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Abstract

Aim:The aim of this study was to explore the experiences and perceptions of the service providers on the way existing intimate-partner violence (IPV) services are organised to address the needs of people with disabilities exposed to IPV.

Methods: The researchers conducted in-depth interviews with 17 IPV service providers working in: health care, social work, police, women's shelters and at the Center against violence. A semi-structured, open-ended interview were conducted between March 2020 and December 2020 and transcribed verbatim. A constructivist grounded theory approach that is based on the principles of symbolic interactionism was used with the purpose of explaining how IPV services are organised for people with disabilities in Sweden.

Results: In the resulting theoretical framework service providers framed their experience and perceptions of providing IPV services to people with disabilities to require coordination and multisectoral collaboration between different sectors and actors was viewed as ideal for providing adequate services to women with disabilities, however this was not always the actual approach adopted by all providers. The providers further illustrated that service provision for women with disabilities was organised around four overarching themes; pathways; screening and identification; protection and care; empowerment and independence.

Conclusion: This study indicates that providing adequate IPV services to people with disabilities require multisectoral collaboration. This approach was considered instrumental for women with disabilities that often face disability-related challenges that created difficulties in navigating several services on their own.



The perspectives of professionals on providing services to women with disabilities that experience intimate-partner violence

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Conclusion: This study indicates that providing adequate IPV services to people with disabilities require multisectoral collaboration. This approach was considered instrumental for women with disabilities that often face disability-related challenges that created difficulties in navigating several services on their own.

Background

Intimate partner violence (IPV) is the most common form of gender-based violence reported to occur in all countries, all culture and at every level of society [1]. Current evidence suggests that IPV disproportionately affects women with disabilities worldwide [2-4]. Moreover, increased vulnerability to IPV among women with disabilities varies by type and degree of disability [2]. Additional factors that place women with disabilities at increased vulnerability include stigma, discrimination, lack of social support, dependence on others for long-term care, among other factors [3-5]. Previously, violence against women was mainly understood as a social and legal problem and sometimes as a private problem rather than a health threat [6]. In the recent decades, IPV has increasingly been recognised as a major public health threat against women that increases physical and mental health problems like, injuries, depression, post-traumatic stress disorder, and poor sexual and reproductive health outcomes [1, 2, 7, 8].

IPV services play a critical role in minimizing the negative health and social impact of IPV [9, 10]. Timely and efficient IPV responses prevent fatal outcomes and foster recovery from the physical and emotional impact of IPV and improve functionality and resilience [10-14]. Despite the well documented benefits of IPV services, women with disabilities report difficulties in accessing IPV services due to infrastructural barriers such as inaccessible facilities [15]. Additionally, women with communication and mental disabilities report difficulties in seeking for help and in disclosing abuse [16]. In particular, women with disabilities that need assistance in their day-to-day life, report that seeking IPV services is problematic if the caretaker is both the partner and the perpetrator [16]. Other barriers to accessing violence related services include lack of confidence in the providers, services that are not adapted to the needs of the people with specific disabilities and the providers failure to screen for abuse [17].

Research concerning the perspectives of the health and social professionals directly working on violence against women is gradually increasing in Europe [18, 19]. But this research is often restricted to a specific dichotomy of fields and hardly consider other providers outside each field. Literature further reveals that services oriented toward combatting IPV are fragmented and that it lacks mutual integration [20]. Moreover, these studies tend to look upon IPV service provision from the broader perspectives of women in general, lacking a focus on women with disabilities. There is an urgent need to understand how the different IPV service providers respond to the needs of people with disabilities given that this population face unique circumstances that might influence their access to IPV services. This study builds on existing findings and adds to the limited body of research in this field by exploring the views of IPV service providers in Sweden regarding their experiences of providing IPV services to women with disabilities.

IPV services in Sweden

In this study we define IPV services as any form of professional help sought or offered to persons that experience or are at risk of experiencing abuse or violence from an intimate partner. Ending IPV is a high priority on Sweden's political agenda, evident in the many policies established to end men's violence against women [21]. Sweden recognises violence against women as a legal and social problem and explicitly declares "violence within close

relationships” a public health matter whose mitigation requires coordinated actions between multiple societal institutions [22]. This paper focuses on professionals working in healthcare, social services, police, and women shelters to understand how services are organised for women with disabilities exposed to IPV. Below we describe how IPV services are organised within the Swedish setting. Within the healthcare sector, National Board of Health and Welfare (NBHW) puts emphasis on IPV prevention through early detection of those at risk using routine healthcare enquiry about violence and preventative work with perpetrators. The health sector operates at the regional level within the 21 regions in Sweden. The Health and Medical Services Act provides a legal framework that gives parameters against which activities such as the goals of the health sector, and the duties of healthcare providers and personnel are measured [23]. In 2014, the national goal for public health addressing violence against women developed new goals to increase efficiency in the healthcare system, sharpen interventions, increase quality in care and add a more holistic perspective on patients. In the region of Västerbotten where the current study was conducted, health care work on IPV is organised within the Care Program (Vårdprogram). The care program provides an overview of IPV knowledge and general routines for executing IPV services. These routines are then adapted to the respective health care units and spread in the various working groups. In addition to this general care program, several units have additional activity-specific routines.

IPV service provided by the social workers is regulated by the Social Services Act (2001:453) for all citizens, with and without disabilities [24, 25]. In addition, the Act concerning Support and Services for people with Certain Functional Impairments (1993:387) gives people with certain disabilities more extensive rights [26]. Social services are implemented in all 290 municipalities across the country, steered by a local municipality Social Welfare Committee [27]. Social Services can be organized differently by the different specialized units or as integrated services [28]. IPV work within Social Services is regulated by the national legislation. The NBHW entrusts each municipality with the responsibility of creating goals and strategies in accordance to the national directive [29]. The directive (SOFS 2014:4) states that organisations should clearly indicate who is responsible for investigating, making decisions, and following up cases concerning victims of violence or children who have witnessed violence. The guideline further stipulates that the personnel who handle and follow-up violence related cases do so in accordance with the Social Services Act. The personnel should be knowledgeable of violence and other abuse by or against close relatives. Further, they should be able to translate knowledge into practical work, for example by identifying a person exposed to violence and ensuring that she or he receives the necessary help. The investigation should account for the nature and extent of the violence, the consequences of violence, if the victim needs support and the urgency. Furthermore, staff who carry out interventions that focus on support for adults should have a degree in Social Work.

The police operate within the Swedish criminal justice system and recognizes IPV as a prevalent global problem [30]. The mission for the Swedish police is to reduce crime and increase public safety as described in the Police Act (1984: 387). Members of the criminal justice system, specifically police and prosecutors are tasked with the responsibility of responding to acts of IPV and protecting the exposed from future violence [31]. Each police district has its own specific unit working exclusively with IPV. The police uses a structured violence risk assessment tools to prevent future IPV [32]. The structured risk assessment tools help to guide decision-making on case prioritization and the implementation of appropriate risk management strategies such as safety talks, alarm packages, contact with social services and shelter accommodation [21, 33].

Women's shelters to a large extent operate as voluntary organisations although occasionally they receive government grants and/or municipal reimbursement for services and some may have employees [34]. Most women's shelters belong to the National Organisation for Women's and Young Women's Shelters in Sweden or the Swedish Association of Women's Shelters and Young Women's Empowerment Centres. Each of these organisations includes about 100 centres across the country [35].

Study Aim

The aim of this study was to explore the experiences and perception of the service providers on the way existing IPV services are organised for people with disabilities exposed IPV.

Methods

Study design and participants

This study applied a constructivist grounded theory approach that is based on the principles of symbolic interactionism with the purpose of explaining phenomena (Charmaz, 2014). Grounded theory allows for the development of the substantive theory to explain the previously undescribed subject of how existing service cater for the needs of women with disabilities exposed to IPV. The perspectives of different service providers were considered pertinent as they were best positioned to explain their role, actions, and interactions with women with disabilities seeking for their services. Our team aimed to capture the experiences of IPV service providers from various sectors who meet people living with disabilities. Thus, multiple dissemination methods were used to best reach a diverse group of service providers in terms of geography and nature of services. We circulated information about the study through community-based organizations, disability-related websites, and social media of individuals active in the disability community.

The study team has extensive experience using various qualitative research approaches. The second author primarily conducted all the interviews except for a few conducted by the third author. The first author joined and listened to several of these interviews. The original plan was to interview participants face-to-face, but due to COVID-19 outbreak we opted for digital interviews. All interviews were conducted over skype and zoom, meetings lasted, on average, 60 minutes. All participants consented to participate both verbally and by providing a signature. Additionally, prior to the start of each interview, the interviewer reminded participants that they could skip questions or refuse to answer any questions or ask that the recording be turned off during any portion of the interview. Nineteen interviews were audio-recorded and transcribed verbatim.

Participants

This study included seventeen service providers working in: health care, social work, police, women shelters and the Center Against violence. Participants from the healthcare were included a doctor, physiotherapists, counsellors, and psychologists. The social workers were employed within municipalities and offered counselling to clients that experienced abuse. Aside from providing IPV services, some of the heterogenic duties of the social workers include social care, drug and alcohol treatment, social assistance, and financial guidance. The

service providers working at shelters were trained to offer counselling and support at safe houses, the secret locations where women can flee from the abusive partners and service providers at the Center against violence described their role as offering support to women who experienced IPV and their children. The police informants worked in specific units for targeting violence, their primary role was to investigate whether a crime has been committed. However, the police also worked in partnership with other organizations and service providers, at the municipality level, victim support groups and with voluntary organizations that providing sheltered housing [36].

Data Analysis

The first author completed the coding of the transcripts using MAXQDA.20.2 software to facilitate data analysis. Analysis followed Charmaz's constructivist grounded theory that requires the researcher to move from the experiential text to a theoretic text, through an inductive and iterative process. Coding of the data followed standard procedures for grounded theory, starting by initial or open coding where we did line-by-line coding examining each line of data and defining actions or events within. Each new transcript was coded and compared to previously analysed interviews, this allowed for refinement of existing codes and development of new codes. The initial codes were then collapsed into smaller list of focused codes. Visual models were created to better organised and conceptualize the focused codes. Finally, the focused codes were compared and related to each other for theoretical coding to develop core concepts for the theoretical model. These codes were shared with the co-authors to allow for contrast and comparison. All correspondence between authors were done via email and zoom meetings. When needed, FN returned to the data to respond to questions and concerns. Several iterations of the model were produced before the final model was agreed upon by the authors.

Ethics

Ethical approval for the DIS-IPV project was obtained from the Swedish Ethical Review Authority [Dnr 2019-05249]. All interviews were conducted after appropriate verbal and written consent from the participants.

Results

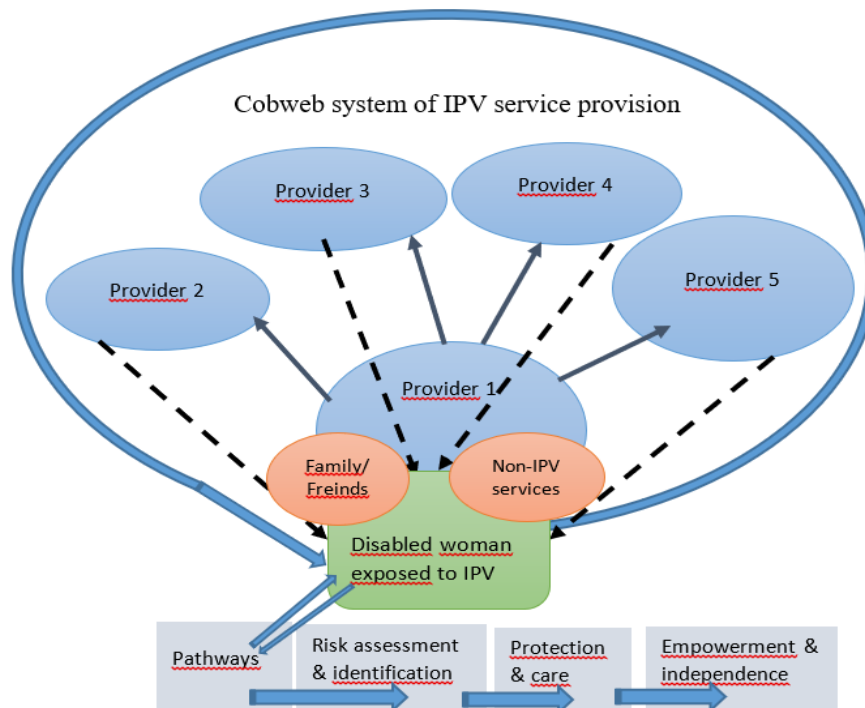
Participants

Seventeen service providers were recruited in total from the Västerbotten region consisting of healthcare professionals, social workers some employed as counsellors and others as financial advisers at the municipality social service department; police officers working with violence; staff employed at the non-governmental women's shelters. Providers were at varying stages of their career ranging from having worked for 2 to more than 20 years.

The conceptual framework

The theoretical framework that emerged as the core category from this study is “coordination and collaboration” to provide IPV services to women with disabilities. The process of coordination and collaboration was characterised by four interrelated themes; pathways; risk assessment and identification; protection and care; and empowerment and independence (Figure 1).

Figure 1: A theoretical framework which models the service providers’ approach to IPV service provision among women with disabilities.



All service providers regardless of work institution identified coordination and collaboration as essential in providing IPV services to women with disabilities. The providers mentioned providing adequate services required engaging several actors and identifying a person or an agency to help coordinate the process of service provision together with the disabled woman or on the disabled woman’s behalf. The coordinator assumed the responsibility of establishing and maintaining the necessary collaboration between the disabled woman and the different identified actors, hence building bridges between the disabled woman and the rest of the support system. Well as all providers perceived that coordination was important, it was only providers working at women’s shelters that described themselves as often taking on the coordination role, as illustrated in the following quotes, "We usually become some kind of spider-in-the-net, which is usually very much appreciated, that she gives us permission to talk to all her other contacts and that we can then help to keep track of everyone else, because no one else takes this role, the spider-in-the-net role. (LL). In some cases, the coordination role could be assumed by someone from the civil society such as the contact person if a disabled woman lived in a service home, as described by one provider: “The people I have met who, for example, live in service homes, they often have a contact person in the service home these take the role of being the spider-in-the-net. Then in this case we will only be there to offer support to that person” (AK).

Service providers indicated that collaboration involved engaging several parties including the disabled woman; IPV service providers working in other organisations, other agencies that do not necessarily address IPV but whose services are needed by the disabled woman; and the woman's social network of friends and family. The decision on whom to include in the collaboration often depended on the assessment of the individual needs of the disabled woman and her consent. For each woman, the chain of collaborators looked differently depending on the needs, and varied overtime based on continuous needs evaluation. The providers emphasized the importance of establishing a collaborative system around a disabled woman or girl. This was seen as important element especially when disability is present because these clients often faced unique disability-related challenges that made it harder for them to navigate the different IPV services on their own. Service providers for example mentioned that women with communication difficulties, hearing difficulties, eyesight problems, development disorders and mental disorders faced extra barriers that made it difficult to independently seek for IPV services. These disability-related challenges were perceived by providers to discourage women from seeking services or to dis-continue services, thus making it crucial to have someone to help with coordination.

Collaboration between the disabled woman and the service provider that a woman establishes initial contact with was viewed as a key for successful collaboration. This type of collaboration required building trust between the two parties. Trust would lead to cooperation in understanding the problem, the type of help a woman needed and how to get this help. "We learn things, we find together with the woman things that would work in everyday life that make it easier to move forward in what we are going to talk about, about the exposure to violence. (KN). It was important that a woman felt that she could trust the provider they first established contact with, and that they could also trust other providers that were needed for additional services a woman needed.

Providers also described collaboration as crucial to involve other service providers offering different services that a woman may require. Whom to include in collaboration was often assessed on a case-by-case basis. For example, if a woman came first through police or social services, this first provide would ensure that the woman is connected next provider needed to address the identified needs. "Yes, if there is on-going violence, occurring right now, we talk about the Center against violence, where they have both department for children, Center against violence for children, women and men. We also talk about that; we give then small business cards with phone numbers and information (AC).

Providers further indicated that a successful collaboration for providing IPV service involved engaging other providers that do not necessarily offer IPV services. The non-IPV service providers helped to ensure that a woman received comprehensive support that goes beyond IPV services to cater for other needs of the woman for her general wellbeing. Identifying the suitable non-IPV providers to collaborate with was based on the individual needs assessment. Examples of such providers included care takers, housing companies, migration offices, childcare services, as was expressed by one social worker: "We help to try to bring in different help and call different authorities and caregivers and, with preschool classes and housing and all those practical things, we do a lot. We keep in touch with the Swedish Social Insurance Agency and the Swedish Migration Board" (LL).

Providers described that IPV services provision often succeeded when the provider worked closely with the woman's social support network. If a disabled woman already had her own support network, for example an active family member or caretaker, it was often enough for

the providers to work hand in hand with this network. However, if the disabled woman had no such social support network, providers worked together with the woman to create one. Providers shared that social networks were very important especially when attending to women with disabilities, because many of these women lived in isolation and had limited social interaction. In as much as this was the ambition, providers also highlighted that this was not always possible to accomplish.

Another form of collaboration mentioned was not necessarily tailored around the needs of the individual woman but rather at a structural level cross-sectoral collaboration for capacity strengthening. This involved working with the different institutions to organise joint staff trainings on violence, develop training materials, assessment of how work on violence was organised. As described “We have produced a joint handbook, or administrator support, for collaboration. All parties have their administrative support. But we have developed one that will apply to us in collaboration. That handbook consists a bit of "what is violence? “also, to be able to identify anxiety for example, what may be behind anxiety, depression, headaches, shoulder pain, abdominal pain or so on” (KH). “meeting others who work in the same, it's incredibly helpful, then we also try to learn things” (KN).

Themes in coordination and collaboration for providing services to women with disabilities.

Service providers describe the coordination and collaboration system of service provision for women with disabilities as characterised by five interrelated themes including pathways; risk assessment ; identification; protection and care; and empowerment and independence.

The pathways to services

The providers indicated that clients that often sought for services came through three different pathways: own agency, the whistle-blower and the professional.

Own agency: Service providers revealed that disabled women sometimes took own initiative to seek for professional help when faced with IPV. "Of course, some have no problem getting here and being here themselves" (AK). When own initiative was taken it often followed a series of crises where a woman was in a violent situation with an intimate partner on several occasions. The providers also noted that disabled women that often sought for care and support on their own, were knowledgeable of the existing IPV-related services, able to communicate and to move independently. In these cases, the woman would directly call a police hotline, contact a social service centre, visit a women’s shelter or a health care facility. However, providers also noted that it was rare for disabled women to take an initiative and seek for IPV help on their own. The following quote from the provider illustrates this. “The absolute most unusual way is that they themselves look for services themselves” (AN).

The Whistle Blower was the second pathway described by the service providers as used by women with disabilities to gain access to IPV services. In this case, contact to the provider was initiated by a third party, not the woman herself and not a service provider. This often resulted from someone else taking notice that a woman was experiencing intimate partner abuse and reaching out to connect her to the service providers. This person would either help the woman to initiate contact or would directly contact the service providers. The commonly mentioned whistle blowers were care givers, heads of home care centres, mentors, and a

“Godman”, who is described as a publicly commissioned guardian appointed to oversee the economic and judicial matters affecting citizens with intellectual disabilities [37]. Some providers described this as follows, "It can also be a goodman, or possibly a relative, but more often a goodman or mentors if they are these younger people, or personal assistants, or housing supervisors who flag (AGN)". “It may, for example, happen that you live in an LSS home and may get help from the staff to get in touch here and book an appointment for a call here on site (AK).

Professional agency was by far the largest pathway described by providers that women with disabilities used to access IPV services. The providers mentioned that during their day-to-day work they came across women with disabilities in need of IPV services. “vi kommer ju i kontakt med personer med funktionsnedsättning utifrån jobbet helt enkelt”. (ALG). There was clear a distinction in the ways this transpired, for example professionals whose main job task included providing IPV counselling reported that they screened for IPV regularly whether a woman expressed IPV concerns or not. Identified clients were informed about the available IPV services, even if clients came primarily seeking for other services. However, providers whose primary responsibility was not offering IPV services indicated that they did not regularly screen for IPV among women with disabilities. These instead asked about IPV when they suspected that a woman was currently being abused for example having visible bruises. Other warning signs seemed to differ from sector to sector. For example, community social workers whose many task was offering financial advice screened for IPV if a woman was continuously struggling to maintain her economy. Below is an example of how a service provider described warn signs that triggered IPV screening. “That it is visible that the patient has bruises or something else, or if it appears that they have finances issues, I think ... that one does not take care of their finances or that they feel exposed in different ways, so in that way it can come out. Then we ask the group of professionals if maybe the patient wants to continue talking or needs to talk in different ways, this we can manage to offer, we the counsellors ... then we usually also ask the patients. But many times, this can be a process” (MK). Providers also said that another common way of identifying women with disabilities was through referral by other providers. “So, but the one that is the most common, I would imagine .. there is some kind of personal that already exists around them. In other words, some form of professional in any case that exists around them (AGN). “One can get a referral both from primary care, from the university hospital and other units. Referrals can come from different places” (MK).

Risk assessment

Once contact was established between the disabled woman and the provider, the next step was to assess whether the woman was at risk of experiencing IPV. Providers mentioned that risk assessment was made at an early stage to identify current or future potential IPV risk. The provider below expressed this as follows: "The first thing I do when I meet a patient is to do an inquiry, where I then ask about their experience with intimate-partner violence, if they have experienced it and what it looks like" (ALG). The risk assessment process involved gathering detailed insights on what was happening within the intimate relationship. Providers mentioned that often risk assessment was an ongoing process, clients did not mention IPV at the first visit or even directly came seeking for IPV services on their first visit as illustrated by this quote, “One does not say this in the first conversation that it is about violence. Instead, perhaps one is applying for housing, or yes...support for substance abuse or something else.

Then after meeting the provider for some time, the experience of violence begins to come out". (AGN). Providers described that it required being careful in establishing rapport and building trust were the key facilitators that enabled women to open about their IPV experiences. "You also have to be very careful not to scare people somehow when you ask questions. You have to create an environment that enables her to tell you herself" (DH).

The approach used in risk assessment was often described differently by the providers depending on the provider's primary job description. Providers whose primary tasks included providing IPV services, these routinely conducted risk assessment for IPV. These also sometimes mentioned that they had a standardized IPV risk assessment tool. However, even though some of these providers reported having IPV assessment tools and protocols, they acknowledged difficulties in using these tools when working with women disabilities. The biggest challenge identified with these tools was that they were designed for use with all women in general and not adapted to the specific needs of women with disabilities. A few providers mentioned having screening tool adopted for the deaf women.

Providers whose primary task did not include offering IPV services often mentioned that they did not routinely screen for IPV in all disabled clients, but rather preferred to refer them to other providers. Rather they took an opportunistic approach, which involved screening for IPV in clients that they perceived to be at risk of experiencing IPV. Providers who worked within the health care mentioned that they usually initiated IPV screening when women presented with health problems that could indicate being exposed to IPV. For example, if a woman had bruises, wounds, unexplained fracture, and chronic somatic problems. Health care providers that primarily worked with children, saw a need for IPV risk assessment if a mother missing her child's appointment frequently or when a child developed emotional or behavioural problems. Some social workers who did not directly work with IPV described to consider risk assessment if during a session involving a couple, the partner behaved in a controlling manner toward the disabled woman. Even for providers who did not routinely assess risk to IPV, they generally viewed routine IPV assessment as important and mentioned that they had received information and some training on risk assessment from their respective institutions. However, time constraints and heavy workload was often reported as the main barriers to routine risk assessment as expressed by this provider, " You do not have time to talk so much. I think it is good, but sometimes it also takes time ... You send them to a psychologist or to someone who can take care of them, to the psychiatric clinic" (DB). These who were constrained to screen often chose to refer clients to other providers whom they thought had time to provide comprehensive IPV services.

Identification

Professionals expressed the importance of early identification of IPV among women with disabilities. They framed early identification as an important step that often led to timely IPV interventions leading to risk reduction and management strategies. IPV identification could take several forms, for some clients it was straight forward if they sought for IPV services by themselves in the first place. However, most clients it was not, in some cases women had visible signs like bruises, so the provider would straight away suspect IPV but needed to the woman to validate this. In such cases there was no signs and so the process began by establishing building rapport, risk assessment and identifying IPV. Some providers mentioned

that they paid special attention to the clients throughout all their interactions in the activities that the client engaged in looking for signs that might suggest IPV risk. This process tended to progress gradually until the client gains trust in the provider and is able to open up about the abuse, as expressed by here: “People might meet someone at the front desk, maybe someone who leaves blood samples at the lab... Someone notices during this visit that there is something that is not right. Then one can say that, I think there is much more going on in this family, to this person” (DH).

Ability to establish trust often resulted from asking questions that would help expand on whether the disabled woman was still experiencing abuse and how urgent the intervention was needed. Some professional indicated that even though this activity was performed at the beginning of contact, IPV identification was often an ongoing process repeated over the course of contact as the woman provided new information on her evolving life circumstances. Providers saw their role at this stage as one of providing information about IPV and listening empathetically. The level of information given by the service providers varied considerably based on the client’s needs.

Once IPV was recognised, the providers together with the woman worked to identify appropriate interventions. The provider informed the client about the available IPV services and how to access them. This included assuring the woman that IPV services would be confidential, personalised, and tailored to her situation. In addition, the provider would initiate collaboration with other providers that the woman chose to engage. Providers noted that offering personalized care was key when working with people with disabilities and it required the disabled woman being engaged in the process. The woman’s needs were constantly reviewed, and her consent continuously sought out.

Protection and safety

Once IPV was identified, the next step was to ensure protection and safety of the disabled. Protection involved engaging in activities that shielded the disabled woman from the abuser and created safety as illustrated by this participant, “We then first identified whether the person needed immediate protection or support. We assess whether or not there is a need for protection immediately ... an assessment must be made as to whether it can be stepped up, whether the person can be taken out of the home, whether there is danger to the person's life if there are children or other family members who may be exposed. contact police” (KH). Efforts were first geared towards establishing an immediate safe environment at home. Short term measures included providing access to a protected shelter in cases were a woman needed to move away from the abuser. Providers working at shelters indicated that a woman could find safety in the shelter. "One can definitely live in our sheltered housing if one needs to move from where they live right now due to violence" (LL). Once this was achieved, the provider and the disabled woman began to work on long term protection and safety by helping a woman to ensure a safe and healthy environment free from IPV. Some examples of how this was practically realised was discussions on always keeping the door locked, establishing who the visitor was before opening the door and reducing contact with the abuser. In cases were the woman continued to stay with the abuse, providers offered information on how to behave when the abuser came home. These activities and information were provided to enhance the woman’s own ability to ensure safe environments on a long-term basis.

Ensuring a woman's safety involved collaborative work not only between the woman and the provider, but it was also described to often stretch to include several IPV service provision agencies, supportive family members and friends to enable safe exit from abusive relationship. Where shelters being not viable options, finding an emergency home would require working with other in the woman's social networks. In addition, protection and safety also included providing hidden identity and, minimising harm to children. In the example below this provider offered support that involved accompanying the woman to other providers. "But also, there is more, we follow them to the lawyer and the police and the healthcare, very much (LL).

Where children are involved, protection and safety were also extended towards children. As discussed by the provider below, when children are involved the dynamics of service provision significantly changed such that cases were handled faster to ensure that children were removed from an abusive environment. In addition, the providers noted that such investigation remained open for a long time. "child social workers and those who have children, when there are children in the picture, they have a slightly greater responsibility... So, they do not close down their cases as quickly as we close. But the group of children, for example, they must have the case open longer. And if you have a contact with the adult group, it can be such a matter that goes on for a year longer, for example offering support or that one continues to have follow-up" (AK). In such circumstances, the consent of the woman was never a priority, rather providers were driven by the state duty to report violence where child abuse was evident or suspected. Providing protection and safety was not simply a stage that one reaches and passes, it was described as a continuous process that was examined and maintained regularly. Protection was often difficult to offer in cases where the provider suspects abuse, but the disabled woman does not disclose any abuse. In such cases the providers offered general inform to the woman about the type of help available, where, and how to find it. This was explained by one participant.

Empowerment and independence

According to our participants, a large component of the service provision included empowering women with disabilities. Empowerment was often expressed as providing a disabled woman with an economic standing, independent living and autonomy in decision making. Municipality social workers primarily working with individual, and family economic matters described offering economic and financial support as their primary task. They worked towards directly alleviating the client's financial concerns through offering economic sustenance in cases where the disabled woman was financially dependent on the abuser. This provider described this as follows "some women who come here for the first time and... no longer live with their husbands, we say, it's about money, it's about housing and it's about support. It's the first three, the first things" (AK). In some cases, some disabled women had their own income but needed support on how to manage this i.e., creating a bank account, accessing a credit card. For some women with disabilities who could work, the provider would support then in creating a CV and searching for employment.

Additionally, providers viewed empowerment to include a major component of enabling the disabled women to establish autonomy and self-determination. This involved creating opportunities for woman with disabilities to adapt their own individual strategies for assessing

their risk to IPV, risk management and identifying own strategies for IPV prevention. Providers also often described actively engaging the disabled women in decision-making on what services to access, when and where to seek for services. Autonomy was considered important even when disability was present, even though this was described as challenging. Challenges mentioned often varied depending on the nature of the disability. For example, women with mental or intellectual disabilities and those with communication difficulties were described to face unique difficulties in attempting to establish autonomy in a way that ensured safety from violence. In the example below, the provider describes a situation when the disabled woman seeks to act autonomously, and the several obstacles encountered in doing so: “I have met a woman with a mild developmental disorder. She has quite a lot of integrity and tries to make own decisions concerning her life herself.. but then she calls me one day and she is very very upset, she had met a man in town who asked if he can follow her home. She accepted to go with him, he then beat her and tried to rape her .. she calls me when he has just left and she is really upset and cries a lot and screams and it was very difficult to understand her because this woman also has a language impairment. So I go to her and we talk and she is very sad and very upset and I talked to her about reporting this to the police .. she wanted to go there by herself, she does so... Then time passes for a while and she calls again and again when she is with the police and it is very difficult to understand what they are asking her. They want to of course do what they can to try to keep an eye around the city regarding which people follow her around, but it gets no signals.” (AS).

"We have also had a group for young girls with intellectual disabilities to promote their self-defense, tell them that one has a right to say no, you have the right to like know what it means to have the right to your own body? As part of this to make things clear” (LL). Empowerment also included facilitating the client’s own participation in self-care activities.

Discussion

The current study provides the perspectives of IPV service providers on what works in providing services to disabled women exposed to IPV. Creating a “coordination and collaboration system of IPV service provision was identified as a preferred approach for providing service in this population. This approach involved multisectoral collaboration, steered by a coordinator described as a “spider in the net”. The providers further illustrated that service provision for women with disabilities was organised in four overarching actions described as pathways; screening and identification; protection and care; and empowerment and independence.

The current core of IPV service provision for women with disabilities was built upon a system of referral, professionals continuously evaluated the degree of correspondence between the woman and the referral service provision sectors. However, providers noted that when a woman is disabled referral was not enough, putting a lot of emphasis on the need for active collaboration instead of referring the women. However, we noted a mismatch between current practice and what the providers wished. Ideally, the wish and ambition of the providers was to establish comprehensive collaboration for each disabled woman seeking IPV service. At the same time, many admitted that they often resorted to the traditional referral system, referring clients to other providers where they assumed would have enough time to coordinate services on the client’s behalf. It was obvious that in judging how successful service provision was for people with disabilities some providers relied heavily on the performance of other actors where they referred cases and not on their own. Relying on the performance of other

providers has implications on the quality of services offered, it is possible that all providers assume that the next provider will do a better job which might imply that the needs of the disabled women could remain unmet. There is a need for a central person ensuring thorough collaboration and coordination.

In this study risk assessment was viewed as an important step for identifying abused women with disabilities and those at high IPV risk. This finding supports evidence showing that assessing IPV leads to women's receipt of interventions and improved health [38]. This also further emphasizes that health sector, police and social work is keen at promoting the importance of risk assessment through screening for exposure to violence [36, 39-42]. However, despite this awareness, we identified a need for specialized training on IPV risk assessment within the disabled context. Providers revealed that risk assessment among women with disabilities presented unique challenges related to lack of skills on how to implement screening among women with disabilities related to communication. Additional providers reported a lack of screening tools adapted for use among women with the different forms of disabilities. In addition, lack of confidence and knowledge on dealing with situations involving IPV, lead to hesitation to address IPV. We recommend increased training and refresher courses for service providers who meet people with disabilities. It is valuable to develop an interactive screening tool for training all professionals (e.g., health care professionals, social workers, police officers, non-government professionals working in women shelters) who meet regularly meet and work with disabled women. This tool should later be adapted for each professional sector. Moreover, proper risk assessment tools are shown to enhance facilitation of communication with providers in other settings such as police, prosecutorial and judicial responses to IPV as they provide a consistent language regarding risk factors and the measurement of risk [42].

We call for a more systematic approach in the way organisational settings integrate IPV risk assessment/screening by professionals that interact with abused women with disabilities. Extensive literature shows that successful implementation of IPV work is dependent on the extent to which organisational settings promote the implementation of the required changes [43, 44]. The extent to which new changes are implemented is partly a function of organizational climate that provides incentives for implementation and removal of barriers to implementation [44]. In the current study some providers pointed to time constraint as a major barrier in screening for IPV as this task was viewed as a secondary. Failure to screen for IPV, say in health settings represents a missed opportunity as routine IPV screening may be the only chance for the abused women to access structured IPV intervention [43]. Women with disabilities are considered high-level health care consumers due to high rates of mental disorder, exposure to multiple forms of abuse and high rates of child sexual abuse [45]. Taking the opportunity to screen for IPV should be included among the primary role of practitioners in these organisations. Campbell et al. (2001) defined environmental support for screening as having protocols for screening and intervention, brochures, posters, and intervention check lists for staff to use following the identification of victims [46]. We call for more coordinated efforts to ensure that service provision sectors within the Swedish society have such tools pertaining to screening for IPV among people with disabilities. In addition, there is need for trainings and re-trainings aimed at increased awareness of the importance of screening for IPV among women with disabilities. This is especially important in this population as providers in this study observed that disabled women rarely initiated seeking for IPV services on their own.

This study further showed that service providers consider client empowerment and independence as major milestones in providing services to women with disabilities. IPV interventions that address IPV survivors' housing insecurity and financial autonomy were key in enabling the disabled women to dare to leave the abusive partner. Women shelters were viewed as an effective housing intervention in times emergency and a good starting point for establishing safety and enabling the disabled women to live independently. Previous findings indicate both traditional shelter services and innovative interventions (e.g., rapid rehousing, flexible funding) contribute to housing strategy effectiveness [47].

Even though the focus of this study was on the role of professional services providers, we found evidence that supportive informal networks are important to include in the coordination and collaboration system of providing IPV services. Informal networks including family members and friends of the disabled woman were suggested as a crucial group that can help with facilitating collaboration with the different actors. This finding is in line that identified the importance of informal networks, showing that abused women were more likely to confide in someone close to them other than the professional service providers. Quantitative data indicated that women are more likely to talk to a family friend (69%) than to a domestic violence program, doctor, or nurse (34%), mental health counsellor (30%) [48]. Also reports from Sweden reported similar observations (Handu, 2007). However, in this study the providers noted that this group was not often very active in helping women with disabilities to access IPV services.

Conclusion

Interviews with service providers yielded the coordination and collaboration IPV service provision as ultimately an important model for providing IPV services among with disabilities. This model emphasizes the importance of collaboration steered by a coordinator who was described as the spider-in-the-net". This approach was considered instrumental because women with disabilities often faced several disability related barriers that made it difficult to access all the necessary service on their own. We further identified a need for increased provider awareness on the importance of routine risk assessment and risk identification among women with disabilities. There is a need for more research on how to organise collaboration one of the possible solutions would is to create platforms that increase participation and interaction of the different networks of IPV service professionals that meet women with disabilities. Such networks will in turn recommends actions for improving IPV services for all women with disabilities and reducing social and health inequalities by developing policies and targeted interventions for women with disabilities.

Reference

1. Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH, Health WHOM-cSoWs, Domestic Violence against Women Study T: **Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence.** *Lancet* 2006, **368**(9543):1260-1269.
2. Hughes K, Bellis MA, Jones L, Wood S, Bates G, Eckley L, McCoy E, Mikton C, Shakespeare T, Officer A: **Prevalence and risk of violence against adults with**

- disabilities: a systematic review and meta-analysis of observational studies.** *Lancet* 2012, **379**(9826):1621-1629.
3. Brownridge DA: **Partner violence against women with disabilities: prevalence, risk, and explanations.** *Violence Against Women* 2006, **12**(9):805-822.
 4. Jones L, Bellis MA, Wood S, Hughes K, McCoy E, Eckley L, Bates G, Mikton C, Shakespeare T, Officer A: **Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies.** *Lancet* 2012, **380**(9845):899-907.
 5. Nosek MA, Foley CC, Hughes RB, Howland CA: **Vulnerabilities for Abuse Among Women with Disabilities.** *Sexuality and Disability* 2001, **19**(3):177-189.
 6. Andersson T, Heimer G, Lucas S: **Violence and health in sweden : a national prevalence study on exposure to violence among women and men and its association to health.** In: *NCK report*. Uppsala: National Centre for Knowledge on Men's Violence Against Women (NCK); 2015: 94.
 7. Thomas KA, Joshi M, Wittenberg E, McCloskey LA: **Intersections of harm and health: a qualitative study of intimate partner violence in women's lives.** *Violence Against Women* 2008, **14**(11):1252-1273.
 8. Ellsberg M, Jansen HA, Heise L, Watts CH, Garcia-Moreno C, Health WHOM-cSoWs, Domestic Violence against Women Study T: **Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study.** *Lancet* 2008, **371**(9619):1165-1172.
 9. **Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook**
 10. Evans MA, Feder GS: **Help-seeking amongst women survivors of domestic violence: a qualitative study of pathways towards formal and informal support.** *Health Expect* 2016, **19**(1):62-73.
 11. Rose LE, Campbell J, Kub J: **The role of social support and family relationships in women's responses to battering.** *Health Care Women Int* 2000, **21**(1):27-39.
 12. WHO: **Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.** In. Geneva, Switzerland: World Health Organisation; 2013.
 13. McFarlane J, Symes L, Maddoux J, Gilroy H, Koci A: **Is length of shelter stay and receipt of a protection order associated with less violence and better functioning for abused women? Outcome data 4 months after receiving services.** *J Interpers Violence* 2014, **29**(15):2748-2774.
 14. Feder GS, Hutson M, Ramsay J, Taket AR: **Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies.** *Arch Intern Med* 2006, **166**(1):22-37.
 15. Fraser-Barbour Ellen F, Crocker R, Walker R: **Barriers and facilitators in supporting people with intellectual disability to report sexual violence: perspectives of Australian disability and mainstream support providers.** *The Journal of Adult Protection* 2018, **20**(1):5-16.
 16. Evans MA, Feder GS: **Help-seeking amongst women survivors of domestic violence: a qualitative study of pathways towards formal and informal support.** *Health Expect* 2016, **19**(1):62-73.
 17. Trevillion K, Howard LM, Morgan C, Feder G, Woodall A, Rose D: **The response of mental health services to domestic violence: a qualitative study of service users' and professionals' experiences.** *J Am Psychiatr Nurses Assoc* 2012, **18**(6):326-336.

18. Di Napoli I, Procentese F, Carnevale S, Esposito C, Arcidiacono C: **Ending Intimate Partner Violence (IPV) and Locating Men at Stake: An Ecological Approach.** *Int J Environ Res Public Health* 2019, **16**(9).
19. Young CR, Arnos DM, Matthews LT: **A scoping review of interventions to address intimate partner violence in sub-Saharan African healthcare.** *Glob Public Health* 2019, **14**(9):1335-1346.
20. Autiero M, Procentese F, Carnevale S, Arcidiacono C, Di Napoli I: **Combatting Intimate Partner Violence: Representations of Social and Healthcare Personnel Working with Gender-Based Violence Interventions.** *Int J Environ Res Public Health* 2020, **17**(15).
21. NCCP: **National Council for Crime Prevention (NCCP). Brott i nära relationer: En nationell kartläggning. [Crimes committed within an intimate partner relationship: A national survey (Brå-rapport 2014:8)].** Stockholm: Author. Retrieved from www.bra.se. In.; 2014.
22. SOU: **Våld i nära relationer – en folkhälsofråga. [Violence within Close Relationships - A Public Health Issue].** Stockholm: Fritzes; 2014:49. 2014.
23. Gunnarsson Å, Svensson E-M, Davies M: **Reflecting the Epistemology of Law - Exploiting Boundaries.** In: *Exploiting the limits of law : Swedish feminism and the challenge to pessimism.* edn.: Ashgate, Aldershot; 2007: 1-15.
24. **Social Services Act (SoL) (2001:453).** Swedish Parliament.
25. Tideman M: **Education and support for people with intellectual disabilities in Sweden: policy and practice.** *Research and Practice in Intellectual and Developmental Disabilities* 2015, **2**(2):116-125.
26. **Act Concerning Support and Service for Persons with Certain Functional Impairments (LSS), (1993:387).** Swedish Parliament.
27. Perlinski M, Morén S, Blom B: **Evaluation and the organization of social work in the public sector.** . In: *SVUF conference *Utvärdering i politiken och politiken i utvärdering**. vol. 13-15 november 2013. . Stockholm; 2013.
28. Perlinski M, Blom B, Morén S, Lundgren M: **The Dialectics Between Specialization and Integration: Politicians' and Managers' Views on Forms of Organization in the Swedish Social Services.** *Administration in Social Work* 2010, **35**(1):60-87.
29. NBHW: **NBHW. National Board of Health and Welfare. (2014) Directives. Violence in close relations. SOFS 2014:4.** Stockholm: National Board of Health and Welfare. 2014.
30. Strand SJM, Fröberg S, Storey JE: **Protecting victims of intimate partner violence: Swedish prosecutors' experiences of decision-making regarding restraining orders.** *Journal of Scandinavian Studies in Criminology and Crime Prevention* 2018, **19**(2):170-186.
31. Belfrage H, Strand S, Storey JE, Gibas AL, Kropp PR, Hart SD: **Assessment and management of risk for intimate partner violence by police officers using the Spousal Assault Risk Assessment Guide.** *Law Hum Behav* 2012, **36**(1):60-67.
32. **The Swedish National Police Agency. (2010). Inspektion av polismyndigheternas hantering av rutiner vid bl.a. riskanalyser. Inspektionsrapport 2010:8. [An inspection of the routines the police use when handling risk analysis. Report 2010:8].** Stockholm: Rikspolisstyrelsen.
33. Broidy L, Albright D, Denman K: **Deterring Future Incidents of Intimate Partner Violence: Does Type of Formal Intervention Matter?** *Violence against women* 2015, **22**(9):1113-1133.
34. L. M: **Motivations, opportunities and constraints. Voluntary labour in women's refuges and crisis centres.** . In: *Meddelanden från Socialhögskolan 2003:4 Social*

- consequences of changing labour market conditions and undeserved personal virtues Lectures on age, class, ethnicity and gender. Volume (no. 4, pp. 78–89). edn. Edited by IL H. Lund: (no. 4, pp. 78–89). 2003.*
35. Helmersson S, Jönson H: **The use of ‘empowerment’ among organisations supporting victims of domestic violence in Sweden.** *European Journal of Social Work* 2015, **18**(1):51-64.
 36. **The Swedish National Police Agency. Inspektion av polismyndigheternas hantering av rutiner vid bl.a. riskanalyser. Inspektionsrapport. 2010:8 . [An inspection of the routines the police use when handling risk analysis]. 2010:8.Stockholm. Rikspolisstyrelsen**
 37. Mallander O: **Young adults with intellectual disabilities in Sweden: power, self-determination, and self-organisation in everyday life.** *Research and Practice in Intellectual and Developmental Disabilities* 2015, **2**(2):194-206.
 38. McCloskey LA, Lichter E, Williams C, Gerber M, Wittenberg E, Ganz M: **Assessing intimate partner violence in health care settings leads to women's receipt of interventions and improved health.** *Public Health Rep* 2006, **121**(4):435-444.
 39. O'Doherty L, Hegarty K, Ramsay J, Davidson LL, Feder G, Taft A: **Screening women for intimate partner violence in healthcare settings.** *Cochrane Database Syst Rev* 2015, **2015**(7):Cd007007.
 40. Sprague S, Slobogean GP, Spurr H, McKay P, Scott T, Arseneau E, Memon M, Bhandari M, Swaminathan A: **A Scoping Review of Intimate Partner Violence Screening Programs for Health Care Professionals.** *PLoS One* 2016, **11**(12):e0168502.
 41. Feltner C, Wallace I, Berkman N, Kistler C, Middleton JC, Barclay C, Higginbotham L, Green JT, Jonas DE: **U.S. Preventive Services Task Force Evidence Syntheses, formerly Systematic Evidence Reviews.** In: *Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: An Evidence Review for the US Preventive Services Task Force.* edn. Rockville (MD): Agency for Healthcare Research and Quality (US); 2018.
 42. Messing JT, Thaller J: **Intimate Partner Violence Risk Assessment: A Primer for Social Workers.** *The British Journal of Social Work* 2014, **45**(6):1804-1820.
 43. Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R, Kuntze S, Spencer A, Bacchus L, Hague G *et al*: **How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria.** *Health Technol Assess* 2009, **13**(16):iii-iv, xi-xiii, 1-113, 137-347.
 44. Klein KJ, Sorra JS: **The Challenge of Innovation Implementation.** *The Academy of Management Review* 1996, **21**(4):1055-1080.
 45. Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, Teesson M, Bryant R, McFarlane AC, Mills KL *et al*: **Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function.** *Jama* 2011, **306**(5):513-521.
 46. Campbell JC, Coben JH, McLoughlin E, Dearwater S, Nah G, Glass N, Lee D, Durborow N: **An Evaluation of a System-change Training Model to Improve Emergency Department Response to Battered Women.** *Academic Emergency Medicine* 2001, **8**(2):131-138.
 47. Klein LB, Chesworth BR, Howland-Myers JR, Rizo CF, Macy RJ: **Housing Interventions for Intimate Partner Violence Survivors: A Systematic Review.** *Trauma Violence Abuse* 2019:1524838019836284.

48. Goodman L, Dutton MA, Weinfurt K, Cook S: **The Intimate Partner Violence Strategies Index: Development and Application.** *Violence Against Women* 2003, **9**(2):163-186.