physical and sexual violence against women with acquired (not congenital) disabilities.	<ul style="list-style-type: none"> • WWD experienced abuse (including disability-related violence and sexual assault) at the same rate or at higher rates of abuse than women without disabilities.

25 WWD stands for women with disabilities and PWD stands for people with disabilities.

		<ul style="list-style-type: none"> • WWD were abused for longer periods of time by a broader range of perpetrators, compared to women without disabilities. • WWD experienced disability-specific forms of violence. • Risk factors contributing to violence were: isolation, abuse by multiple potential perpetrators, dependency as a result of a disability, difficulties in identifying disability-related abuse and cultural or societal barriers.
Martin, Ray, Sotres-Alvarez et al, 2006	A population-based, representative sample of 5,694 non-institutionalised adult women from North Carolina based on a random digit dial household telephone survey in 2000 and 2001.	<ul style="list-style-type: none"> • WWD were more than four times as likely to have experienced sexual assault in the past year compared to women without disabilities, though not significantly more likely to have experienced physical assault in the past year.
Casteel, Martin, Smith et al, 2008	America's first comparative dataset analysis of data from a 1995–1996 survey of 6,237 non-institutionalised women, of whom just less than five per cent (n=280) had severely limiting impairments and 15.7 per cent (n=985) had moderately limiting impairments.	<ul style="list-style-type: none"> • Less than four per cent (n=218) reported a physical-only assault and less than one per cent (n=37) reported being sexually assaulted in the year before the survey interview. • Women reporting severe activity limitations were four times more likely to be sexually assaulted in the year before the survey.
Brownridge, 2006, 2009	A Canadian national, representative population sample of 7,027 heterosexual women living in intimate relationships. WWD were defined broadly. This study also tested an explanatory framework for risk based on relationship factors, victim-related characteristics and perpetrator characteristics.	<ul style="list-style-type: none"> • This study found that WWD had a 40 per cent greater risk of experiencing violence at the five-year point than women without disabilities, which rose to an 85 per cent likelihood at the 10-year point. • Perpetrator characteristics alone accounted for the elevated risk of IPV against women with disabilities.

While the studies summarised above used different criteria in determining disability status, violence, perpetrators and time frames they consistently concluded that women with disabilities are at greater risk of violence than women without disabilities and that women with particular impairments (variously identified as intellectual, mental ill health or as severely limiting) are at greater risk of sexual assault, in particular. They also consistently urged for more robust data collection and consideration of risks for different sectors of service provision.

Further, Brownridge's finding that perpetrator characteristics alone accounted for an elevated risk of targeting of women with disabilities suggests that perpetrators' use of coercive control (such as controlling access to medication, mobility and external supports) and violence is fuelled by compounding disablist and sexist views (Brownridge, 2009). This leads the perpetrators to seek out partners they view as submissive or deserving of abuse because of their disability (Brownridge, 2009; Copel, 2006; Healey et al, 2013).

Australian and Victorian data

There is no consistent and inclusive national data available on the intersection of gender, disability and violence that enables reliable ongoing trend analysis into prevalence rates, for either family violence or sexual assault (Murray and Powell, 2008; Frohmader 2011). The Australian Bureau of Statistics (ABS) has no standard national data collection recording the experiences of violence among adults with disabilities although it has been working on this issue (ABS, 2013).

Table 3: Findings from Australian studies on the extent of violence against women with disabilities

Author(s)	Methodology and sample	Key Findings
Vos, Astbury, Piers et al, 2006	Using burden of disease methodology, this study calculated population attributable fractions from prevalence survey data on exposure to IPV and survey data on IPV health consequences in Australia to estimate the health risks of IPV among women in Victoria.	<ul style="list-style-type: none">IPV is the leading preventable contributor to death, disability and illness in Victorian women aged 18–44 years of age and was a larger risk to health than well-known risk factors traditionally included in burden of disease studies (such as high blood pressure, smoking and obesity).

Cockram, 2003	<p>Survey of Western Australian agencies from which 709 WWD who had sought assistance in the two years preceding the survey had experienced domestic violence (the largest study of violence against WWD in Australia).</p>	<ul style="list-style-type: none"> • 38 per cent (n=270) had disabilities that were a consequence of family violence. • 72 per cent (n=513) experienced emotional violence. • 58 per cent (n=395) experienced controlling behaviours involving restricting access to friends and family and removing or controlling communication aids. • 55 per cent (n=360) experienced sexual violence. • 50 per cent (n=355) experienced physical violence. • 39 per cent (n=274) experienced stalking. • 32 per cent (n=230) experienced threats to third parties, such as children. • 29 per cent (n=204) experienced threats to withdraw care. • 27 per cent (n=190) experienced discriminatory practices related to their disability, which included withholding or forcing medication, removing or disabling a wheelchair or criticisms targeting their disability. • 9 per cent (n=70) experienced spiritual deprivation.
Heenan, Murray, 2006	<p>A study of 850 rapes reported to Victoria Police from 2000 to 2003 drawn from analysis of the Victoria Police Law Enforcement and Assistance Program (LEAP) database.</p>	<ul style="list-style-type: none"> • In 26 per cent of cases, victims had a disability, predominantly psychiatric or intellectual, and were found to be among the least likely cases to result in charges being laid against the offender and twice as likely to be determined as false. (This in the context of only 15 per cent of the reported rapes examined leading to offenders being charged and with more than 60 per cent of investigations not being pursued by police.)

It is worth pointing out that the present sources of Victorian data relating to family violence and gender do not permit measurement of the prevalence of family violence in the community. While there has been an 82 per cent increase in the number of family violence incidents reported to Victoria Police across the 11 years of police data (1999–2000 to 2009–2010), this is a reflection of increased reporting rather than an increase in incidents (Diemer, 2012).

As the family violence trend analysis report states, there are some limited sources of information that link disability (of victims and perpetrators), violence and gender. For example, the Victorian Supported Accommodation Assistance Program (SAAP)²⁶ collected information from family violence clients seeking support from SAAP-funded agencies. The most consistent measurement of disability among these clients was based on receiving a disability support pension. However, the criteria for eligibility was narrowly defined and would therefore exclude a majority of women with disabilities and in doing so, bias the sample to represent those with more severe disabilities (Diemer, 2012).

Further, neither the Victorian Magistrates' and Children's Courts nor Victoria's public hospital emergency departments (VEMD) routinely collect data in relation to the co-occurrence of disability and family violence. Police may collect data on victim and perpetrator disabilities if the latter is evident or disclosed and VEMD would record a disability in case notes if relevant to the medical history or nature of the injury, particularly in the case of psychiatric-related problems. Such medical information, however, cannot be used for public reporting on disability and, in any case, would only provide a snapshot of patients presenting with health-related disabilities only (Diemer, 2012).

Key findings from the latest trend analysis report indicate that the demographics of SAAP family violence clients with a disability have remained fairly constant over the last 11 years and they are somewhat older and less likely to have children accompanying them into services as compared with women without disabilities. Police data indicates increased identification of victims with a disability, as one might expect as police become more confident in responding to family violence incidents following the introduction of a *Code of Practice for the Investigation of Family Violence Incidents* in 2005. Finally, Victoria Legal Aid's collection of information from family violence clients revealed a significant rise in disclosures of disability when staff are trained or encouraged to ask about the presence of impairments. This was illustrated by a rise from two per cent to three per cent of clients in the years prior to 2009–2010, to 10 per cent disclosure among clients in 2010–2011 (Diemer, 2012).

²⁶ The national Specialist Homelessness Services collection, including the homelessness database, Specialist Homelessness Information Platform (SHIP), has now replaced SAAP and will record core activity limitations in relation to self-care, mobility and communication based on questions used by the ABS to identify disability in a range of surveys.

Challenges in collecting data on violence against women with disabilities

Limitations into researching violence against women with disabilities need to be placed within the broader context of the challenge of collecting statistical information about the problem of family violence and sexual assault more generally. There is a lack of consistent data collection on violence against women and children across all states and territories and national jurisdictions in Australia. The Australian Bureau of Statistics (ABS) recently published a conceptual data framework that outlines the background and policy context in relation to family, domestic and sexual violence and describes the challenges and complexities involved in their statistical measurement (ABS, 2013).

Issues making it difficult to estimate incidence and prevalence of family, domestic and sexual violence include:

- under-reporting of crimes to police and other authorities
- under-recording due to procedural variations in recording incidents by authorities and services
- hidden reporting where a victim seeks services but does not disclose family, domestic or sexual violence as the reason for the contact
- different recording rules across the country's states and territories
- fear of asking questions about sensitive and personal issues (ABS, 2013; Diemer, 2012; Heenan, Astbury, cited in VicHealth, 2004).

Under-reporting is more likely to occur when women with disabilities live in institutional settings, supported residential units or in rural and remote communities; have poor telecommunication access or face communication barriers owing to disability, race or ethnicity; or, as an Aboriginal or Torres Strait Islander or asylum seeker, where reporting to an authority never represents a route to safety; or where women with disabilities lack a stable home (Commonwealth of Australia, 2009; see also Fitzsimons, Hagemeister, Braun, 2011).

It is not uncommon for ethical and technical challenges to stall and thus exclude women with communication limitations or cognitive impairments where communication requires third party assistance (Halse and Honey, 2005; Nosek, Howland, Hughes, 2001). A further contributor to under-reporting is the reluctance of some police to take statements from women with cognitive disabilities who report violence, believing the women with cognitive disabilities will not be seen as credible witnesses in court (Camilleri, 2009).

The nature of violence against women with disabilities

Women with disabilities experience many kinds of violence that are the same as those experienced by women without disabilities, but there are also many kinds of violence that are specific to women with disabilities. Behaviours and relationships are two integral features that are considered when defining family, domestic and sexual violence and are discussed below (ABS, 2013).

We must also consider the settings in which women with disabilities experienced violence, particularly given that so little is known about the incidences of violence against women (and men) with disabilities living in, or moving between, diverse institutional settings. These settings include not only disability residences and services providing day care activities, but also aged care facilities, detention centres, prisons and correctional services and psychiatric inpatient units (for example, see Clark and Fileborn, 2011). The isolation of women may be further deepened depending on their cultural background, sexual identity, age, status as citizens and geographic location.

Disability-specific behaviours of violence

Table 4 illustrates disability-specific violence and cites studies that discuss these forms of violent behaviours.

Table 4: Studies that discuss perpetrators' use of violence specific to women with disabilities

Physical violence Dillon, 2010 Hague, Thiara, Mullender, 2011b Healey et al, 2008 Oktay, Tompkins, 2004 Saxton, Curry, Powers et al, 2003 WWDA, 2007	<ul style="list-style-type: none">• administration of poisonous substances• administration of inappropriate medication• withholding food, water or heat• rough handling when undertaking care work• use of physical or chemical restraints• withholding equipment, medications or transportation• refusal to provide assistance with essential daily care• confinement• alteration, destruction or use of assistive equipment• neglect, abandonment and deprivation – often cumulative.
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<p>Sexual violence</p> <p>Bedson, 2012</p> <p>Brown, 2003</p> <p>Clark, Fileborn, 2011</p> <p>Dillon, 2010</p> <p>Hague et al, 2008</p> <p>Healey et al, 2008</p> <p>Murray, Powell, 2008</p>	<ul style="list-style-type: none"> • sexual activity demanded or expected in return for care • taking advantage of physical impairment and inaccessible environment to force sexual activity • sexual assault under the pretence of 'sex education' • being left naked or exposed • denial of sexuality.
<p>Emotional and psychological violence (abuse, neglect, discrimination)</p> <p>Hague, Thiara, Mullender, 2011a</p> <p>Healey et al, 2008</p> <p>Reichard, Langlois et al, 2007</p>	<ul style="list-style-type: none"> • denial of impairments • withholding or altering aids or assistive equipment • threats to withdraw care or services • ignoring requests for assistance • threats of punishment or abandonment • threats to institutionalise • denial of rights • violations of privacy • restricting access to services • being angry when 'gratitude' is not expressed for care provided • neglect, abandonment and deprivation – often cumulative.
<p>Economic abuse</p> <p>Brown, 2003</p> <p>Curry, Renker, Hughes et al, 2009</p> <p>Thiara, Hague, Mullender, 2011</p>	<ul style="list-style-type: none"> • controlling use of funds for impairment-related needs • theft of disability-related payments • bank fraud • abuse of enduring Power of Attorney • structural problems in the benefits system.

Reproductive violence and abuse Brown, 2003 Healey et al, 2008 Murray & Powell, 2008 Tilley, Walmsley, Earle, Atkinson, 2012 Ortoleva, Lewis, 2012 Zampas, Lamackova, 2011	<ul style="list-style-type: none"> • controlling menstruation by sterilisation • controlling termination of pregnancy (particularly women and girls with intellectual disabilities) • denial of sex education • denial of appropriate reproductive health care.
Disability 'hate crime' Oschwald, Curry, Hughes et al, 2011 Roulstone, Thomas, Balderston, 2011 Salthouse, 2007 Sherry, 2010, cited in VicHealth 2012 Sin, Hedges et al, 2009	<ul style="list-style-type: none"> • hostility expressed as antisocial behaviour (theft, property damage, bullying or cyber bullying) • criminal assault or other act against a person viewed as less than human owing to a perceived or actual impairment • infanticide (particularly of girls with disabilities).

It should also be pointed out that many of the kinds of violence that are common to all women take on added power for women with disabilities, particularly Indigenous women and those without permanent residency, which make disclosure even more unlikely.

Relationships

The range of relationships within which violence is perpetrated against women with disabilities extends well beyond those that are typically regarded as pertaining to women without disabilities. Although intimate male partners of women with disabilities are the most common perpetrators (Cockram, 2003; Martin, Ray, Sotres-Alvarez et al, 2006; Milberger, Israel, LeRoy, Martin et al, 2003; Smith, 2008), personal assistants working in both institutional and private residential settings are a significant perpetrator group (Cambridge, Beadle-Brown, Milne, Mansell, Whelton, 2006; Hague, Thiara, Magowan, Mullender, 2009; Hague, Thiara, Mullender, 2011b; Oktay and Tompkins, 2004; Saxton, Curry, Powers, Eckels, Gross, 2001; Sobsey, 1994). Women with disabilities are also at risk of experiencing violence by other support staff, service providers, medical and transportation staff and taxi drivers, peers and male residents of a shared residential home (Frantz, Carey, Bryen, 2006; Sobsey, 2000).

Settings

The relationships and the settings in which violence against people with disabilities occurs are varied and complex. Settings in which violence is perpetrated range from hate and other crimes in the community to institutional practices of violence (including unethical, unauthorised and unprofessional practices) in service and institutional settings (some of which are carried out under the authority of the state) and family violence and other practices within the privacy of a person's home (Ortoleva and Lewis, 2012).

These settings are supported by systemic violence, constituted by discriminatory practices towards people with disabilities that restrict equal access to mainstream services and public resources (Brown, 2011; Cambridge, 1999; Clark and Fileborn, 2011; Fitzsimmons, 2009; Ortoleva and Lewis, 2012). Australian researchers have noted that responses to violence in institutional settings for people with disabilities are often driven by procedural and managerial imperatives and fail to understand the broader issues of "culture, environment and the impact of funding rules and regimes" (Robinson and Chenoweth, 2011, p. 65).

Section 4: Barriers to services for assistance for violence

Women with disabilities do not have access to the resources or services that are necessary for them to be free of violence. To a large extent these barriers stem from society's disabling environments – human rights, legislative and policy failures that do not permit equitable access to work, education, secure housing or the built environment for people with disabilities – that result in poverty and isolation. This means that many women with disabilities do not have the personal resources to protect themselves or escape from violence. Further, as we have seen, the community or institutional environments in which they live do not provide sufficient protections. Barriers also arise from limited integration between the service sectors that could potentially provide assistance and from their failure to be culturally and physically accessible to women with disabilities.

Fears of reprisal, not being believed, trivialisation of violence and abuse, feelings of shame and secrecy and social and economic dependence on a partner or care provider, in the case of women with disabilities, are common barriers to disclosure that many women who experience violence share. There are also many different situations and ways in which women with disabilities experience violence due to the perceptions about their identities not only in terms of impairment, but also race, ethnicity, residency status, sexuality, age and socioeconomic status. Added to this is the question of where women with disabilities are living, whether they are in the community, a rural or metropolitan area or in institutions and, if the latter, whether it is a residential disability or aged care home, a prison, detention centre or psychiatric unit.

The diversity of these lived experiences adds to the complexity of how women with disabilities experience the potential barriers in seeking assistance for violence. This also impacts in how professionals in justice and human service institutions and the systems within which they operate work. The very reasons why women with disabilities are targeted by perpetrators are also the reasons why they cannot access services, thereby perpetuating a vicious cycle. For example, perpetrators may perceive women with disabilities as easy targets because of stereotypes and low rates of detection or because it is easier to isolate women with disabilities in the privacy of their homes when they are dependent on them for assistance (Brownridge, 2009; Copel, 2006; Oktay and Tompkins, 2004; Sobsey, 1994).

The following summarises the barriers to services for women with disabilities who have experienced violence. It uses case studies collected by the organisations researching and supporting the Voices Against Violence Research Project in order to highlight the complexities of the barriers that women with disabilities face when seeking assistance.

Community understanding of disability

Stereotypes of disability continue to inform societal practices that discriminate, devalue and marginalise people with disabilities, aimed (as a psychoanalytical approach would argue) at distancing those with disabilities from those without (Chouinard, 2012; Mays, 2006). These stereotypes interact with other systems of exclusion and domination: sexism, racism, homophobia, classism and so on (see, for example, Cramer and Plummer, 2009). A number of studies into the criminal justice services, for example, indicate that crimes against women with disabilities have been inadequately investigated, remain unsolved or perpetrators are given minimal sentences. Part of this is due to negative attitudes about disability that are endemic to our society, including the view that women with cognitive disabilities have a propensity to lie, are sexually promiscuous or are unreliable witnesses because they have poor memory recall or are highly suggestible (Camilleri, 2009; French, 2007; Goodfellow and Camilleri, 2003; Victorian Law Reform Commission [VLRC], 2004).

The belief that women with disabilities are dependent on others for every aspect of their life is a fallacy for the majority, yet in different ways the most basic human rights to live meaningful, autonomous lives are thwarted by a social and built environment that is designed to put obstacle upon obstacle in the way.

An Indigenous woman was not believed by her case manager when she disclosed that her partner was abusive towards her. The perpetrator always presented with a caring persona and was able to say 'the right things' to the right people. In this way, he was using the woman's disability against her as it was her disability that enabled him to be a care provider. By being able to present himself in a credible way to people in a position of influence, the perpetrator became even more powerful in the relationship. His story was viewed as more plausible than hers and this undermined her ability to exert influence on the relationship' (WWDA and WDV, 2011, p. 10).

Community understanding of violence against women with disabilities

The *National Survey on Community Attitudes to Violence Against Women 2009*²⁷ indicates there is poor community understanding of the nature, impact and greater risk of experiencing violence for women with disabilities and little awareness of the barriers to disclosing violence (VicHealth, 2009). When community attitudes trivialise violence or shift blame to the victim, it undermines efforts to prevent violence, including protecting victim–survivors and holding perpetrators to account (Flood and Pease, 2006). It also influences women's responses to violence resulting in the internalisation of oppression, which makes it even more difficult for women with disabilities to speak out about violence. Should they be able to do so, they are often not believed (Chenoweth, 1996; Murray and Powell, 2008; Sobsey, 1994; VLRC, 2004; WWDA, 2007b).

²⁷ This survey, which may include some new disability data or comparative analysis on views on violence against women with disabilities across the two surveys, is currently being re-run by VicHealth. Findings will not be publicly available until 2014.

Lack of education and information on violence for women with disabilities

Services continue to avoid providing education to young people with disabilities about relationships and recognising inappropriate and violent behaviour. Families are often reluctant to acknowledge that their children may want intimate relationships and therefore are wary of providing opportunities or education in this regard. Women with disabilities, particularly those with intellectual impairment, may not understand that what has happened to them is violence. Some may lack the language skills needed to describe violence, particularly when it has been perpetrated by a care provider who is a family member or a friend and particularly where, as children, they have been exposed to sexual and physical violence and denied any education or information about sexuality and what constitutes safe and healthy, intimate and non-intimate relationships (Price-Kelly, Attard, 2010; Chenoweth, 1996; Copel, 2006; Frawley, 2012, 2013; Hassouneh-Phillips and Curry, 2002; Healey et al, 2008; Jennings, 2003; Salthouse and Frohmader, 2004; Saxton et al, 2001; WDA, 2007b).

The experiences of Jane²⁸ are a sad illustration of a young woman with an intellectual disability who has experienced ongoing sexual and physical violence by her father and others since childhood and continues to be exposed to commercial sexual exploitation. The reports of the Guardian at the Office of the Public Advocate indicate that Jane's way of relating to men, particularly older men, has so internalised the sexualised 'relationships' of the past that this is the habitual way in which she has learnt to have 'friends', by 'pleasing them'. Jane's mother, also with an intellectual disability and sexually abused from childhood, was in no position to teach her daughter about how to protect herself. The Guardian at the Office of the Public Advocate sees a need for Jane to learn about healthy, safe relationships but fears that, despite relocation, the opportunity will not be available (Dillon, 2010, p. 15–16).

Access barriers to other violence response services

Access barriers to services can be summarised as twofold. Firstly, they can be physical, limiting the ability to get into buildings, use transport or find information in accessible formats, as outlined below. Secondly, they can be programmatic, as in the sense of an agency lacking a service philosophy that considers the needs of women with disabilities when planning and developing its services. Overcoming access barriers thus requires government infrastructure resources, regulatory frameworks, workforce development as well as cross-sector collaboration between the disability, mental health, family violence and sexual assault services (Frantz, Carey, Bryen, 2006; Healey, Humphreys, Howe, 2013; Rose, Trevillion, Woodall et al, 2011). It means the restructuring of budgets over the long term in order to work towards securing universal accessibility to services and for agencies to become proactive in supporting women with disabilities (Healey, Humphreys, Howe, 2013; McLain, 2011).

28 Personal names in the cases outlined have been changed to protect women's privacy.

A Family Violence Court Applicant Support Worker (ASW) provided the following two cases. The first illustrates the vital work of the ASW and the burdens placed on this single role within the small number of Family Violence Courts Programs and Family Violence Specialist Services that exist across Victoria.²⁹ Both cases highlight the inaccessibility of courts in terms of building design and legal language (improvements in these would assist all people regardless of ability) and provide insights into the serious gaps in providing equitable access to justice and other responses.

Daisy's experiences

Daisy identifies as having an intellectual disability and a learning delay. She lives with her partner Dan. Neighbours called the police when they heard distressing noises coming from Daisy and Dan's house. Police visited and found Daisy had been seriously assaulted. She had been choked and her arm was broken. Police took out an interim intervention order on her behalf. The order was to exclude Dan from the home for several days and to prohibit him coming near Daisy. Police explained to Daisy that the order meant "You two can't speak to each other until you go to court", which Daisy took literally and didn't speak to Dan. It had not been explained to her that Dan was excluded from the house, so they continued living together.

Another serious assault occurred, leaving significant bruising on Daisy's arms. This was not reported to police. These breaches of the intervention order are criminal offences, but it appears that Daisy did not have the information required to access her right to protection. [It is also unclear how effectively Dan was warned of the implications of breaching the order.]

Dan and Daisy travelled to court together for the intervention order review date. Dan was happy to organise everything as he was keen to get the order finished and behind him.

At court, Daisy was referred to the...ASW. The ASW couldn't help but notice that Daisy was terrified to be in court, she thought she was getting in trouble. Daisy had no legal representation. The Police Prosecutor who was on duty applied for an intervention order on Daisy's behalf. In this instance, the ASW was able to accompany her into court.

²⁹ The Family Violence Court Division is a division of the Magistrates Court of Victoria and operates at Heidelberg and Ballarat Courts. The Specialist Family Violence Service operates at Melbourne, Frankston, Sunshine and Werribee Magistrates Courts. Only these six courts have AWSs.

Daisy had no understanding of court proceedings and did not know when she was being addressed. She had a panic attack and became frozen. The Magistrate had a reasonable understanding of the family violence risks Daisy faced and served... [an intervention order with limited conditions]. This meant, while they would continue living together, Dan was prohibited from using violence against Daisy.

Overall, the ASW was able to spend 40 minutes with Daisy. There were no services in place to do any ongoing work with Daisy (WDV, 2013: p7).

This story illustrates the importance of adequate information being provided by police at the time of making the order and of the importance of adequately resourcing court staff to provide the level of support required and ongoing assistance required for Daisy to be safe.

Alia's experiences

Alia arrived at court to... [apply for] an intervention order because her partner was abusive. She waited in the queue for the Registrar. When she got to the front of the queue the counter was high above the height of her mobility scooter. The Registrar could not understand Alia's stroke affected voice and referred her to the ASW. Alia explained how her partner would hide her scooter battery and put important things out of her reach. He was increasingly pushing her out of her scooter. The court's lift was too small to fit Alia's scooter. Alia returned to court with a smaller, borrowed manual wheelchair and, because the chair required pushing, a disability support worker accompanied her. The only available floor space in the courtroom was in front of the door. She waited for her case to be heard as the door swung back and forwards into her and people stepped over her. The witness box was not accessible, so Alia spoke from the floor (WDV, 2013, p. 8).

This second case illustrates how several access barriers undermined Alia's communication with the court. The ASW reported that the hearing was "typically rushed" and observed that the community legal service lawyer had no training or experience working with clients with communication impairments. (WDV, 2013, p. 8).

Lack of safe accommodation options

The majority of women with disabilities live in their own homes within the community, but if they are unable to stay safely in their home they need to have physical access to refuges or temporary accommodation. They also need to know that they can have their personal needs met, regardless of whether that involves having their own wheelchair or other assistive devices, assistant dog or personal care provider with them.

Most Victorian crisis refuges and transitional accommodation are not built according to universal design standards and thus are not accessible to women who use assistive equipment. Women have spoken of being very fearful of the unfamiliar surroundings that they would have to share with others, particularly if they have physical, vision and cognitive impairments or mental ill health, and where other residents and staff may not be very understanding and where there may be little privacy or access to quiet areas (see the case of Fran in Healey et al, 2008).

Women with disabilities who have children with disabilities, particularly children with cognitive disabilities, greatly fear the prospect of leaving the familiarity of their home, particularly if modifications have been made to meet their disability needs (Baldry, Bratel, Breckenridge, 2006; Breckenridge, Mulroney, 2007; Healey et al, 2008). Women have spoken of having to move into new housing due to long delays before home modifications are made (see the case of Jane in Healey, et al, 2008). And, while Victoria has had a 'safe at home' family violence policy in place since the mid-2000s, this requires police and courts to be able to respond promptly and effectively to breaches of intervention orders that exclude perpetrators from the home.

Lack of transport options

Women with disabilities have fewer transport options because of their impairments or because of living on low incomes, which make it difficult for them to seek assistance or flee from violent situations (Chang, Martin, Moracco et al, 2003; Swedlund and Nosek, 2000). This is further compounded if they are living in geographically isolated areas such as on rural properties or in areas where there are few public transport options (see the case of Jane in Healey et al, 2008).

Barriers to communication, language and information

There is a significant need for family violence and sexual assault service information to be more widely available, for it to cater to individuals' diverse information needs and for it to be available in safe, public places that women are likely to attend. To be inclusive of women with diverse disabilities (and many other women at a time of great stress), information needs to be available in Easy English and culturally accessible (Lightfoot and Williams, 2009). It also needs to be available in a range of formats, including Braille for women who are vision impaired, a communication assistant for women with speech impairments and access to Auslan interpreters and a telephone typewriter for women who are hearing impaired (Frantz et al, 2006; Healey, Humphreys, Howe, 2013; Jennings, 2004; WWDA, 2007b).

Email is an increasingly important way for many isolated women with different impairments to gain safe access to information. Hearing impaired women have noted reservations about using the access relay services where confidentiality is not assured, with operators listening in, or accessing sign language interpreters when they live in small communities (Anderson, Leigh, Samar, 2011). Communication with women with intellectual and cognitive impairments needs to be provided in such a way that women are not bombarded with information that they do not understand. It may be better to convey information over a number of short sessions and provide a time for women to discuss what they have understood.

This is an abbreviated version of a letter by Caroline's social worker, which highlights, among other things, the problem of what is legally acceptable as evidence in the context of communication impairments.

Caroline has cerebral palsy, [does not speak, uses a wheelchair and is] totally dependent on carers for all personal and daily living activities. Cognitively very aware, she depends on assisted communication to enable her to communicate. When I first met Caroline she was attending a mainstream high school and looking forward to completing her schooling and going on to further education.

Caroline lives with her mother, who is also her primary carer. Upon her arrival at school Caroline would be met by her Integration Aid and would then complete each school day in the school's special education unit.

At 18, Caroline embarked upon her VCE studies with much anticipation and excitement, but... this was very short lived. Within a few days of the commencement of her year 11 studies, Caroline was sexually assaulted by the taxi driver who picked her up from home and drove her to school. Having collected her from home, he raped her and then drove her to school. On arrival at school her Integration Aid went to assist her out of the taxi and found Caroline in a dishevelled and extremely distressed state.

One can only assume that the taxi driver must have thought that being non-verbal, Caroline would not be able to pursue the matter, but pursue it she did. The incident was reported to police and an investigation began. Caroline was required to provide evidence... Caroline uses a communication book... but her communication book did not have the vocabulary she needed to describe what had happened to her... such as 'penis' or 'rape', and the police would not allow these words to be added after the incident because as the police explained, in court this would be seen to be leading the witness. The police even advised her mother, school staff and me not to talk to Caroline about what had happened to her because the defence would again be able to assert that the witness had been led...

Deeply traumatised by the assault, Caroline struggled to give voice to the degradation of the assault and the terror that she now lived with. It is hard to imagine what it must have been like for this young woman, unable to defend herself physically at the time of the assault, unable to communicate what had happened to her afterwards and then on top of all that, unable to even be given the support she needed in order to find the words that would enable her to give evidence.

If this had happened to someone unable to speak English they would automatically have been provided with an interpreter. They would also have been able to seek support and comfort from those they trusted and from those mainstream services that have been set up for this purpose. Instead Caroline was deprived of the advocacy and support she had a right to. The justice system not only failed her, it actively discriminated against her because she has a disability and because, unlike you or me, she cannot talk.

Despite Caroline's extraordinary efforts the police were unable to lay charges due to insufficient evidence... there was no process in place that allowed for the sort of assistance and support that Caroline needed in order to give evidence in a manner that met the requirements of the legal system.

Two years on, Caroline still suffers the repercussions of Post-traumatic Stress Disorder as a result of her sexual assault... (Kelly, Nicholson, de Kretser, 2012, pp. 9–10).

Were the diverse information and communication needs of women with disabilities embedded in an organisation's inclusive policy and practised, this would bring them into line with relevant anti-discrimination disability legislation. This includes the *Disability Discrimination Act 1992* (Cth), the *Disability Act 2006* (Vic), and the *Victorian Charter of Human Rights and Responsibilities Act 2006* and our United Nations human rights obligations to several conventions and declarations.

Barriers to cross-sector collaboration

Programmatic accessibility requires workforce development and collaboration between agencies in order for staff, agency and institutional philosophies to change their attitudes and to endorse and enact a social model of disability that supports the autonomy of, and equality for, women with disabilities. The disability, mental health, family violence and sexual assault services are still in the early stages of developing sustainable partnerships that will enable them to provide violence prevention initiatives and interventions that respond effectively and ethically to women with disabilities who experience violence.

Building collaborative partnerships takes time and diplomacy because services can be protective about their knowledge, resist learning from different paradigms about gender, disability and violence and seek to protect or control the status quo in their respective sectors; for example, disability and mental health services have a great need for regular embedded training on family violence and sexual assault and family violence and sexual assault services have a great need for similarly embedded training on disability (Healey et al, 2008; McLain, 2011). In part, this requires the development of standards that address preventing and responding to violence across all human services and the justice sector.

For example, while gendered understandings of violence and abuse have been the focus of mental health service initiatives in recent years (see DHS, 2006; and Department of Health, 2011) and violence against women and children is incorporated into the new integrated human services model, Services Connect (see DHS, 2013), these will need to be translated into the new standards for DHS services. Currently, there is no explicit identification of sexual assault and no recognition of the gender-based understanding of violence or of the higher risks for women and girls with disabilities of experiencing family violence and sexual assault in the present standards policy and evidence guide for human services.³⁰ Further, the women's health service, Women's Health West (WHW), found that the only form of violence that is addressed in assessment tools used in the disability sector relates to the client's use of violence against others (WHW, 2013).

³⁰ The 2013 Department of Human Services *Standards Policy* refers to the 'right to be free from abuse, neglect, violence and preventable injury' in the standard for 'well-being' (DHS, 2013) and while family violence is named in the *Department of Human Services Standards Evidence Guide*, sexual assault is not mentioned (DHS, 2011b). Documents available at: www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/department-of-human-services-standards.

Kelly's experiences, brought to light by Community Visitors from the OPA, are illustrative of an agency's failure to engage in cross-sector work in order to respond effectively to Kelly's allegations of sexual harassment.

In 2009, a young woman residing at an SRS [Supported Residential Service] in the southern region was referred by her Community Mental Health Service case manager to a Community Care Unit (CCU) for a four-week assessment.

On the first day that she was at the CCU, Kelly telephoned her SRS manager at 4pm and begged him to let her come back to the SRS. She told him that she was being sexually harassed. She was distressed and said that none of the staff at the CCU would help her. She tried to call the SRS again an hour later but could not get through to the manager.

Late that evening Kelly returned to the SRS by taxi. According to the SRS manager, she was in an extremely distressed state, confused and afraid [that] 'the man' would get her. The SRS manager calmed her down and her roommate took her to bed at around 1am. The next morning Kelly's case manager telephoned and asked Kelly to return to the CCU. Kelly was still very distressed and refused to return.

Kelly's case manager visited her two days after the alleged harassment.

Community Visitors were told what had happened a week later by the SRS manager when they visited the facility. Community Visitors made a 'notification for investigation' to DHS. The authorised officer's investigation outcome summary shows that they referred the sexual harassment allegations and the 'lack of responsiveness' by Kelly's case manager to the relevant Community Mental Health Service (Bedson, 2012: 10).

As Bedson notes, the SRS manager's response to the allegations was 'inadequate' (Bedson, 2012: 11). Aside from following DHS administrative protocols, no attempt was made to ensure that the allegations were responded to by involving the police, Kelly's case manager or a sexual assault support agency and no report was forthcoming on the outcomes of the complaints that Community Visitors took to the regulator on Kelly's behalf.

Reluctance and fears of women with disabilities to disclose

Women with disabilities are often reluctant to disclose that they are the targets of violence and abuse due to a number of legitimate fears. These fears may be the result of many barriers, but most particularly are the result of the lived experience as women with disabilities in a social and built environment that endlessly reinforces their marginalisation and denies their basic human rights to live, be meaningfully employed, be educated, have somewhere safe and secure to live and have safe relationships. Reluctance to disclose is thus both an outcome of the other barriers and a barrier itself.

These fears may include a general fear of authority figures for women with specific disabilities, such as mental ill health, intellectual or communication impairments, or be the result of years of emotional and psychological abuse by perpetrators who targeted their disability, intelligence and other core aspects of their identity.

Those who are mothers fear losing their children. Removal or threats to remove children from mothers are not unique to women with disabilities. Indigenous women and others (with or without disabilities) who live in fear of manipulative allegations from perpetrators or who have experienced the forced removal of children by statutory agencies have also experienced this (Hague, Thiara, Mullender, 2011a; Healey et al, 2008).³¹ But mothers with disabilities, in this project and others, have spoken of their partners colluding with other family members or statutory authorities, which has resulted in the removal of their child or children (Hague, Thiara, Magowan, Mullender, 2008).

³¹ See Victoria's Public Advocate Colleen Pearce's critique of the discrimination against parents with a disability following the removal of a child from her young mother with a disability in December 2012: www.theage.com.au/federal-politics/political-opinion/disability-no-bar-to-good-parenting-20121214-2bf75.html.

Fran has an intellectual disability, as does her son. They have both experienced 17 years of violence and abuse from the son's father, which started from the time they married, a marriage that Fran described as "being treated like a personal whore and a slave... [and being] tricked into" (Healey et al, 2008, p. 115).

Throughout her [teenage] son's life... Fran... felt her capacity to mother... [was always being] called into question. When he was a few months old, she became very ill and was hospitalised for some time, during which time the boy's father was neglectful and physically abusive on one occasion [to the son]. As a result, family services and child protection removed the son to a foster home for three months. Fran was unable to see her son and felt the unfairness of this, felt that he had been 'kidnapped'. Once her health improved she was able, with the help of family services, to have her son back home with her and family services subsequently helped her leave her husband for the first time by finding a flat to rent and organising home help.

As her son grew older, Fran began to have concerns about his increasingly aggressive behaviour. Her new family support worker did not believe her and was critical of her "mothering", telling her the difficulties with her son were all her "fault". Eventually, her son was diagnosed with an intellectual impairment and at the age of eight, he was moved to a special school. Fran decided to return to live with her husband, believing that his presence would be positive for the boy. However, her husband was as abusive and controlling to both of them as before. The boy's school became concerned about his deteriorating behaviour and reported their concerns to DHS. Fran by this time was trying to leave her husband for the second time and her son's social worker helped her get in touch with the domestic violence crisis service (Healey et al, 2008, pp. 57–58).

Fran was fortunate in that her son was returned to her care, but this should not diminish the long-term emotional impact that his removal had for her, as she harboured the fear that it could happen again at any time.

Section 5: Promising practice

This section outlines examples of positive initiatives in Victoria that may repair the harm or prevent the injustice of violence in the first place. Some are currently underway, or have been recently conducted. This section indicates ways in which this work may be extended.

Preventing violence and responding to it go hand in hand, for the two reinforce each other (Fergus, 2012: 7). The Voices Against Violence Research Project believes further work needs to be done to identify and prevent both gender-based and disability-based violence, as well as to respond to existing violence. Extrapolating from violence prevention policy and programming as it relates to women and girls to a particular focus on women and girls with disabilities, it is clear that prevention policy and programming for preventing violence against women and girls with disabilities require:

- that the state has primary responsibility for prevention of violence against women and girls with disabilities, as established under international law, as civil society organisations alone lack the resources, reach and mandate of the state to sustain the widespread changes that need to occur
- that prevention strategies are informed by research and evidence, including evidence identifying and addressing the underlying causes of gender-based and disability-based violence informed by a human rights-based analysis (as discussed in previous sections)
- that “holistic, multi-sectoral and sustained strategies are necessary to achieve results” (Fergus, 2012, p. 24).

Prevention programs for women with disabilities

The following are examples of prevention initiatives underway in relation to gender, violence and disability. They also align with the current Victorian Government’s focus on prevention in two key areas. These areas are firstly, the need for education to change attitudes and behaviours and to promote respectful, non-violent relationships, and secondly, the engagement of organisations and communities to promote gender equity and to stop violence.

Living Safer Sexual Lives: Respectful Relationships (LSSL: RR)

This is a program about relationships for people with an intellectual disability. It draws on stories by, and for, people with an intellectual disability as a basis for discussion and insight into sexuality, rights in relationships, respectful and safe relationships, gender-based violence in relationships, violence and abuse prevention, sexual abuse and accessing relationships and sexuality supports and services. Developed by Dr Patsie Frawley (La Trobe University) and a team including women with intellectual disabilities, it is a community-based, cross-sectoral model for people with an intellectual disability aimed at preventing violence and abuse. It was

initially funded by the Australian Government during the pilot period (2009–2011), but is now driven by community-based organisations, which comprise the LSSL: RR network. At present, there are programs operating in regional Victoria. A ‘train the trainer’ program is utilised to train peer educators (people with intellectual disabilities) to work with co-facilitators (such as people working in disability, sexual health or educational services) (Frawley, Barrett, Dyson, 2012)).

Tell Someone Program

The Southern Integrated Family Violence Executive developed a website and video resource in 2011 called *Tell Someone* as a resource to educate people with a mild intellectual disability, their families and the broader community about family violence. It is, however, a resource for everyone. The *Tell Someone* DVD can be downloaded for free from the *Tell Someone* website at www.tellsomeone.org.au. The website provides information about going to the police, courts and specialist family violence services.

DVRCV information for women with disabilities

DVRCV provides internet-based information and stories for and about women with disabilities who have experienced family violence and sexual assault at www.dvrcv.org.au.

Building professional capacity in the disability and family violence–sexual assault sectors

The following initiatives and strategies are concerned with the long-term process of building professional capacity within and across the disability and family violence–sexual assault sectors, so that professionals are better skilled at identifying and responding to women with disabilities who are at risk of violence or are experiencing it, and become aware of the benefits of working in partnership with each other.

Gender and disability workforce development

A key initiative of Women with Disabilities Victoria is the development of a cultural and organisational change program that aims to increase awareness about how to deliver gender equitable and sensitive services as a strategy for violence prevention and improving women’s well-being and status. This program is being trialled in 2013 and 2014 with funding from DHS. The intention is to use the ‘train the trainer’ model involving women with disabilities and registered trainers as co-facilitators based on the VicHealth violence prevention model. Given the issues of institutional and care-related violence experienced by women with disabilities, this program will target managers as well as frontline staff across the range of disability support and allied services. The program will also introduce a *Living Safer Sexual Lives* program for people with disabilities using the participating disability services.

Improving responses to violence against women with disabilities

Getting safe against the odds: family violence and women with a disability

DVRCV has a program that is open to workers in the family violence and disability sectors to gain a better understanding of violence against women with disabilities. It explains the gendered dynamic of family violence and sexual assault, the heightened risk of women with disabilities experiencing violence and explores best practice responses, including risk assessment and safety planning. Importantly, it has the potential to provide a vehicle for enabling disability, mental health and family violence–sexual assault workers to share strategies that will improve their organisations' responses to women with disabilities who are experiencing violence and build regional partnerships across these sectors. However, the program only ran for a few years up until 2009 and only once in early 2013 and there appears to be capacity and demand challenges, making its future uncertain.

Standards and guidelines for responding to people with disabilities affected by violence

There are different understandings of the term violence across the sectors of disability on the one hand, and family violence and sexual assault services on the other, and no common approach to identifying or responding to violence against women with disabilities (WHW, 2013).

The *Building the Evidence* research illustrated that the limited access to family violence services for women with disabilities is reflected in the absence of, or poor attention to, content in family violence sector standards, guidelines and codes of practice about the potential support needs of women with disabilities who experience violence. These standards guide the work of specialist and mainstream professionals (including police, community lawyers and community and social workers working with women, children and men) in identifying and responding to family violence.

In most of the eight documents analysed in the *Building the Evidence* research, the specific issues facing women with disabilities were simply not reflected. This led to the identification of eight minimum standards that need to be incorporated into the documents in order to include the experiences of women with disabilities.

Although the documents do not represent a change strategy, they provide a platform from which managers and staff can lead, train and shift practices in and across organisations with respect to women with disabilities who experience family violence. Most importantly, the minimum standards establish the participation of women with disabilities as advocates in mainstreaming disability within the family violence sector as critical and provide a matrix against which those responsible for updating existing standards, guidelines and codes of practice can identify areas for improvement (Healey, Humphreys, Howe, 2013; Healey et al, 2008).

The OPA has led the way in the disability sector in developing good practice guidelines. The Interagency Guideline for Addressing Violence, Neglect and Abuse - IGUANA is for organisations and staff (including volunteers) working with adults at risk of violence, neglect or abuse (OPA, 2013). However, this response guideline is not directed towards addressing the underlying causes that support the perpetration of gendered violence by both staff and co-residents within disability services.

Targeted cross-sector responses

The *Victorian Systemic Review of Family Violence Deaths – First Report* highlights prevention in the context of victims with disabilities or mental ill health as requiring “improved responsiveness” (Walsh, McIntyre, Brodie, Bugeja, Hauge, 2012: 47). The report notes that if these victims had received a better service response, they would have been less isolated, more likely to seek assistance from services, and workers might have a better understanding of the situation and thus averted fatalities. This finding provides incontrovertible evidence for the importance of professionals responding to violence to be proficient in working across the disability, mental health and family violence –sexual assault sectors.

The following initiatives specifically target women (or people, more broadly) with disabilities experiencing violence and involve developing and strengthening cross-sectoral collaboration, including the criminal justice system (police, courts, community legal centres and forensic medical services), family violence–sexual assault specialist services, health and welfare services and disability services.

Home security initiatives for women with intervention orders: BSafe and CCTV

During the pilot period of the BSafe alarm system, at least 10 women with disabilities (including hearing, visual, intellectual and physical impairments) and their children who were living in rural Victoria were able to stay in their own home due to the installation of a simple alarm system (Taylor and Mackay, 2011). To be eligible for the alarm, women had to have an intervention order with an exclusion condition in place, but were fearful of it being breached. The alarm system (involving a pendant, home telephone unit and/or mobile device) provided reassurance to the women that a police emergency response would be set in motion on their behalf once activated (Taylor and Mackay, 2011; Nicholson, 2012).

As the technology improved, the accessibility of the alarm for women with communication impairments was enhanced (the system does not rely on the user speaking to an operator) and is therefore ideal for women with hearing or speech impairments or women lacking proficiency in English, as well as other women with disabilities living in isolation (Nicholson, 2012).

This program, coordinated by Women’s Health Goulburn North East (WHGNE), did not secure support for its continuation despite positive feedback from users and the integrated efforts of services responding to family violence and sexual assault in the region. One aspect of the alarm system, however, is currently under development by the Safe Futures Foundation in

Melbourne's eastern metropolitan region, in consultation with WHGNE and Victoria Police. It may improve police ability to prosecute intervention order breaches through the deployment of cost-effective CCTV monitoring equipment installed in women's homes (personal communication with Janine Mahoney, Safe Futures Foundation, 20 September 2013).

Disability and Family Violence Crisis Response

This initiative assists women with disabilities, including women with children with disabilities, who are experiencing family violence and who have been assessed as requiring immediate protection (following a comprehensive risk assessment) by a specialist family violence service. If women with disabilities or women with children with disabilities are in need of family violence crisis accommodation, this can be arranged (depending on availability) and short-term funding provided to meet disability-related support. The latter can be used to cover the costs of attendant care support (personal care, shopping assistance, meal preparation or support in providing care to children), equipment hire (where personal equipment cannot be accessed) or linkage with the Statewide Equipment Program, sign/Auslan interpreting (where the DHS interpreter service is unavailable) and transport costs. Support is provided for up to 12 weeks to a maximum of \$9,000 per person. During this time, women are assisted by a Family Violence Worker to explore the options of remaining safely in their own home or community or securing alternative accommodation. Following a successful pilot of the initiative in Melbourne's eastern metropolitan region, its continued funding by the Victorian Government was confirmed in June 2013.

Family Violence Intensive Case Management Model

A project in Melbourne's western metropolitan region seeks to increase access to family violence services for women with disabilities primarily through intensive case management (Women's Health West, 2013). The Intensive Case Manager has a community development role, engaging workers from other sectors in an advisory group and secondary consultation. The project also explores opportunities and models for outreach into disability services and communities of practice with disability workers that are complicated to develop and maintain (see also <http://whwest.org.au/resource/fv-women-disabilities/>).

Making Rights a Reality Project 2012–2014

This two-year pilot program aims to increase access to the criminal justice system for people who have been sexually assaulted and who have a cognitive impairment (such as ABI, intellectual disability, dementia) or mental ill health issues or communication difficulties. It is being coordinated by the Federation of Community Legal Centres Victoria, South Eastern Centre Against Sexual Assault (SECASA) and Springvale Monash Legal Service (SMLS) and is an outcome of the Sexual Offences Project, which began in 2002 as a result of concerns about the lack of justice for victims and survivors of sexual offences, in particular the failure of sexual assault reports to progress through the criminal justice system (Goodfellow and Camilleri, 2003; Camilleri, 2009).

Evaluation of the first year of operation (from September 2012 to March 2013) indicated that SECASA and SMLS were identifying clients with cognitive impairments and disabilities and providing appropriately skilled staff, such as counsellors and SECASA advocates and legal advocates, which enabled them to access Victims of Crime Assistance Tribunal (VOCAT) and be supported during court appearances (Frawley, 2013). The second phase evaluation will explore the degree to which the model provides justice for people with cognitive impairments or communication difficulties who have been sexually assaulted.

Crisis accommodation

Crisis accommodation and transitional housing for women with disabilities who need to escape from family violence situations are not available in most of the state's refuges. At present, the Safe Futures Foundation in Melbourne's eastern metropolitan region is particularly active in developing the dispersed model of separate units, which are appropriate for the diverse range of needs for women with disabilities who are unable to remain in their own home, and are built to universal access standards. Having units built to such standards does not automatically mean they are dedicated over the medium to long term for use by women with disabilities or women whose children have disabilities. Molly's House (now renamed) located in Melbourne's western metropolitan region, for example, was unable to sustain appropriate crisis accommodation for women and children with disabilities, 'despite being recognised, for a time, as a positive development'. (Healey, Howe, Humphreys et al, 2008).

Areas for further attention

This paper does not seek to make extensive recommendations on what is required, however, the *Voices Against Violence Research Project, Paper One: Executive Summary and Recommendations* makes recommendations based on all aspects of the research undertaken. The following outlines some of the areas for further attention in relation to the initiatives and issues raised in this paper.

Extend prevention initiatives

Prevention initiatives need sustaining over the long term if family violence, sexual assault, mental health and disability service management and staff are to become skilled in preventing violence, and for people with intellectual disabilities to learn to enjoy intimate, safe relationships. In different ways, they highlight the need for mainstream violence prevention work in the community and have potential significance for other sectors of human services, such as health (mental, psychiatric and mainstream health facilities and aged care facilities), justice (correctional facilities) and education and training.

This needs to happen on more than one front, involve both genders and target young people as well as adults at age- or developmentally appropriate levels. Firstly, people with disabilities (particularly those with intellectual disabilities) and those who support them in their lives need to participate collaboratively in violence prevention initiatives as educators, presenters, advocates and planners. Secondly, those who support people with disabilities as care providers, whether families or support services, need to understand the gendered dynamics of violence and be involved in prevention initiatives alongside those they live or work with as co-learners, not just as ‘protectors’.

These initiatives do not necessarily require onerous financial commitments. At a minimum, they require funding of programs, support and initiatives that include people with disabilities and for disability organisations to develop resources and guidelines for care providers (personal communication with Patsie Frawley, 21 August 2013).

Research and data collection

In the immediate short term in Victoria, a documentary analysis comparable to the *Building the Evidence* report’s analysis of family violence sector standards needs to be undertaken for sexual assault and disability sector standards to make visible the issues of gender- and disability-based violence to practitioners and professionals. This would be potentially useful if it could be integrated into training materials, assisting the development of local partnership networks across disability and family violence–sexual assault services (including justice responses) and assisting in the development of disability action plans for family violence–sexual assault services.

We have established the need for national research into the prevalence and nature of violence against women and girls with disabilities that covers the diverse community and institutional living situations as well as the establishment of unified national data collection mechanisms across the different sectors and jurisdictions to inform future policy, service and practice relating to violence prevention inclusive of women and girls with disabilities. To this end, we endorse the provisional recommendations of the national Stop the Silence Stop the Violence Project, currently underway.

Court services

Support for women with disabilities requiring criminal and civil justice interventions would be particularly enhanced if the role of the Family Violence ASW within the Family Violence Court Programs was strengthened and extended across the state’s Magistrates’ Courts and equipped to respond to women from diverse backgrounds and diverse impairments. More broadly, given that the Department of Justice has developed the Justice Disability Action Plan 2012–2016, there is potential for this to assist with improving accessibility, for example, in the short term, to improve signage and access to service counters within court precincts and, in the longer term, to plan infrastructural improvements that will either give greater accessibility (to toilets, witness boxes and lifts) or devise alternative arrangements such as remote access.

Implications for Services Connect and the NDIS

The Victorian Government is currently developing 'joined up' human services that include housing, drug and alcohol, family violence and family support services (DHS, 2013). Women may benefit from stronger cross-sector collaboration between disability, family violence, housing, family support and community legal sectors; for example, through secondary consultation. Access for women with disabilities from CALD, Aboriginal communities or same-sex relationships may require the exploration and development of targeted strategies to address additional barriers facing women from these communities in accessing prevention and intervention initiatives. This will require the integration of specialist and generalist services resourced to work effectively together.

Further, dedicated intensive case management for women with disabilities has been found to be crucial within the family violence sector because of the additional complexities that result from disability. The family violence intensive case management model provides support to women from diverse backgrounds and with diverse impairments for longer periods of time than is feasible within the current crisis response time frame and has been shown to be a supportive initiative that could usefully be extended across all regions (Women's Health West, 2013). While not all women with disabilities who have experienced violence require linkage with disability support services or ongoing support, there are always some women who require considerably longer periods of support (Desmond, 2011; Healey, 2009). This will be especially relevant to women with particular types of disabilities, such as intellectual and mental ill health issues.

At present, eligibility for the Disability and Family Violence Crisis Response Initiative is based on the *Disability Act 2006*'s definition of disability, which excludes women with mental ill health and chronic health issues. The decision to base eligibility on a definition that excludes subgroups of women who require substantial support in relation to disability and experiences of violence is a barrier to their access. This would require government or departmental leadership to rectify the barrier in the context of implementing Services Connect.

The introduction of the NDIS is a critical point for violence prevention and response. The National Disability Insurance Agency (NDIA) has a responsibility to ensure women with disabilities are linked to violence response services which will require an informed assessment by NDIA staff. Cross-sectoral cooperation and referral pathways are essential and it is vital that the new NDIS workforce is well trained in applying the principles of good practice learnt from other sectors. Standards and costing within the NDIA must take account of these gendered concerns in the national implementation process.

Further, the NDIA may also be required to fund initial violence response services. For example, the Disability and Family Violence Crisis Response Initiative currently funded through the Victorian Disability Services will be carried across to the NDIS program and it is vital this service is not lost in transition.

Conclusion

The critical engagement of disability, mental health, family violence and sexual assault (including justice) experts collaborating on violence prevention and services that respond to violence is essential. It is through involvement in local and regional integrated networks of agencies (government and non-government) and the collaboration on solutions and programs that agencies will develop their professional capacity, change organisational cultures and knowledgeably plan for the necessary long-term infrastructural and cultural changes that will make their organisations accessible, inclusive and responsive to the needs of all women, including those with disabilities and mental illness, who experience violence.

This work cannot be sustained over the long term without commitment from national and state governments to resource such initiatives. Nor can such work be systematically incorporated into or used to inform policy and practice across all sectors, thereby effecting widespread sociocultural and organisational change, without government commitment to upholding human rights obligations. Part of the challenge is in effecting cultural change in the broader community about practices and attitudes to all people with disabilities, and raising awareness of the fact that women with disabilities have the greater risk of experiencing violence.

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