

Changing relationships: services for disabled women experiencing domestic violence in the UK

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Abstract

It is estimated that between one in three and one in four women experience domestic violence at some point in their lives, and there is some evidence to suggest that disabled women are likely to experience longer periods of violence than non-disabled women. Given shifting government policies and professional arenas in the UK, it seems likely that disabled women and social workers will interconnect around domestic violence more often in future. Based on findings from a small local study (which aimed to identify the appropriateness and accessibility of disability and domestic violence services for women), this paper shows some of the difficulties as well as the potential for social workers working with disabled adults. It provides an overview of the literature on the identification of barriers facing disabled women accessing domestic violence services, then goes on to present some of the findings from the disability agencies and services. Addressing these dilemmas in a discourse which recognises domestic violence as a crime, this paper offers some opportunities for changing relationships between disabled women, domestic violence services and social workers.

Keywords: Domestic violence, disability, relationships

Introduction

It is estimated that in the UK between one in three and one in four women experience domestic violence at some point in their lives (Home Office, 2000 & 2003) and publicity about this issue continues to grow (Home Office, 2006). Domestic violence is about "men's violence against women within existing relationships and postseparation" (Hester, 2000, p. 150). British Crime Survey findings indicate that women who report that they are in 'poor health' have suffered more than twice the rate of domestic violence than those that report that they are in good health (Walby & Allen, 2004) and that disabled women experience more incidents of domestic violence than non-disabled women. It is likely that many of these women (particularly those with children) will have had contact with

social services or known social workers (Fawcett, 2000) and been involved in assessments (Preston-Shoot, 2003). Furthermore, given that social workers' focus of work is increasingly to 'help' disabled people 'live at home' (Department of Health, 2003 & 2004), it seems likely that disabled women and social workers will interconnect around domestic violence more often in future.

Disabled women who were actively involved in the feminist activism against domestic violence - leading marches, setting up refuges, writing and other work in the 1970s and early 1980s - were not always 'identified' as such (and many found it liberating to be accepted as women in their own right, not being called 'disabled'). However, Morris (1996) has claimed that non-disabled feminist academics' exclusion

of disabled women's experiences from research on domestic violence has often been based on prejudice and discrimination, and argues that this is also reflected in agency approaches. This paper attempts to address these points. It is based on a report from a pilot study, commissioned by Middlesbrough Domestic Violence Forum (MDVF), which aimed to identify the appropriateness and accessibility of disability and domestic violence services (including any gaps in current provision) for women in the area (Radford *et al.*, 2005). An additional reason for the study related to a local incident, the domestic murder of a disabled woman in Middlesbrough in 2002. During the investigation of this crime, it came to light that the murdered woman had not been in contact with any local domestic violence agencies (Radford, 2002).

The paper begins with an overview of the literature on the identification of barriers facing disabled women accessing domestic violence services and then provides a brief search of the literature around social work, disability and domestic violence. The paper then goes on to present a small section of the results from the pilot study¹, focussing on some of the data from disability agencies and services. Adding this local knowledge to the national and international research highlights some of the difficulties in balancing workers' desires to maintain clients' independence and privacy with their concerns about adequate protection. Addressing these dilemmas in a discourse which recognises domestic violence as a crime, offers a crucial starting point for social workers – one which could herald a changing pattern of relationships between them, disabled women and domestic violence services.

Given the relative lack of UK research literature in this area, this review draws primarily on studies from North America and Australia, where more research has been undertaken with disabled women and on investigating barriers to services. Whilst

it is understood that the legal and 'welfare' systems in North America and Australia are organised differently from those in the UK, and therefore statistical and interpretative parallels cannot be made directly, there are a number of useful concepts and relevant issues to draw on. In line with feminist approaches to the study of domestic violence and the social model of disability, this literature review focuses on recent studies and practice-based literature which take a less victim-blaming approach and put the voices and experiences of disabled women in the foreground.

Disabled women's experiences and the impacts of violence

In relation to domestic violence, in common with non-disabled women, the literature indicates an overall pattern of power and control, which escalates over time. However, disabled women often find that their disabilities are used against them by non, or less, disabled violent men as a further means of control and dehumanisation. The research indicates violent men use prejudices about people with disabilities combined with patriarchal assumptions and ideologies to humiliate their partners and destroy their sense of self-worth, which may already be low as a consequence of previous disabling life experiences, such as social isolation (Erwin, 2000).

Sexist and heterosexist normative ideologies combined with disablist attitudes and assumptions are illustrated in accounts from disabled women in a study from Western Australia, (Cockram, 2003). This study showed that, in common with non-disabled women, disabled women's accounts illustrate that they may make several attempts to escape the violence and get protection. As with other women, the decision to leave can be triggered by increasing episodes of life-threatening violence and/or recognising its impacts on children. Strategies used by the abuser to

increase their social isolation and deny them access to money, transport or communication with others, as well as locking them in the home, can make escaping even harder (Cockram, 2003).

Disabled women's accounts also indicate that they frequently face institutional and social barriers when trying to get away. For example, women may be in contact with professionals who fail to ask about domestic violence, making it difficult for women to seek help (Lapidus *et al.*, 2002). Further, disbelief from others including family members, neighbours and agencies such as the police, may be a key factor that prevents women from escaping the violence (Helfich & Simpson, 2006). Saxton *et al.* (2001) found that where women had to rely on partners for personal care, this increased the difficulties women had in leaving an abusive relationship. Other barriers were the inadequacy of domestic violence and disability services in providing the appropriate care and support that women may need once they have escaped from the violence, and the focus by agencies on a woman's disabilities rather than on the violence they have experienced from a partner (Erwin, 2000; Nosek *et al.* 2001; Cockram, 2003).

The Leeds Inter-Agency Project (LIAP) found that when disabled women did approach domestic violence services:

they were viewed first and foremost as disabled women. The fact that they were experiencing violence was not seen as a priority. (LIAP, 2005, p. 16)

LIAP also found that disabled women believed that these services would not be accessible to them as disabled women (LIAP, 2005) and that women "who disclosed violence and abuse to disability services were often told that they could not be helped, as that was not the organisation's expertise" (p. 16). They also experienced 'patronising and negative attitudes from the

professionals' who 'took over' and denied them choices and decision-making. Further, some women did not feel able to disclose experiences of violence because they felt it would not be treated 'confidentially'.

Most women in the consultation organised by Women with Disabilities, Australia (WWDA) (2004) had many similar concerns. WWDA has also contributed to the debate around 'neglect' as a form of domestic violence, which is often omitted from many mainstream domestic violence definitions. WWDA defines neglect:

Neglect refers to the harm caused by failure to provide adequate support, food, shelter, clothing or hygienic living conditions. It also includes failure to provide adequate information and education in the use of poisons, alcohol, drugs. For women with disabilities neglect may include leaving a woman in soiled clothes for 'punishment', or leaving her for extended periods in bathtubs or beds, or forcing her to eat at a pace that exceeds her ability and comfort. (WWDA, 2004, p. 8)

But as WWDA (2004) point out, the pervasiveness of neglect, in this context, makes its inclusion in definitions of violence difficult. It may be useful for social workers to think of neglect as another form of controlling behaviour in an overall pattern of domestic violence where physical violence or threats are used. It is also crucial for social workers to be aware of their own potential to compound the problems for disabled women by misinterpreting, minimising or dismissing their experiences, or by patronising them or making decisions for them. Morris (1996) draws parallels between the ways society takes power and choice from disabled women and domestic violence survivors. She argues that like domestic violence survivors, disabled women are not passive victims to be pitied, but survivors who cope, struggle and resist oppression.

In relation to learning disability services in the UK, McCarthy and Thompson, (1996 & 1997; McCarthy, 1999; Thompson, 2000) identified a number of failings in relation to residential community provision, particularly in relation to a tolerance of sexual violence against learning disabled women. Whilst recent changes in the law in relation to sexual offences in the UK, should make it easier to prosecute rape and sexual assault against women with learning disabilities², these are aimed at dealing with offences from staff and therefore do not deal with the main problem of women with learning disabilities being assaulted by their male partners or 'boyfriends' with learning difficulties. Furthermore, in the UK, attrition studies on rape and sexual assault have shown that complaints made by women with learning disabilities or mental health problems are least likely to be investigated by the police (Kelly *et al.*, 2005).

Social work, disability and domestic violence in the UK

Outside the UK there seems to be a reasonable record of addressing domestic violence issues in social work (for example Solokoff, 2005; Buzawa *et al.*, 2007; Eastman & Bunch, 2007), and more recent studies do occasionally address disability issues (Milberger *et al.*, 2003; Baldry *et al.*, 2006; Brownridge, 2006; Olsvik, 2006). This does not seem to be the case in British social work literature. Research about social work and domestic violence in relation to disabled women (or children) seems to continue to be negligible in volume. There are a few examples of social work research and practice in relation to domestic violence but, with the exception of this work (Radford *et al.*, 2006), very little has been published relating directly to disability or 'impairment' and domestic violence since Mullender's work on social work 'in health and adult care settings' (1996, p. 107). It is even more difficult to find information about domestic violence

and disability in official policy or practice guidelines. A recent³ search of four of the UK's social work websites⁴ (whose roles are to develop knowledge about good practice, promote high quality learning and provide invaluable routine professional support and advice) led either to material about children and young people and adjacent issues, or to North American sites about domestic violence.

It is not surprising therefore, that there is little information about disability and domestic violence in British social work practice or research. Mullender and Hague (2005), in their paper on service user groups, draw out the parallels between attitudes to disabled people and domestic violence survivors, with tendencies to pity and protect rather than involve and empower. However, more social work texts are including sections or chapters on domestic violence and do occasionally refer to health or disability. For example Taylor-Browne's chapter (2005) helpfully points out that 'health professionals' find it difficult to ask women about domestic violence (p. 95), but does not discuss services for, or needs of, disabled women.

As indicated earlier, it is assumed that social workers' growing involvement with many disabled people and their carers in their assessment and other work, might bring them into contact with these agencies and might place them in a position of influence. Social workers' most common role in current British practice is as assessors and regulators of services, and this is likely to be particularly so in the emerging multi-disciplinary and inter-agency settings. Currently in England, inter-agency, multi-agency and multi-disciplinary working is developing in relation to services for adults and services for children (Department of Health 1998; Department for Education and Skills, 2003) and the Home Office has encouraged similar initiatives in relation to domestic violence since 1990⁵ (Hague & Malos, 1998). These developments could

place social workers in a key position to influence disability services, and improve the experiences of disabled women who experience domestic violence. However, although government policies continue to encourage improvements and develop strategies to address domestic violence as “core business – not an optional extra” (Local Government Association, 2006, p. 5), the involvement and role of social workers remains undefined. The only potential area for social work, currently defined as being primarily the responsibility of “the director and lead member for children’s services and Local Safeguarding Children’s Boards” (p. 7) is related to child protection work.

In contrast to these local and national strategies and policies, which appear to overlook or side-line social work, there are examples of research and practice that place social workers in key positions. A number of recent studies that have adopted a closer and more detailed approach to research and practice with women who have experienced domestic violence, suggest a variety of potential social work roles. Cavanagh (2003) clearly demonstrates women’s responses to abuse and violence as dynamic, involving a ‘repertoire of responses’ to survive, reduce and resist men’s attacks. Humphrey’s *et al.* (2005) explore more complex analyses and responses to domestic violence and substance use and Hester (2005) highlights other problematical professional and policy discourses which social workers might address in:

- *seeing as separate issues violence by men towards women and violence by men towards children;*
- *construing a gap between ‘violent men’ and ‘fathers’ so that violent fathers become invisible;*
- *blaming mothers for lack of contact between children and fathers; and*
- *not incorporating children’s voices and perspectives.* (p. 176)

Enosh and Buchbinder (2005) explore autobiographical methods for research and practice with women in constructing memories and narratives of violent experiences and Hague *et al.* (2003) demonstrate the crucial position of ‘domestic violence survivors’ as service users, to be “both heard and heeded ... in service planning, provision and delivery” (p. 2).

On the whole, however, the literature suggests that neither policy makers, service providers, professionals nor disabled women themselves have a great deal of confidence in the appropriateness of services for disabled women experiencing domestic violence. This raised a number of questions that the study attempted to address and results showed some contrasting evidence, including the improved accessibility of Middlesbrough Refuge (Radford *et al.*, 2005).

Methodology

Ethical approval was obtained and the study was undertaken at the beginning of 2005. Representatives of member agencies of MDVF and Cleveland Disability Forum (CDF) were contacted by phone and email, and invited to participate in the survey. Twenty out of the 25 members of CDF participated, most had charitable status and many relied almost entirely on voluntary workers and funding. Those providing information were offering services to between 40 and 10,000 clients. They had different practice responsibilities and policy experiences, and adopted a variety of approaches. For example, the WRVS has over 60 years’ experience, whereas the Shaw Trust was established in 1982, during the International Year for Disabled Persons. One of the participants in the research, and a key player in this area, was the Cleveland Disability Forum which co-operates and consults with the voluntary sector, Local Authority, statutory bodies and all who plan

and provide services/facilities to those with disabilities.

Using semi-structured, telephone-interviews, 20 participants, representing disability services and agencies were interviewed, using a semi-structured framework. Of the 20 participants, twelve were from voluntary agencies and eight were from statutory agencies (health and social services). Most of the twelve voluntary agencies offered a range of services. One provided crisis and financial help, two offered advocacy and information services, three provided counselling, two provided training and nine offered various kinds of day facilities or domiciliary support. The eight statutory agencies included six multi-disciplinary teams, four of which included social workers. They focussed mostly on assessments with day facilities or domiciliary support, though one also provided adaptations and two provided residential facilities. The individuals who took part in the telephone interviews were mostly paid workers (13), two of whom were social workers, but one student and four volunteers also participated.

Results

The results reported here relate to the 20 disability agencies' understandings about domestic violence and to their policies, procedures and training provisions in this regard.

Definitions and estimates

On the whole, participants from the disability agencies were confident about defining disability and willing to estimate numbers or percentages of different forms of disabilities. Their client base (as a whole, not referring to clients disclosing domestic violence) was varied, and included deaf and hearing-disabled people, blind and partially-sighted people, wheel chair users, mentally ill and learning disabled people⁶. Participants were less confident about

defining or estimating experiences of domestic violence but, despite none of the participants' knowledge of any 'official' or 'agency' definition of domestic violence, many of them seemed reasonably aware and had a general understanding of the issues. One or two felt their knowledge was poor or limited (and a small number included child abuse in their descriptions), but most of them were eager to seek help from elsewhere.

Participants were not asked to calculate or estimate any correlations between different types of disability and domestic violence, nor make any other comparisons or analyses. However, some participants offered their analyses and understandings. Only two people spoke of domestic violence as a gendered phenomenon within the context of patriarchal social relations, though most implied this awareness by referring to 'mostly men' as perpetrators and 'mostly women' as 'victims'. Almost all referred to the different and sometimes overlapping forms of abuse and many knew about shame, secrecy and silence:

I have personal experience of domestic violence - it comes in many shapes and forms ... People forget the mental attachment, for example non-verbal threat, fear, wondering about when it's going to happen next, not knowing ...

As far as the participants were aware, none of the agencies kept statistics about domestic violence and only six of them were able to estimate what proportion of their women clients experienced domestic violence. The estimates of these six participants varied considerably (from less than 1% to 60%), although it is not entirely clear whether they were estimating the number of clients disclosing domestic violence, or estimating the numbers they suspected were experiencing it. Two participants gave the numbers they knew of saying, for example "two or three in eight years", but most had "no idea" or "knew of

none". A few participants pointed out that they had never asked about domestic violence, and some conceded that although it probably did occur, it was too difficult for them to conjecture. However, despite their admitting to having limited knowledge/experience of domestic violence in their agency, some of them attempted to estimate specific forms of domestic violence in relation to their particular clients.

Participants were asked about clients' experiences of physical, emotional and sexual violence and financial abuse, and also about withholding medication/aids (a form of domestic violence identified in the literature). Ten participants thought that "some" clients experienced physical violence and one person estimated that this might be as many as 50% of clients; however, five participants thought that none of their clients experienced physical violence. With regard to emotional violence or mental cruelty, eighteen participants thought that this was "likely in many families" and two people thought that around 80% of clients experienced it. Six participants thought clients commonly experienced sexual violence. There were marked differences between participants' estimates relating to experiences of financial abuse. Four people thought this was common, including one participant who said this was "the most common form" and another who estimated that over 60% of their clients experienced this. However, five participants felt that this did not occur. Participants also thought that the withholding of medication or aids was uncommon and only one person estimated that around 20% of clients experienced this. It is impossible to know whether the large differences between respondents' estimates reflect personal or societal myths and stereotypes about disability, or are indeed based on workers' practice wisdom and considered calculations about particular service users and specific disabilities.

Agencies were also asked about disclosures, and about when or where this might happen. Although ten representatives confirmed that this had never happened (as far as they were aware), others said domestic violence was frequently disclosed either during the admission/initial interview stage, or later, as relationships with staff built up over time, often in the context of 'life history' work. One participant said that domestic violence was occasionally reported by telephone (as part of their 'safe and well check' procedure), and another participant explained that their clients participated in training about violence and personal safety, which includes domestic violence, and was a regular point for disclosures. This was a significant finding and led into discussion of how disability agencies responded to disclosures (whether this information was just noted in people's files or reported as 'crime') by asking about policies and procedures.

Domestic Violence Policies and Training

Only two agencies screened their clients for domestic violence (as part of a risk assessment during the admissions process) and none collated information about disclosures or incidents (though some recorded such information individually on clients' files). Only seven agencies had some kind of domestic violence policy in place, for example 'referring on' to another agency, and only two had specific policies. Most incorporated domestic violence under more wide-ranging policies, for example relating to 'Vulnerable Adults', National Care Standards, bullying and harassment policies. In order to identify how these policies might work, participants were asked what support services were offered. Most agencies (13) talked about referrals (mostly to social services), but generally they revealed a wide range of good and less good policies and practices.

Only seven participants said that they or their colleagues had undertaken domestic

violence training, and some of that was as part of other training programmes, for example child protection training. One or two of these few agencies had had a range of training, but on the whole the training was non accredited, provided in house or by the National Health Service (NHS) or a local government department. Twelve agencies reported that they had no training at all about domestic violence and two participants were doubtful about the relevance of domestic violence training and one representative said:

it wouldn't benefit me in any way, shape or form.

Although only one view, it serves to highlight the importance of professional accredited training for all agencies, one of the key recommendations of the study's final report (Radford et al., 2005).

Discussion

Although the respondents were able to define disability and readily able to estimate (if not quote) numbers and 'categories' of disabled people in their groups or agencies, they were less experienced and confident about their knowledge of domestic violence and most agreed that domestic violence training would be beneficial. Similarly, although many were enthusiastic about the subject and willing to acknowledge their own and their agencies shortcomings in this area, on the whole they had no knowledge (and certainly no consistent record) of the extent of domestic violence and were unable to identify domestic violence policies or facilities.

Overall, the experiences of disabilities agencies were very mixed. Some reported that they never received domestic violence disclosures from clients and others reported "very few". In contrast one agency estimated that as many as 50% of clients had experienced physical violence and 80% cruelty, neglect or emotional violence, though it is unclear whether these figures refer to

disclosures or to cases where staff suspected domestic violence. It is important to note that agencies which undertook screening and kept statistics about domestic violence reported higher figures than agencies which estimated numbers.

Unfortunately the population of women with disabilities remains undefined and this is particularly problematic in relation to vulnerability and risk. For example, the risks faced by women with mobility problems are likely to be different in kind to those faced by women with mental health problems; the vulnerability of women with learning disabilities might be very different from those who are blind or who have communication difficulties. It seems likely that the type of domestic violence, and the appropriate interventions, may also reflect these factors. Any offer of help or support should take the different dependence needs into account, especially around issues of neglect and abuse. On the whole, disability agencies seemed to describe emotional abuse and controlling care as "neglect", rather than framing it in the prevention, protection, justice and support discourses of domestic violence. This highlights a tension between the welfarism of the medical model of disability and the human rights approaches of domestic violence discourses.

It is important not to stereotype disabled women as being all the same, nor as helpless victims of men's violence, and to avoid concentrating on discussions around dependency and vulnerability. One way to do this is to focus on disabled women's experiences, and particularly on what they say in relation to agencies and to their 'carers'⁷. This might be particularly revealing in relation to the very different estimates by agencies about disabled women's experiences shown earlier. Disabled women do not want services based on 'guesstimates', nor to be treated as special 'tragic cases', they want equal treatment and inclusion in adequately provided and appropriate services. Whilst

power and control tactics may operate differently in certain contexts and there may be a wider range of perpetrators for disabled women, social workers should be stressing the commonality of their experiences with non-disabled women in relation to domestic violence and building our relationships around such allegiances.

This research is one of the few recent studies to engage with this issue, and although local, its findings are of national significance. It has shown that little is known about the prevalence of domestic violence among disabled women, nor about their carers, and suggests that although training would be welcomed by most, it might not address all of the political and personal complexities that are involved. As social workers become more involved with disabled adults they need to shift their relationships away from a pattern of ambivalence – on one hand desiring to maintain clients’ independence and privacy whilst on the other intervening and protecting their ‘vulnerabilities’. Social workers must work within the domestic violence discourse, recognising it as a crime and distinguishing between perpetrators (who need criminal interventions) and survivors/victims (who need support) (Home Office, 2006). Social workers must move away from the ‘family violence’, ‘dysfunctional families’ and couple counselling discourses of the past and replace their qualifying education, on-going training and current practice with models that emphasise gender relations, disablism and poverty (Mays, 2006), allowing them to make new relationships with their clients that are built on genuine consultation with disabled women and with women who have experienced domestic violence.

Endnotes:

¹ The pilot study consisted of two parallel surveys of member agencies of (i) Middlesbrough Domestic Violence Forum (MDVF) and (ii) Cleveland Disability

Forum (CDF), offering support services in the fields of domestic violence and disabilities respectively). By surveying agencies affiliated to both forums, it drew together insights and experiences of agencies that have operated alongside each other for a number of years, but with only limited interaction between them.

² The Sexual Offences Act (2003) provides a clearer and more comprehensive framework (and guidelines) for different agencies and professionals, for example clarifying issues surrounding consent in rape and sexual assault cases. The government has also introduced guidelines on procedures for protecting ‘vulnerable’ adults (Department of Health, 2000).

³ Summer, 2006.

⁴ Social Care Institute for Excellence (SCIE), Higher Education Academy - Social Policy and Social Work (SWAP), British Association of Social Work (BASW), Association of Directors of Social Services (ADSS).

⁵ Multi-agency working has been in place in the Middlesbrough area since 1992.

⁶ Other disabilities were also referred to in smaller numbers: autism, cerebral palsy, Downe’s syndrome, Angelman’s syndrome, epilepsy, global developmental delay, ADHD, Arthritis, Parkinson’s disease, M.S., epilepsy, dyslexia, brain injuries, stroke, Huntington’s disease, HIV, amputees, deep vein thrombosis, hepatitis, disfigurement, old age, infirmity, elderly, dementia/confused, Alzheimer’s disease, diabetes, fractured femur.

⁷ An area that was beyond the remit of this pilot study, but hopefully to be part of a second stage.

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All three authors are researchers with strong records of research and publication in the fields of domestic and sexual violence. All have histories in feminism and are actively involved in promoting justice and protection for women and children and challenging gender violence in their practice.

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